1995

Experience with the DMPA injectable contraceptive: Findings from a survey of DMPA acceptors

Maria Carmela Patron

Marilou P. Costello
Population Council

EXPERIENCE WITH THE DMPA INJECTABLE CONTRACEPTIVE:

Findings from a Survey of DMPA Acceptors

PHILIPPINES

Maria Carmela Patron
Marilou Palabrica-Costello

Final Report

USAID Contract No. DPE-3030-Q-00-0023-00
Strategies for Improving Family Planning Service Delivery

FAMILY PLANNING OPERATIONS RESEARCH AND TRAINING PROGRAM (FPORTP)

The Population Council, Manila
in collaboration with
the Department of Health

ASIA & NEAR EAST OPERATIONS RESEARCH AND TECHNICAL ASSISTANCE PROJECT

August 1995

ACKNOWLEDGEMENT

This study was made possible with support from the Population Council's Asia and Near East Operations Research and Technical Assistance (ANE OR/TA) Project. The ANE OR/TA Project is funded by the U.S. Agency for International Development, Office of Population, Health and Nutrition, under Contract No. DPE-3030-Q-00-0023-00, Strategies for Improving Family Planning Service Delivery.

The authors wish to acknowledge, with sincere thanks and gratitude, the following individuals and institutions for their valuable contribution to this study:

1) the Department of Health, Office of Special Concerns under the leadership of Dr. Carmencita Reodica:

2) the Department of Health, Family Planning Service division, under the leadership of Dr. Rebecca Infantado;

3) the regional, provincial and city health and population officers, family planning coordinators and staff of Baguio City, Quezon City, Laguna, Pangasinan, Cebu, Davao del Sur, Davao City, Surigao del Sur and South Cotabato;

4) the DMPA service providers of the sampled health facilities;

5) the research staff of the Research Institute for Mindanao Culture (RIMCU) of Xavier University, under the supervision of Prof. Lita Sealza; the Social Development Research Center (SDRC) of De La Salle University under the supervision of Dr. Trinidad Osteria; and the Social Research Office (SRO) of Ateneo de Davao University under the supervision of Prof. Marlina Lacuesta, who were responsible for data collection and data processing;

6) the staff of the Family Planning Operations Research and Training Program (FPORTP) of the Population Council, Manila; and

7) the 899 women from Baguio City, Quezon City, Pangasinan, Laguna, Cebu, Davao del Sur, Davao City, Surigao del Sur and South Cotabato who so generously gave their time to participate in the survey.

TABLE OF CONTENTS

TABLE OF CONTENTS (Continued)

Page

LIST OF FIGURES AND TABLES

Title **Page**

EXPERIENCE WITH THE DMPA INJECTABLE CONTRACEPTIVE: Findings from a Survey of DMPA Acceptors

INTRODUCTION

This report presents the results of a survey of 899 DMPA acceptors who availed of injectable contraceptive services from public health facilities under the Philippine Department of Health's (DOH) DMPA Reintroduction Program. The survey is part of the DMPA Monitoring and Follow-up Studies which was sponsored by the Population Council Manila office in response to a request by the DOH to provide operations research support to the program.

Depot-medroxyprogesterone acetate (DMPA), commonly known as Depo-Provera, is a three-month injectable contraceptive. It was recently officially endorsed as a family planning program method by the DOH, following its approval by the Philippine Bureau of Food and Drugs (BFAD) in November 1993.

The DMPA Reintroduction Program: Background Information

DMPA as a program method was launched by the DOH in April 1994 in six provinces and four chartered cities spread over seven administrative regions throughout the Philippines (see Figure 1). The program aims to reintroduce DMPA into the Philippine Family Planning Program (PFPP) through the training of local-level midwives, nurses and doctors as DMPA service providers, and by the provision of free DMPA services in selected public health facilities nationwide. It is being implemented in three phases between 1994-1995.

Baguio City

Quezon City

Pangasinan
Laguna
Cebu
Iloilo City

Surigao del Sur

South Cotabato
Davao City
Davao del Sur

Figure 1. LGUS Involved in Phase I of the DMPA Reintroduction Program

Phase I concentrates on ten pilot local government units (LGUs) composed of Baguio City, Quezon City, Laguna, Pangasinan, Cebu, Iloilo City, Davao del Sur, Davao City, South Cotabato and Surigao del Sur. Phase II calls for the expansion of DMPA services in early 1995 to the rest of the cities and provinces within the seven regions where the ten pilot LGUs are located. By the third phase, it is envisioned that DMPA services will be available in all of the 15 regions of the Philippines (Population Council, 1994:3).

The DMPA Monitoring and Follow-up Studies

The Population Council Manila office, through its Family Planning Operations Research and Training (FPORT) Program, has undertaken the DMPA Monitoring and Follow-up Study as a technical assistance project in support of the DOH's DMPA Reintroduction Program. The study aims to provide the program, through the DMPA Task Force, with data on DMPA utilization, on drop-out and continuation rates, and on the experiences of users, drop-outs and service providers of this particular method. It is expected that results of the study will serve as a basis for policies and program interventions that would enhance quality of care for clients.

The overall DMPA project used four data collection strategies:

1) a regular, monthly monitoring system that kept track of the number of DMPA acceptors and continuing users in 1,380 DMPA-dispensing facilities located in the ten LGUs covered by Phase I of the program;

2) a longitudinal study which would follow the experience of approximately 900 DMPA acceptors and identify reasons for continuation and dropping out, including issues of side effects management

3) focus-group discussions (FGDs) with DMPA drop-outs, non-users and husbands of DMPA acceptors to further explore the issues that emerged in

the survey findings; and

4) interviews with selected DMPA service providers.

This report focuses on the results of the first survey conducted between February and March, 1995, among 899 randomly selected women who had their first DMPA injections between April and September, 1994. The respondents were drawn from a list of acceptors in 100 sampled public health facilities located in nine of the ten pilot LGUs covered by Phase I of the program.

OBJECTIVES OF THE SURVEY

The first survey was undertaken primarily to draw a socio-economic and demographic profile of DMPA acceptors and to determine their knowledge, perceptions, attitudes and experience with DMPA. Information drawn from this study will serve as inputs to the program in order to help program managers address the needs and problems of their clientele, and to develop appropriate interventions which could help improve the existing FP service delivery system.

Specifically, the survey sought to gain information on the DMPA acceptors':

1) socio-economic and demographic profile: age, education, place of birth, religion, employment and income (including that of their husbands');
2) marital history: age at marriage, type of marriage;
3) contraceptive history: first FP use, previous method prior to DMPA, reasons for discontinuing use of method prior to DMPA;
4) reproductive history: pregnancy, miscarriage/abortion, parity;
5) reproductive plans: desire to have more children, when and how many;
6) knowledge of DMPA and other FP methods: sources of information, what

they know about DMPA;

7) motivation/reasons for using DMPA;
8) experiences with DMPA use, particularly side effects;
9) management of DMPA side effects;
10) reasons for continuing or stopping DMPA use;
11) communication with husbands about FP, desired family size and DMPA use; and
12) peer and family opinions about DMPA.

DMPA acceptors were also asked to evaluate the program in terms of accessibility and availability of services and supplies, quality of counselling, screening and "post-injection" care given by the service providers, as well as the availability of IEC materials on DMPA. This sort of information should prove helpful in determining where improvements in service delivery are needed.

METHODOLOGY

Sample Size and Sampling Procedure

A total of 899 DMPA acceptors were randomly selected from 100 public health facilities covered by Phase I of the DMPA Reintroduction Program. Except for Iloilo City[1], all of the pilot LGUs were included in the original sampling frame. These included Baguio City, Quezon City, Laguna and Pangasinan in the island of Luzon; Cebu in the Visayas; and Davao City, Davao del Sur, South Cotabato and Surigao del Sur in Mindanao.

The sampled facilities were selected from among a list of barangay health stations (BHSs), rural health units (RHUs), main health centers (MHCs), public hospitals and other

[1] Iloilo City was excluded in the sample due to the relatively small number of DMPA acceptors reported at the time of sample selection.

government facilities in the nine LGUs, which had recorded at least ten DMPA acceptors between April and September, 1994. The probability proportionate to size (PPS) technique was used in carrying out this step. The list was based on the monthly reports received by the DMPA Monitoring Study team. One hundred facilities were selected, with the appropriate number of respondents per facility being randomly drawn from the clinic records of DMPA acceptors between April and September 1994.

The distribution of the sample facilities and respondents per LGU is presented in Table A below.

Table A. Distribution of Sample Facilities and Respondents per LGU

LGU	Number of Facilities	Number of Respondents (DMPA Acceptors)
LUZON		
Baguio City	3	36
Quezon City	8	122
Laguna	6	55
Pangasinan	30	251
VISAYAS		
Cebu	18	151
MINDANAO		
Davao City	4	32
Davao del Sur	17	127
South Cotabato	13	106
Surigao del Sur	1	19
TOTAL	100	899

Survey Instrument

A standard, structured survey instrument was developed by the Population Council Manila office for this study. The original was in English, but it was later translated into four local dialects, namely Tagalog, Pangalatok, Ilocano and Cebuano.

The instrument was divided into nine blocks or sections of information, as follows:

Block A - Respondent's Background
Block B - Husband's Background
Block C - Marital History
Block D - Pregnancy/Childbearing History
Block E - Contraceptive History
Block F - Adoption/Use of DMPA
Block G - Respondent's Experience with DMPA
Block H - Husband-Wife Communication Over Family Size and Family Planning Practice
Block I - Relatives' and Peer Opinion on DMPA

Data Collection

The actual survey was conducted between February and March, 1995 by three collaborating research institutions. The interviews in Luzon were conducted by the staff of the Social Development Research Center (SDRC) of De La Salle University, under the supervision of Dr. Trinidad Osteria. Data collection in Visayas was undertaken by the staff of the Research Institute for Mindanao Culture (RIMCU) of Xavier University and supervised by Prof. Lita Sealza, while the survey in Mindanao was conducted by the staff of the Social Research Office (SRO) of Ateneo de Davao University, under the supervision of Prof. Marlina Lacuesta. Overall coordination of the study was done by the Population Council Manila office.

Data Processing and Analysis

All questionnaires were field edited by the respective survey team supervisors before the data were coded. All coded questionnaires were then sent to RIMCU for further editing, encoding and processing, using the SPSSPC+ software.

Data analysis and write-up of the report were subsequently carried out by the FPORTP staff. In this report, frequency distributions of the variables will be presented, with some measures of central tendency (mean and median) wherever appropriate. Crosstabulations were also done especially where comparisons between groups of women (e.g., first-time FP users, vs. method-shifters, pregnant vs. "non-pregnant" women, "spacers" vs. "stoppers") were being made with respect to certain key variables. This paper, however, will largely confine itself to a descriptive analysis of the frequency distributions observed for the major study variables.

RESULTS OF THE STUDY

PROFILE OF DMPA ACCEPTORS

Seven out of ten DMPA acceptors were born in a rural area. Almost all (97%) were residing within the catchment area of the sampled health facilities. Most (82%) of the women were Catholic (see Table 1).

The respondents were relatively young: a little over half (55%) were no more than 29 years old. The youngest respondent was 17 years old and the oldest was 45. The average age was 29.2 years.

The women were also highly educated. Seven out of ten (73%) have attended at least one year in high school, including a fifth (21%) who have reached college. Average number of years in school is 8.9, which is equivalent to a third year level in high school.

Despite their education, a majority (62%) of the women were not gainfully employed. Only 38 percent were engaged in some income-generating activity at the time of the survey.

Among those who were working, a majority (61%) were self-employed. Almost half (45%) earned their incomes from a commercial or sales position. Some were employed as production workers (20%), professionals (9%), clerks (4%) or worked in the service industry (15%). A few (7%) helped on the farm.

Monthly incomes earned by working women ranged from as low as P30 to as high as P21,000, with the average coming to P1,888 per month. The median income per month was P1,000 which means that half of the working women were earning this amount or even less.

PROFILE OF RESPONDENTS' HUSBANDS

Seven out of ten respondents have husbands who were also born in a rural area. Most (82%) husbands were also Catholics.

The husbands were slightly older than their wives. On average, a respondent's spouse was three years older than she, at 32.6 years of age.

The respondents' spouses were also relatively well educated. Seven out of ten (72%) have had at least some high school education, including a quarter who have completed at least a year in college (see Table 1). Average number of years in school is 9, which is equivalent to a third year level in high school.

Most (97%) of the husbands were gainfully employed. Three out of ten worked as farmers or fishermen. The rest were employed in the transport industry (24%), crafts and production (21%), services (9%), sales (6%) and mining (2%). A few worked either as professionals (3%) or clerical workers (2%).

Forty-three percent of those who were currently employed worked in the private sector, while 36 percent were self-employed. Eight percent worked in the public sector.

Monthly incomes ranged from as low as P133 to as high as P20,250. At an average of P2,939 per month, the husbands were earning about one and a half times as much as their wives. Half of the husbands, however, have monthly incomes of no more than P2,500.

Total household incomes ranged from as low as P48 to as high as P60,000 per month. The mean household income was P3,675 while the median was only P3,000.

Table 1. Profile of Respondents and their Husbands

Variable	Respondents	Husbands
A. Place of Birth		
% Rural	69.9	70.2
B. Location of current residence		
% Within catchment area of health facility	97.0	-
C. Religion		
% Catholic	81.8	81.9
C. Mean age (years)	29.23	32.55
D. Education		
% No schooling	0.6	0.3
% Grade school	26.1	27.5
% High school	52.0	46.7
% College/Post-graduate	21.2	25.5
Mean no. of years in school	8.9	9.0
E. Employment		
% Currently employed	37.6	97.4
F. Type of employment		
% Self-employed	61.5	35.8
% Works in private sector	17.8	43.4
% Works in public sector	10.4	7.9
% Others (not specified)	10.4	12.9
G. Occupation		
% Farming/fishing	7.4	30.6
% Sales	44.7	6.0
% Production/crafts	19.5	21.4
% Transportation/communication	0.3	23.6
% Professionals/administrative positions	8.6	3.0
% Clerical workers	4.1	1.6
% Service workers	15.4	9.2
% Mining	0.0	1.6
H. Monthly Income (pesos)		
Range	30 - 21,000	133 - 20,250
Mean Income	1,888	2,939
Median Income	1,000	2,500
I. Monthly Household Income (pesos)		
Range	48 - 60,000	-
Mean Income	3,675	
Median Income	3,000	

Number of cases (n) = 899 except for items (F) and (G) where n is equal to the number of currently

employed.

MARITAL HISTORY

In general, the women married young. Fifty-seven percent were already wed at age 20. By age 22, about eight out of ten (77%) respondents had married. The average age of marriage among the female respondents was 20.3 years (see Table 2).

On the other hand, the average age of their husbands at marriage was 23.5 years. At age 22, only half of the husbands have been married but by age 26, this figure had climbed to almost eight out of ten (79%).

Six out of ten respondents (62%) were married in church. About one in four had a civil wedding while 13 percent were living in a consensual union. For most (97%) of the respondents, their present marriage was their first.

Table 2. Marital History

Variable	Percent [a]
A. Respondent's Mean Age at Marriage (years)	(20.3)
B. Husband's Mean Age at Marriage (years)	(23.5)
C. Type of Marriage	
Married in church	62.0
Had a civil wedding	24.5
Consensual union	12.6
Others	1.0
C. Number of Times Respondent Ever-Married	
Once	96.6
More than once	3.4

[a] Number of cases = 899

REPRODUCTIVE HISTORY

Of the total sample, only one respondent was without a child. The rest had from one to as many as ten children. About two-thirds (64%), however, had three or fewer children at the time of the survey. The average number of children per respondent was 3.2 (see Table 3).

Four out of ten respondents have very young first-borns, aged between 0 to 5 years. Thirty percent have first-borns aged 6 to 10 years old. On average, the first-born children of our respondents were 7 years old.

The reported number of pregnancies per respondent ranged from one to 13; or an average of nearly four (3.6) pregnancies per woman. A majority (54%), however, have not had more than three pregnancies.

Twelve percent of the women have had at least one child who died, and one in four have had at least one miscarriage or abortion. Two out of three deaths to children occurred before the age of one while about three out of ten (29%) occurred between ages 1 to 5 years.

Table 3. Reproductive History

Variable	Percent [a]
A. Current Number of Living Children	
0	0.1
1-3	64.0
4-6	30.3
7-10	5.6
Mean number of children	(3.18)
B. Number of Pregnancies	
1-3	54.5
4-6	36.4
7-13	9.1
Mean number of pregnancies	(3.62)
C. Number of Children who Died	
0	88.1
1-3	11.8
4-more	0.1
D. Number of Miscarriages/Abortions	
0	75.0
1	21.7
2	2.9
3	0.4
E. Age of Child at Death (years)	
0	66.4
1-5	28.9
Older than 5	4.7

[a] Number of cases (n) = 899 except item (E) where n is equal to the total number of child deaths

DMPA ACCEPTORS WHO ARE CURRENTLY PREGNANT

Since a majority (68%) of the respondents were current users of DMPA at the time of the survey, it was expected that the incidence of pregnancy in the sample would be quite low and that pregnancy would be found only among the drop-outs. The findings show that,

of the 899 women who were surveyed, 15 (or 1.7%) were found to be currently pregnant. Nine women were on their first trimester of pregnancy while the remaining six were on their second trimester of pregnancy (see Table 4).

Of the 15 pregnant women in the sample, 13 have had only one DMPA injection, which they received between June to August 1994. All except one have already discontinued use of DMPA, due to a large extent to the side effects (67%) which they have experienced. These include amenorrhea, headaches and abdominal pain.

Table 4. Profile of Currently Pregnant Women

Variable	Frequency	Percent [a]
A. Number of Months Pregnant		
First trimester: 1-3 months	9	60.0
Second trimester: 4-6 months	6	40.0
B. Total Number of Injections Received as of Survey		
One	13	86.7
Two	1	6.7
Three	1	6.7
C. Month/Year of First Injection		
June 1994	3	20.0
July 1994	6	40.0
August 1994	5	33.3
September 1994	1	6.7
D. Reason for stopping DMPA use		
Experienced side effects	10	66.7
Missed appointment	1	6.7
No medicine available	1	6.7
No response	3	20.0

[a] Number of cases = 15

On average, the pregnant women in the sample were younger by two years than their "non-pregnant" counterparts. They also had, on average, one less child than those who were

not pregnant at the time of the survey. Data in Table 5 show that the average age of pregnant women was 26.9 years compared to 29.3 years for non-pregnant women. Meanwhile, the average number of children among the pregnant women was 2.3 compared to 3.2 among those who were not pregnant.

The desire to have at least one more child was also more pronounced among the pregnant women. Fifty-three percent of those who were pregnant wanted to have at least one more child in the future, compared to only 38 percent of those who were not pregnant at the time of the survey.

Table 5. Comparison of Pregnant and "Non-Pregnant" Women

Variable	Pregnant women (n=15)	Women who were not pregnant (n=884)
A. Mean Age (years)	26.96	29.3
B. Mean Number of Children	2.3	3.2
C. Desire for another pregnancy		
Wants to have at least one more child	53.5	38.2
Does not want any more children	46.7	61.8

FUTURE PLANS ABOUT PREGNANCY

A majority (62%) of the respondents said that they do not want to have any more children in the future. The remaining 38 percent, however, wanted at least one more child (see Table 6).

Among those desiring to have another baby, 69 percent wanted just one more child, while a quarter wanted two more children. The rest (6%) wanted more than two children.

Three out of four did not want to have their next baby until after two or more years. Fifteen percent wanted to have a baby sooner; that is, within the next two years or earlier. Ten percent were "not sure" when they would prefer to have their next child.

Table 6. Future Plans About Pregnancy: Comparison between Respondents and their Husbands

Variable	Respondents	Husbands
A. Do you plan to have any more children in the future?		
% Yes	38.5	44.6
% No	61.5	55.4
B. If yes, how many more?		
% One more child	69.5	65.0
% Two more children	24.6	26.9
% Three or more additional children	6.0	8.1
Mean number of additional children desired	(1.39)	(1.5)
C. If yes, how soon?		
% Next year or earlier	10.2	13.6
% Within the next two years	4.9	5.5
% After 2 or more years	74.9	65.3
% Not sure	10.1	14.2

Number of cases (n) = 899 except for items (B) and (C) where n is equal to the number of respondents and husbands planning to have at least one more child in the future.

Some differences were noted between the women's and their husband's preferences regarding the next pregnancy. More husbands than wives want to have at least one more child in the family. Data in Table 6 show that 45 percent of the husbands want at least one more child in the future compared to only 38 percent of the women. The husbands also want slightly more additional children than their wives. On average, the husbands want 1.5 more children, compared to the wives' average of 1.4. In general, the husbands also want to have the next child sooner than their wives. Nineteen percent of the husbands want to have their next child within the next two years, as compared to only 15 percent of the women.

CONTRACEPTIVE HISTORY

As may be expected, very few (2%) DMPA acceptors used a family planning (FP) method before having their first child (see Table 7). When asked when they first used a FP method, a third (35%) did so only after giving birth to their first-born. About three out of ten (28%) started practicing contraception only after the birth of their second child, while 16% did so only after having three children. The rest (20%) did not start practicing family planning until after the birth of their fourth, fifth or sixth child.

Table 7. Contraceptive History

Variable	Percent [a]
A. When Respondent First Used a FP Method	
Before 1st pregnancy	1.7
Between 1st-2nd pregnancy	35.5
Between 2nd-3rd pregnancy	27.7
Between 3rd-4th pregnancy	15.7
Between 4th-5th pregnancy	8.5
After 5th pregnancy	11.0
B. Ever used a FP method before first DMPA injection?	
Yes	72.7
No	27.3

[a] Number of cases (n) = 899

The data in Table 7 also indicate that a great majority (73%) of DMPA acceptors are method-shifters. The remaining 27 percent reported that they have never used any other FP method prior to their first DMPA injection.

Data in Table 7a show that the method switchers consisted of shifters from the pills (43%), from withdrawal (9%), from the condom (8%), from IUD (7%) and from rhythm/NFP (5%). Hence it can be said that for every ten DMPA acceptors, a little more than four are likely to be shifters from the pill while three could be shifters from other

methods. But perhaps more importantly, nearly three are likely to be "new to the FP program" as first-time users of FP.

Table 7a. Contraceptive Use prior to DMPA Injections

Variable	Percent [a]
A. FP Method Used Before First DMPA Injection	
None	27.3
Pills	43.5
IUD	6.7
Condom	8.1
Rhythm/NFP	4.6
Withdrawal	9.1
Others	0.8
B. Average Number of Months Other FP Method was Used prior to First DMPA Injection	
Pills	21.3
IUD	21.7
Condom	4.9
Rhythm/NFP	23.2
Withdrawal	14.7

[a] Number of cases (n) = 899 except item (B) where n is equal to the number of previous users of each method

On average, the method shifters had already been using the above methods for a year and a half before shifting to DMPA. Specifically, shifters from the pill were taking the oral contraceptive for an average of 21 months before shifting to DMPA. IUD users had been using this method for an average of 22 months before opting for the injectable whereas the comparative figure for rhythm/NFP was slightly longer at 23 months. Shorter durations were found for withdrawal users (15 months on average) and condom users, who had used this method for an average of only five months.

Varied reasons were given for discontinuing use of previous FP methods. In general, one in five shifted to DMPA because they experienced some side effects with their last FP method (see Table 8). Fifteen percent said that they wanted to try DMPA. Other frequently

cited reasons were: method failure (12%), health reasons (11%), inconvenience (8%), and husband's objection (7%). Interestingly, six percent of the method shifters said that they stopped using their previous method because they wanted to get pregnant.

Table 8. Reasons for Discontinuing FP Method Used Prior to First DMPA Injection

Reasons	Percent
Experienced side effects	19.7
Wanted to try DMPA	15.5
Method failure	11.7
Health reasons	11.1
Inconvenience	8.1
Husband's objection	6.6
Desire to get pregnant	6.5
Advised by service provider	1.5
Fear of side effects	1.1
Costly	0.5
No supplies available	0.3
Others (not specified)	17.5

[a] Number of cases = 651 method shifters

As may be seen in Table 9, reasons for discontinuation tend to be method-specific. For example, among previous pill and IUD users, the most frequently mentioned reason for discontinuation was the respondent's experience of side effects. Among condom users, it was the husband's objection which was the most commonly cited cause. Meanwhile, among withdrawal and rhythm users, method failure was mentioned most frequently as the reason for discontinuation.

Table 9. Method-specific Reasons for Discontinuing FP Method Used Prior to DMPA

FP Method Used Prior to DMPA	Reason for discontinuing FP Method (%)										
	Experienced side effects	Husband's objection	Method failure	Health reasons	Wanted to try DMPA	Desire to get pregnant	Inconvenience	Others (specified)	Others (not specified)	Total	Number of cases
Pill	**21.5 (Rank 1)**	0.5 (Rank 7)	3.3 (Rank 6)	12.8 (Rank 3)	15.9 (Rank 2)	6.4 (Rank 5)	10.8 (Rank 4)	3.6	25.1	100.0	390
IUD	**31.7 (Rank 1)**	3.3 (Rank 6)	18.3 (Rank 3)	20.0 (Rank 2)	13.3 (Rank 4)	5.0 (Rank 5)	0.0	6.7	1.7	100.0	60
Condom	8.3 (Rank 5)	**36.1 (Rank 1)**	18.1 (Rank 2)	8.3 (Rank 5)	9.7 (Rank 4)	2.8 (Rank 7)	11.1 (Rank 3)	0.0	5.6	100.0	72
Withdrawal	16.0 (Rank 3)	13.6 (Rank 4)	**29.6 (Rank 1)**	2.5 (Rank 6)	17.3 (Rank 2)	7.4 (Rank 5)	1.2 (Rank 7)	2.5	9.9	100.0	81
Rhythm/NFP	12.2 (Rank 3)	4.9 (Rank 5)	**29.3 (Rank 1)**	2.4 (Rank 7)	24.2 (Rank 2)	12.2 (Rank 3)	4.9 (Rank 6)	2.4	7.3	100.0	41

Numbers in parentheses indicate the order or rank of the response in descending order, with 1 equal to the most frequently mentioned response. "Others (specified)" and "others (not specified)" categories were not included in the ranking.

Some differences were noted between DMPA acceptors who are "new FP users" and those who are method shifters. On the average, "new FP users" were three years younger than the method shifters. Data in Table 10 show that the average age of first-time FP (DMPA) users was 27 years compared to 30.1 years among method shifters.

The new FP users also tend to have fewer children. The average number of children among new FP users was 2.8 compared to 3.3 among the method shifters.

More first-time FP users than method shifters plan to have at least one more child in the future. Comparative figures show that 51 percent of new FP users want to have another child while only 34 percent of the method shifters do.

These two groups also differed with regard to their intentions for using DMPA. A majority (52%) of the new FP users adopted DMPA for childspacing purposes, while almost two-thirds (65%) of the method shifters are using DMPA to stop childbearing altogether.

Table 10. Profile of DMPA Acceptors who are First-Time FP Users versus Method Shifters

Variable	First-Time FP Users (n=245)	Method Shifters (n=654)
A. Mean age	27.0	30.1
B. Current Number of Children		
% with 0 children	0.0	0.2
% with 1-3 children	72.2	60.9
% with 4-6 children	23.3	32.9
% with 7-10 children	4.5	6.1
Mean number of children	2.78	3.32
C. Desire for another Pregnancy		
% who want another child	50.6	33.9
% who do not want any more children	49.4	66.1
D. Mean number of additional children desired	1.48	1.35
E. Intention for using DMPA		
% to space childbirth/delay next pregnancy	52.2	35.3
% to stop childbearing	47.8	64.7

[a] Number of cases (n)

INFORMATION OBTAINED AND SOURCE OF INFORMATION ABOUT DMPA

When the women were asked about their sources of information on DMPA, more than half (55%) cited only one source, 38 percent cited two sources and the rest named more (see Table 11).

For a majority (58%) of the women, the midwife was the most influential source of information in their decision to use DMPA. The rest considered friends (11%), relatives (8%), television (6%), doctors (4%), nurses (4%), neighbors (3%) and radio (3%) as most influential source of DMPA information.

Table 11. Source of Information about DMPA

Variable	Percent [a]
A. Number of Sources Mentioned	
One	55.1
Two	37.9
Three or more	7.0
B. Most Influential Source of Information on DMPA	
Midwife	57.6
Doctor	3.9
Nurse	4.4
Friends	11.0
Relatives	7.7
Neighbors	3.2
Television	5.6
Radio	2.8
Others	3.8

[a] Number of cases = 899

What were they told about DMPA? Almost half (45%) of the respondents were informed that DMPA is an easy and convenient FP method to use. About four out of ten (38%) were told to expect some side effects with DMPA use, including a fifth who were specifically informed that use of DMPA may cause either spotting or amenorrhea. Ten percent of the women were told that DMPA is an effective contraceptive (see Table 12).

Table 12. Women's Knowledge about DMPA

What Women were Told About DMPA	Percent [a]
It is easy/convenient to use	44.9
There are side effects to be expected (including spotting and amenorrhea)	37.8
It is an effective contraceptive	10.0
It has non-FP benefits	1.1
It is a safe contraceptive	1.0
Others	5.1

[a] Number of cases = 899

INFORMATION OBTAINED REGARDING OTHER FP METHODS

Only 37 percent of the respondents reported that they were informed about other FP methods when they went to the clinic for their first DMPA injection (see Table 13). A majority (76%) of those who were not so informed consists mainly of the method switchers (i.e. women who are assumed to be reasonably knowledgeable about the methods available from the program).

Of those who were informed of other methods, most were told about pills (80%) and IUD (73%). A third were informed about condoms (34%) while about one in four (24%) were told of ligation. Thirteen percent claimed they were informed about rhythm, and even fewer (7%) were told about NFP.

Table 13. Knowledge about Other FP Methods

Variable	Percent [a]
A. Was R informed about other FP methods at the clinic?	
Yes	37.4
No	62.6
B. What other methods was R told about? [b]	
Pills	80.4
IUD	73.2
Condom	34.2
Ligation	24.4
Rhythm	13.1
NFP	7.4
Withdrawal	1.3
Others	8.3

[a] Number of cases (n) = 899 except for item (B) where n is equal to the number of respondents who were informed of other FP methods.

[b] Figures in item (B) add to more than 100 percent since multiple responses were coded.

Data in Table 13a show that about the same proportion of women who were informed about other FP methods claimed to have been given reading materials (i.e., pamphlets, leaflets, brochures) about the different FP options offered at the health facility (40%). Sixty-two percent of these women (or 25% of all respondents to the survey) received materials on DMPA. Close to four out of ten (37%) and one out of four (26%) women received materials about IUDs and condoms, respectively. Not even one percent (0.8%) of the women received any materials on natural family planning (NFP).

Table 13a. IEC Materials on FP Methods

Variable	Percent [a]
A. Was R given reading materials about FP methods?	
Yes	40.2
No	59.8
B. What methods were the materials about? [b]	
DMPA	61.8
Pills	42.9
IUD	37.1
Condom	26.3
Diaphragm	3.6
Jelly	0.3
Ligation	3.0
NFP	0.8
Vasectomy	0.3
FP book	0.3
Others	0.6

[a] Number of cases (n) = 899 except for item (B) where n is equal to the number of respondents who were given reading materials on FP methods.

[b] Figures in item (B) add to more than 100 percent since multiple responses were coded.

Forty-three percent of the respondents said that the clinic personnel provided "equally sufficient" information about all FP methods. Most (79%) women, too, claimed that they were not given extra encouragement to choose DMPA over other FP methods. Nonetheless, data from Table 13b do show that in general, more information was provided on DMPA than any other FP method. This may be the reason why almost half (46%) of the women say that the clinic personnel did tend to promote DMPA over other FP methods.

Table 13b. Information on DMPA Compared to Other FP Methods

Variable	Percent [a]
A. How much information was given about other FP methods compared to DMPA?	
More information about DMPA than other methods	46.6
Equally sufficient information for all methods	43.3
More information about methods other than DMPA	0.8
Others	9.4
B. Was R given extra encouragement to use DMPA over other methods?	
Yes	20.6
No	79.4

[a] Number of cases (n) = 899

DECISION TO USE DMPA

After being informed about DMPA at the health clinic, it did not take long for the majority of the women to decide to have their first DMPA injection. About seven out of ten (68%) decided to have their first injection "immediately" after being informed about DMPA's advantages and disadvantages as a contraceptive method. Sixteen percent, however, waited for two weeks before deciding to have their first injection while 17 percent decided only after a month or some longer period (see Table 14).

The lag time was due to a number of reasons. A majority (55%) of the women who

were not able to immediately have their first injection were told to first wait for their menstruation, to be sure that they were not pregnant upon administration of the injection. One out of five said that they still had to ask their husband's permission before having the injection, while 11 percent simply felt that they needed more time to think about whether to use DMPA or not. A few (6%) were still using another FP method at the time.

Table 14. Decision to Use DMPA

Variable	Percent [a]
A. How long did it take R to decide to have a DMPA injection?	
Immediately	67.8
After two weeks	15.5
After one month	9.0
After more than a month	7.7
B. If not immediately, why not?	
Was told to wait for next menstruation	54.9
Had to ask husband's permission	19.8
Wanted more time to think about it	10.8
Still using another FP method	5.6
Others	8.1
C. Reasons for Choosing DMPA	
Convenience	46.8
Recommended by other users	10.6
Effectiveness	8.9
Just wanted to try DMPA	7.7
Advised by service provider	5.7
Husband's approval	5.7
OK for breastfeeding mothers	3.7
Tired of current FP method	3.4
Cannot use other FP methods	2.9
Non-FP benefits	2.8
Others	1.2
D. Intention for Using DMPA	
To space childbirths/delay next pregnancy	39.9
To stop childbearing	60.1

[a] Number of cases (n) = 899 except for item (B) where n is equal to the number of respondents who did not decide "immediately" to have a DMPA injection.

What made them choose DMPA over other methods? The most commonly cited reason was the convenience and ease of using the injectable (47%). Eleven percent adopted DMPA upon the recommendation of other users while a few (6%) did so because they were

advised by the service provider. Other reasons cited were DMPA's effectiveness as a contraceptive (9%), husband's approval (6%), benefits to be derived aside from family planning (3%) and the fact that even breastfeeding mothers can use it (4%). Others simply wanted to try it (8%), were "tired" of their present method (3%), or could not use any other FP method due to some health constraints (3%).

Interestingly, while DMPA is a reversible and "temporary" method, a majority (60%) of the women said that they chose to use it to stop childbearing altogether. Forty percent of the DMPA acceptors said that they were using it for childspacing purposes.

Differences in age and parity were noted between these two groups of women: those who use DMPA for childspacing purposes ("spacers") and those who use DMPA to stop childbearing altogether ("stoppers"). On average, "spacers" are younger by four years than the "stoppers". The average age of "spacers" is 26 years compared to 31.4 years for "stoppers". These data are shown in Table 15 below.

Table 15. Comparison of "Spacers" and "Stoppers"

Variable	Spacers: women who use DMPA to space childbirths (n=359)	Stoppers: women who use DMPA to stop childbearing altogether (n=540)
A. Mean age	26.0	31.4
B. Mean number of children at present	2.13	3.87

As expected, "spacers" also have fewer children than "stoppers". Women who were intending to terminate their reproductive careers already had about four (3.9) children, while those who are using DMPA only for childspacing purposes had an average of only two children at present.

USE OF DMPA

Data in Table 16 show that close to half (46%) of the respondents had their first DMPA injection in a barangay health station (BHS). Three out of ten had theirs at the main health center (MHC) while 16 percent received their first DMPA injection at a rural health unit (RHU).

Most (83%) women received their first DMPA injection from a midwife; 13 percent from a nurse and only 4 percent from a doctor. In most cases (90%), the respondent personally knew the DMPA service provider.

A DOH guideline on DMPA specifies that a "first injection should be administered on any of the first 7 days after the beginning of menstruation" (DOH-USAID, 1994). Despite this, only 58 percent of the respondents reported that they were injected within this prescribed period. The rest of the respondents indicated that they were first injected "after menses" (37%). How soon after this happened was not specified by these respondents. Given the problems with pregnancy during DMPA use, this issue should be explored further.

Table 16. Actual Use of DMPA

Variable	Percent [a]
A. Where R had her first DMPA injection	
Barangay health station (BHS)	45.6
Municipal health center (MHC)	30.3
Rural health unit (RHU)	16.2
Public hospital	1.4
Others	6.4
B. From whom R had her first DMPA injection	
Midwife	83.3
Nurse	12.6
Doctor	3.9
Others	0.2
C. When R had her first DMPA injection	
Before onset of menses	4.8
First 7 days of menses	58.4
After menses	36.7

[a] Number of cases = 899

EXPERIENCES WITH DMPA USE

Nine out of ten women claimed to have experienced some physical side effects since they started using DMPA as a contraceptive. Changes in emotional well-being were also reported by 46 percent of the respondents.

Data in Table 17 show that, among the physical side effects observed, headaches, nausea or dizziness were the most frequently cited (46%). Four out of ten women experienced spotting while about the same number (39%) said that they gained weight as a result of DMPA use. Amenorrhea was experienced by a fifth of the respondents. Thirteen percent had less than usual bleeding while eight percent complained of heavy bleeding. It may be noted that menstruation-related changes such as spotting, amenorrhea, less than usual bleeding and heavy bleeding, when taken collectively (81%), were mentioned far more frequently than any other symptoms.

Table 17. Side Effects Experienced with DMPA Use

Side Effects	Percent of respondents who reported having experienced side effect[a]
Nausea/dizziness/headache	46.5
Spotting	39.7
Weight gain	39.0
Amenorrhea	20.8
Less than usual bleeding	12.6
Weakness	8.3
Heavy bleeding	7.9
Loss of appetite	5.5

[a] Number of cases = 899; Figures add to more than 100 percent since multiple responses were coded.

On the other hand, the most frequently mentioned change in the emotional well-being of the respondents was that they became more irritable and easily provoked (76%). A few (8%) said that they have become "forgetful" after having had a DMPA injection.

RESPONDENT'S MANAGEMENT OF SIDE EFFECTS

What did the women do upon experiencing these side effects? It is interesting to note that seven out of ten (71%) respondents who experienced some bodily changes after being injected with DMPA reportedly did "nothing" about the changes they experienced. One in five, however, returned to the clinic to consult with their service provider, while a few (8%) either took some medicine or tried to eat less so as not to gain any more weight (see Table 18).

Table 18. Management of Side Effects

Management of Side Effects	Percent of respondents mentioning item [a]
Did nothing	71.4
Consulted service provider/followed instructions	21.0
Took medicines/tried to eat less	7.5

[a] Number of cases = 809 women who reported having experienced at least one physical side effect

Among those who went back to the clinic for consultation, a majority (56%) said that they were simply told that such changes in their bodies were "normal" and to be expected. Twenty-seven percent were given prescriptions for pain relievers or vitamins.

Did such advice or prescriptions remedy their situation? A significant number (76%) of women who were either counselled or treated answered in the affirmative. About the same number (75%) expressed satisfaction with the results of the counselling or treatment.

On the other hand, nine out of ten women who had experienced some change in their moods or emotions also did "nothing" about this. A few (5%) returned to the clinic to consult with the service provider.

Of the few who went back to the health center for consultation about these types of side effects, a majority (58%) were likewise told not to be alarmed as such changes in behavior are to be expected. However, 16 percent were told to stop using DMPA. This includes four percent who were advised to shift to another method. For a majority of these women (69%), such advice and reassurance did remedy their situation. The same proportion of women also reported being satisfied with the reassurance, advice or treatment given by the service provider.

SATISFACTION WITH DMPA

In general, shifters to DMPA are quite satisfied with their decision to use the method. Seven out of ten method shifters said that they are more satisfied with DMPA than the other FP methods they have tried in the past (see Table 19). Their satisfaction stems mainly from not having experienced any major adverse side effects from DMPA use (78%).

When asked how long the women intend to use DMPA, a majority (63%) said that they plan to use it for more than a year. On average, the women plan to use DMPA for 22.5 months.

Table 19. Satisfaction with DMPA

Variable	Percent [a]
A. Satisfaction with DMPA vis-a-vis other Methods	
More satisfied with DMPA	69.7
More satisfied with other methods	20.9
Others	9.4
B. Reasons why R is satisfied with DMPA	
No side effects	78.5
Has benefits other than FP	10.9
Effective	8.9
OK for breastfeeding mothers	0.6
Others	1.1
C. How long women intend to use DMPA	
Less than a year	27.9
A year	7.1
More than a year/until menopause	63.2
Don't know	1.6

[a] Number of cases (n) = 653 method shifters except for item (B) where n is equal to the number of women who expressed satisfaction with DMPA.

ACCESSIBILITY OF DMPA SERVICES

The DMPA-dispensing facilities were quite accessible to a majority of the respondents. Six out of ten women merely walked to the nearest health clinic for DMPA services while the rest took a ride. Three out of four respondents need no more than 10 minutes to travel to the nearest DMPA-dispensing facility. On average, it was taking our respondents about 10 minutes to reach the nearest health center. This is not surprising considering that most (97%) of the respondents reside within the catchment areas of the selected health facilities.

QUALITY OF DMPA SERVICES

1. Availability of DMPA supplies

DMPA services were quickly and readily available. Nine out of ten respondents said that they were given their DMPA injection on the same day they went to the clinic to have it. Only ten percent of the women were asked to return on another day for their injection, the main reason being that they had to wait for their menstrual period before they could be injected. Forty-three percent of those who were told to come back cited this reason.

While the DMPA services were designed to be given free of charge in public health facilities covered by the DMPA Reintroduction Program, data from the women indicate that a little more than three out of ten (31%) were asked to make a "donation" to the clinic for their first DMPA injection. The amounts cited ranged from as low as one peso to as high as P101, for an average donation of P14.77 per injection.

2. Availability of DMPA reminder cards

While all DMPA clients are expected to be given a DMPA calendar/reminder card (see Appendix A) after their first injection (to remind them of when their next reinjection is due), this was not the case for a fifth (22%) of the respondents. It would therefore seem that some facilities either have a shortage of DMPA calendars/reminder cards or that their personnel are failing to use these properly.

3. Counselling on DMPA's side effects

Most (84%) of the women claimed that they were told to expect some side effects from their use of DMPA. However only ten percent of the sample were given some specific pointers about dealing with the side effects.

Table 20. Side Effects which Women were Told to Expect from DMPA Use

Side Effects to Expect from DMPA Use	Percent of respondents mentioning item [a]
Spotting	45.8
Nausea/dizziness/headaches	42.2
Amenorrhea	40.4
Heavy bleeding	9.8
Weight gain	9.2
Loss of appetite	1.6

[a] Number of cases = 899; Figures add to more than 100 percent since multiple responses were coded.

Among the side effects that the women were told to expect, spotting, headaches and amenorrhea were the more frequently mentioned (see Table 20). Almost half (46%) of the respondents said that they were told to expect spotting as a result of DMPA use, while 42 percent were warned about the possibility of headaches, nausea or dizziness occuring as a consequence of DMPA use. Four out of ten were also told of the possibility of experiencing amenorrhea especially after prolonged use of the injectable. A few were told to expect heavy bleeding (10%) or weight gain (9%).

Of the few who were informed about what to do when side effects occur, 57% said that they were told by the service provider "not to be alarmed" because these side effects are "normal" and only to be expected. Nine percent were advised not to eat too much while five percent were told to go back to the center for consultation.

4. Screening and Client Assessment

DMPA service providers were trained to ask potential DMPA clients a series of questions as part of the standard screening procedure. While 94 percent of the acceptors were asked at least one of the screening questions listed in Table 21, only a third (32%) were asked all of the 12 required items on the list.

The most frequently asked questions during patient screening were the number of children that they women had given birth to and their menstrual history (see Table 21). Seventy-eight percent of the respondents said that they were asked these questions. Seventy-two percent were also asked if they have breast lumps or an abnormal discharge from their nipples.

Table 21. Questions asked of Respondents During Client Screening and Assessment

Questions[a]	Percent of respondents who said they were asked the question [b]
How many children respondent (R) has	78.4
R's menstrual history	78.3
If R has breast lumps or abnormal discharge from nipples	71.6
If R has blood clots in her legs or has had a heart attack	68.7
If R is pregnant or her menstration is due	68.1
If R has had previous experience with other diseases (i.e., heart, hypertension, etc.)	65.3
If R is breastfeeding a baby less than 6 weeks old	63.8
R's previous contraceptive history	62.4
If R has abnormal, undiagnosed bleeding	59.6
If R has had previous experience with anemia, beriberi or malnutrition	53.9
If R's eyes have turned yellow or her urine dark brown in the last 6 weeks	53.8
If R has had previous experience with reproductive tract infections	53.5

[a] Source: DOH-USAID (1994). DMPA Information Kit.
[b] Number of cases = 899; Figures add to more than 100 percent since multiple responses were coded.

The other screening questions were asked less frequently. A little more than sixty percent of the respondents were asked about their previous experience of heart disease or hypertension (65%), about their contraceptive history (62%), whether they were breastfeeding a baby less than six weeks old (64%), or whether they had any abnormal, undiagnosed bleeding (60%). Fewer still were asked if they have any previous experience of reproductive tract infections (53%), or with anemia or other nutritionally-related diseases (54%).

5. "Post-injection" services

While the women were not expected to come back to the clinic until three months had passed (i.e., for their reinjection), nearly six out of ten (58%) said that they were told by the service provider to go back to the clinic, either for a follow-up or a check-up, after receiving their first DMPA injection.

Moreover, even though the DMPA service providers are not expected to pay their DMPA clients a visit to follow up the latter's status and to remind them of their scheduled reinjections, one out of ten women said that they were visited by a barangay health worker (BHW) or someone from the health center after being given their first DMPA injection. This would therefore indicate that some DMPA service providers did more than what was expected of them to ensure that DMPA users get quality health care.

It is not surprising, therefore, that the respondents generally had positive things to say about their DMPA service providers. Almost all (98%) said that the clinic personnel were quite competent as DMPA service providers. The same proportion also found the clinic personnel to be "friendly and approachable", a finding that is consistent with previous surveys regarding clients' assessment of service providers (Sealza, 1993; Roberto, 1993 and Raymundo and Cruz, 1993).

CURRENT USERS AND DISCONTINUERS

Despite the fact that all of the respondents said that their service provider had informed them when they should return for their next injection, and that most (78%) of them were given a DMPA calendar/reminder card, data in Table 22 indicate that a significant proportion (32%) did not return for their reinjection as scheduled.

At the time of the survey, only 68 percent of the respondents returned for a reinjection on their scheduled appointments and were thus classified as "current users"of

DMPA (see Table 22).

Of the 284 women who did not go back to the health center on their appointed date for reinjection, a majority (64%) said that they have decided to stop using DMPA altogether. These women, representing 20 percent of the total sample, can be considered DMPA drop-outs in the "true" sense of the word.

On the other hand, 27 percent of the "non-returnees" said that, although they missed their scheduled reinjection, they still plan to continue using DMPA. Presumably, these women were still within the "two-week grace period" for a reinjection. This group of women represent eight percent of the total sample. As for the remaining non-returnees (3 percent of the total sample), they said that they were not quite sure whether they would stop or resume DMPA use.

It can therefore be said that, given ten DMPA acceptors, about seven are likely to return for a reinjection; two will purposely drop out of the program; and one would likely miss an appointment without having yet come to a definite decision to stop.

Table 22. Current Users and Discontinuers/Drop-outs

Variable	Percent [a]
A. Did R return for reinjection on scheduled appointment?	
Yes	68.4
No	31.6
B. User Status (at the time of survey)	
Current user: returned for reinjection on schedule	68.4
Discontinuer/Drop-out:	
a) missed appointment for reinjection because R wants to stop using DMPA	20.4
b) missed appointment for reinjection but plans to continue/resume DMPA use	8.2
c) missed appointment for reinjection but R is not sure whether to stop or continue DMPA use	3.0

[a] Number of cases = 899

The drop-outs' reasons for stopping DMPA use varied (see Table 23). Experience of side effects was cited by a majority (52%) of the respondents. Specific side effects include amenorrhea (12%), headaches and nausea (10%), abdominal pain (6%) and spotting (5%). Fourteen percent said that they stopped using DMPA because there were no medicines available in the clinic to relieve the side effects they experienced.

Table 23. Reasons for Stopping DMPA Use

Reasons	Percent [a]
Side effects (not specified)	18.7
Amenorrhea	11.6
Headaches/nausea	10.2
Abdominal pain	6.3
Spotting	4.6
No medicines available	14.1
Missed appointment for reinjection	5.3
Husband objects	4.4
Husband is away	1.4
Fear of rumors about DMPA	3.2
Wants to get pregnant	0.7
Wants to try another method	0.3
Others (not specified)	16.2
No answer	3.0

[a] Number of cases = 284 drop-outs

HUSBAND-WIFE COMMUNICATION

1. On Desired Family Size and Use of Family Planning Methods

a. Before marriage

Respondents were asked if they had ever talked about family size and FP with their future husband before they were married. The results in Table 24 show that these types of discussions were not uncommon. Among the women surveyed, 55 percent said that they and

their husbands did talk at this time about the number of children they would like to have. On average, the women wanted slightly fewer children than their husbands did.

Before marriage, couples were more likely to talk about the number of children they wanted than about contraception and family planning. Of the total sample, only 43 percent of the women had talked to their husbands about using a FP method before they got married. In almost all cases where the couple had talked about FP, both husband and wife were in favor of practicing contraception.

Among those who discussed FP with their husbands, four out of ten (41%) agreed with their spouses that they would practice FP only after the birth of their first child. About a quarter (23%) agreed to use a contraceptive only after having two children. The preferred method then was the pill (53%), followed by injectables (12%), rhythm (10%), withdrawal (8%) and the IUD (6%).

b. After marriage

More couples discussed their desired family size after marriage than before as shown in Table 24. More women also talked to their partners about family planning after they were married. Of the total sample, 76 percent talked about FP with their husbands after they were married, compared to only 43 percent who did so before marriage.

Preferences about the time when they would start practicing contraception, as well as about the method they would use remained virtually unchanged after the couples got married. It is interesting to note, however, a modest rise in the approval of DMPA use among those who discussed FP after marriage. This was accompanied by declines in method preference for the pill and rhythm/NFP.

Table 24. Husband-Wife Communication Over Family Size and Family Planning Practice: Before and After Marriage

Variable	Before Marriage	After Marriage
A. % ever-discussed desired number of children with spouse	55.1	75.9
B. Average number of children desired by wife	3.12	3.11
C. Average number of children desired by husband	3.38	3.39
D. % ever-discussed family planning with spouse	43.3	76.0
E. Couple's opinion about family planning		
% Both husband and wife in favor of FP	96.9	97.2
% Wife in favor; husband was not	2.3	1.8
% Husband in favor; wife was not	0.5	0.6
% Both husband and wife not in favor of FP	0.3	0.4
F. Couple's opinion on when to start using FP		
% Before 1st pregnancy	5.2	1.5
% Between 1st-2nd pregnancy	40.9	39.7
% Between 2nd-3rd pregnancy	22.8	28.4
% After 3rd pregnancy	31.0	30.8
G. Preferred FP method to use		
% None	3.1	0.7
% Pill	52.9	41.6
% IUD	6.2	9.6
% Condom	1.8	4.3
% Withdrawal	8.0	11.0
% DMPA/Injectable	11.6	16.3
% Rhythm/NFP	10.2	6.2
% Ligation	2.7	1.9
% Combination of methods	3.5	8.4

[a] Number of cases (n) = 899 except items (E), (F) and (G) where n is equal to the number of respondents who talked to their husbands about FP.

When was the last time that the respondents talked to their husbands about family planning? For most (93%) of the women, their most recent FP discussion with their husband was after the birth of their youngest child. The topics discussed at this time are shown in Table 24a. For more than a third (36%) of the women, this concerned the need to use a contraceptive to prevent any unplanned pregnancy. Almost half (45%) however, discussed DMPA in particular. The rest (12%) talked about other FP methods.

Table 24a. Topics of Most Recent Discussion about FP

TOPICS	Percent
DMPA	45.1
Need to use FP to control births	36.1
Other FP methods	11.9
Others	6.9

[a] Number of cases (n) = 683 respondents who talked to their husbands about FP

2. On Using DMPA

Communication between husband and wife about the use of DMPA was evident. More than nine out of ten (93%) respondents claimed that their husbands knew that they were using DMPA, while 70 percent of the women said that the decision to use DMPA was a "joint initiative" between them and their husbands. However, about three out of ten (29%) women said that the decision came more from their own initiative than from their husbands' (see Table 25).

Most of the respondents reported that their husbands have been supportive of their use of DMPA, even from the start. About one in ten (11%), though, noted that, while their husbands were supportive in the beginning, they have become more disapproving of late. This disapproval could be brought on by side effects experienced by their wives.

Table 25. Husband-Wife Communication on DMPA

Variable	Percent [a]
A. Husband's knowledge of wife's use of DMPA	
Husband knows	93.1
Husband does not know	6.9
B. Whose initiative was it to use DMPA?	
Joint husband and wife	69.7
Largely wife's initiative	28.8
Largely husband's initiative	1.3
C. Husband's reaction to wife's use of DMPA	
Supportive from the beginning to the present	78.9
Not too supportive in the beginning but becoming more approving	5.1
Was supportive in the beginning but becoming more disapproving	10.9
Has never been supportive at all of R's decision to get DMPA injection	2.8

[a] Number of cases = 899

PEER AND FAMILY OPINIONS ABOUT DMPA USE

Most (84%) respondents have talked to other relatives and family members about their DMPA injection. Two-thirds did so with their sister or sister-in-law while about four out of ten have told their mothers (see Table 26). A third talked to other female relatives about their DMPA injection, while 22 percent discussed it with their mothers-in-law. As expected, very few women discussed their DMPA injection with a male relative other than their husband.

A majority (76%) of these women said that none of the people they talked to objected to their use of DMPA. However, among those whose relatives disapproved, "other female relatives" appeared to be most likely to do so (34%), followed by sisters or sisters-in-law (26%), mothers (22%) and mothers-in-law (13%).

According to a third (32%) of these respondents, the disapproval of their relatives stems mainly from the latter's fear that DMPA has many side effects. In fact, a fifth of the respondents said that their relatives think DMPA can cause tumors. Eight percent also had relatives who feared that, with DMPA use, the respondent will no longer be able to menstruate.

Table 26. Relatives who Know About Respondent's Use of DMPA

Relatives	Percent of respondents who had told relative about their DMPA injection [a]
Sister/sister-in-law	67.0
Mother	39.4
Other female relatives	33.0
Mother-in-law	22.5
Other male relatives (excluding husband)	2.4

[a] Number of cases = 899; Figures add to more than 100 percent since multiple responses were coded.

About as many respondents (87%) have also spoken to their friends about their DMPA injections. In almost all of these cases, the information was shared with a female friend rather than a male friend. More than seven out of ten (72%) of the women who discussed DMPA with friends said that none of them objected to their use of DMPA.

Among those with friends who did disapprove, concern about DMPA's side effects was the most frequently cited reason for disapproval (26%). One in four women had friends who feared that DMPA might cause tumors, while 11 percent were afraid of amenorrhea. While half (52%) of the respondents have heard of some opposition to the use of DMPA in their communities, only a few (6%) actually know of any townmate who were against the use of DMPA.

PROGRAM IMPLICATIONS

A. On Service Delivery

1. Counselling

Survey findings showed that while 84 percent of the DMPA acceptors reported being told what side effects to expect from DMPA use, this means that there were still 16 percent of the women who were not so informed. This is important to note considering that service providers were trained to counsel every DMPA acceptor on the expected side effects of DMPA. This finding implies the need to alert service providers to observe this protocol consistently, and ensure that all clients are made aware, not only of the advantages of DMPA but also its disadvantages, particularly its side effects.

Even more alarming is the finding that only one out of ten acceptors were given information on what to do when side effects occur. The need to educate acceptors on appropriate steps to manage side effects cannot be overemphasized, especially in view of the finding that the experience of side effects was the most commonly cited reason for the women's discontinuation of DMPA. This should be given special attention during training to ensure that service providers include the topic of side effects management and treatment during counselling.

2. Client Screening and Assessment

Findings from the survey showed that only 31 percent of the DMPA acceptors were asked all of the required items or questions for screening and assessing clients. This is quite low considering that service providers were trained to ask all of the screening questions for each potential DMPA acceptor. Given this finding, service providers should therefore be alerted to observe this procedure at all times. This should be especially

emphasized during the training of service providers. When needed and where feasible, other screening procedures such as a pregnancy test should also be done to ensure that women are not pregnant when they are given a DMPA injection.

3. Administration of DMPA

Survey findings showed that only 58 percent of the DMPA acceptors reported being injected within the prescribed period, that is, "within the first seven days after the beginning of menstruation". Given the problems with pregnancy during DMPA use, it is important to call the attention of the service providers to strictly observe the guidelines on DMPA administration. This will not only ensure that women are not pregnant when they are given an injection, but will also contribute to the effective use of the method.

4. Side Effects Management

There is a great need for the program to address the issue of effective management and treatment of side effects from DMPA, considering that nine out of ten DMPA acceptors reported having experienced some physical side effects since they started using DMPA as a contraceptive. Special attention should be given to the treatment of menstruation-related side effects, particularly spotting and amenorrhea which were the most commonly cited side effects in relation to a woman's menses. Post-injection counselling should therefore focus on this topic to assure clients that such side effects are manageable. Such a step will also help to ensure that clients continue using DMPA.

Survey findings also show that despite the high incidence of side effects among the users, very few did anything about such changes in their bodies. Seven out of ten DMPA acceptors reportedly did "nothing" about the side effects they have experienced. Only one out of five users returned to the clinic to consult with the service provider about the side effects that they have experienced. Given the finding that 75 percent of the women who went back for consultation were satisfied with the results of counselling or treatment,

more DMPA clients should therefore be encouraged to go back to the health centers once side effects are experienced. Considering that most DMPA acceptors live within walking distance to the nearest health centers, such return visits should not be all that difficult.

B. On IEC Materials Development and Distribution

1. Availability of DMPA Reminder Cards

Survey results show that 22 percent of the DMPA acceptors were not given DMPA reminder cards, implying the need for an improved distribution system that will ensure the availability of enough reminder cards for all DMPA acceptors.

2. Availability of DMPA Leaflets

Only 25 percent of the DMPA acceptors reported having received a DMPA leaflet or reading material. This is low considering that IEC materials on DMPA were meant for a much wider distribution. Efforts to improve the distribution system and availability of DMPA leaflets, not only for users but also potential acceptors, should therefore be undertaken to educate more women on the advantages and disadvantages of DMPA as a FP method.

3. IEC Materials on Side Effects Management

Given the need to educate women on the management and treatment of side effects occuring from DMPA use, leaflets or pamphlets on this particular topic could be developed and given to every DMPA acceptor after receiving her injection. This will provide women with a helpful reference material or guide in the event that some side effects are experienced and a return visit to the health center is not immediately possible.

REFERENCES

Department of Health and USAID (n.d.). DMPA Information Kit.

Population Council (1994). DMPA Monitoring and Follow-up Studies, Operations Research Proposal. Population Council, Manila.

Raymundo, Corazon and Grace T. Cruz (1993). FP-Client Worker Interaction as an Ingredient of Quality of Care. *Philippine Population Journal*, vol. 9 nos. 1-4.

Roberto, Eduardo (1993). Perceived Factors of Family Planning Clinic Performance and Service Quality. *Philippine Population Journal*, vol. 9 nos. 1-4.

Sealza, Lita-Palma (1993). Factors Affecting the Family Planning Program Drop-out Rates in Bukidnon Province, the Philippines. Population Council, Manila.

APPENDIX A:
Sample DMPA Reminder Card