Chapter 6

Client-Provider Interactions: Discussing Side Effects

This chapter examines some of the daily practices of family planning providers. Since the investigators did not spend time in the clinic on a daily basis and did not observe routine practices, this chapter focuses mostly on how providers and clients discuss the effects of the contraceptives during clinic interactions and what providers said about their own clinical practice. As discussed in the introduction, the client-provider interaction is a central focus for improving the quality of family planning services, although other aspects of service delivery, such as the constellation of methods provided, availability, and access, are also key aspects of quality over which the provider may have little control. (Chapter 5 touched on strategies used by women to increase the somewhat limited choice of family planning methods available at the government clinics, such as going to private clinics and pharmacies for different brands of oral contraceptive pills.) The decision to explore the client-provider interaction over issues related to access was suggested not only by the DHS survey results but also by the study data.

Rapid facility assessments conducted at the four rural health clinics serving the study communities showed that the clinics were at the time adequately stocked, equipped, and staffed. The services provided are free, although a donation is requested. Thus, cost is generally not an issue. Because clinics were located in each barangay, women living in the study areas did not have to travel far to get to a facility. The reasons given by study participants living in these municipalities for discontinuing contraceptive methods when they did not wish to become pregnant were rarely related to access and supply issues but rather side effects and health concerns as the countrywide DHS found. Thus, it was decided to focus on the client-provider interaction rather than the other aspects of quality in family planning services.

A routine family planning client visit involves assessing why the woman came to the clinic, providing information on methods and follow-up, counseling on side effects, and other method use issues. Depending on the method a client is using, a routine visit might involve performing procedures such as taking the blood pressure, obtaining consent and conducting an IUD insertion, giving an injection, and/or providing supplies and referrals. As part of the first-time family planning client assessment, all of the midwives interviewed said that they ask women whether they are married and will only provide services if they say yes. For a new acceptor, midwives said they routinely ask whether their husband knows and agrees with the woman's use of the method requested.

The discussion below illustrates how women's health concerns and reported effects of pharmaceutical contraceptive methods offered through local government clinics are discussed in clinic interactions with midwives. This discussion should not be understood as an evaluation of clinic practice in Quirino Province nor even the four study clinics. Rather, it is intended to illustrate the difficulties encountered by those who counsel on pharmaceutical family planning methods in the Philippine context, the approaches that work, and areas in need of more attention.

6.1 Precounseling on Side Effects

When prescribing a method of contraception to a woman for the first time, clinic procedures require counseling on the side effects of the method. When we asked midwives how they go about this type of counseling with a new pill acceptor, a midwife began with an explanation of why women stop using pills soon after starting:

> *"We have those who take the pill for one or two months, and they feel headache or dizziness, and they will stop taking the pill already."*

To address this, she said,

> *"We tell them that after three months OK, the body will adjust to the medication . . . [Before they start, we tell them] maybe they will have some discomfort like nausea because of taking the pill every day like that, or sometimes others will feel headache but that is normal. After three months, no more. It is just an adjustment. But for some women, it is no problem at all."*

During a clinic visit, another midwife exemplified this type of counseling strategy with a woman returning for a resupply of pills after her first month of use. When the woman told her that she was experiencing headaches, she said,

> *"It is just the side effects. Within three months, we call it as the adjustment period; after that, it will be gone. It is just normal to a new user to be adjusted with the method. What else have you felt?"*

The adjustment period is a clear concept and is taught through precounseling and follow-up counseling. The adjustment period is also described in detail in the UNFPA patient education literature on the pill, which is available in the clinics. Most women interviewed did understand the adjustment period when taking a new method, especially pills, although they spoke about this as an active process. For example, Josie said,

> *"At first, I felt like I was conceiving, and later, I learned to adapt to the method."*

Precounseling on IUD side effects was done a bit differently by the following midwife. She said,

> *"With the IUD, you will have profuse menstruation. That is why the method is not good for an anemic person."*

Rather than saying "maybe" you will experience this side effect, she says you will have this experience. Although her authoritative stand on the method makes her sound sure of herself, the information provided is not accurate from either a humoral or biomedical perspective, and thus, it will likely backfire at some point. It could cause a potential new user to reject the method outright, although it might have been a good option. Or if this woman with a new IUD inserted

does not experience profuse menstruation, it could cause them to question the competence of the midwife.

6.2 Counseling on Weight Gain and Sexual Side Effects

Midwives asked women whether they were "becoming fat" with the method to assess the general acceptability of the method or whether the woman felt *hiyang* with the method. Conversely, clients answered with a statement about growing stout when asked about side effects. For example, one midwife asked,

> *"What are your experiences in using pills?"*

The client answered,

> *"None, I'm getting fat."*

Although this is a general sign of being *hiyang*, not all women desire to gain weight, and this issue came up in the client-provider interactions. During a clinic visit for a DMPA injection, the midwife told Rose that her blood pressure was 120/80 and that she weighed 69.6 kg. Rose commented,

> *"I'm becoming fat already."*

To which the midwife responded,

> *"Better than you become thin. Any other problems?"*

The midwife did not return to the issue of weight later in the interview but rather dropped the subject altogether and thus bypassed an opportunity to explore the side effect. Another midwife did address the issue of weigh gain raised by the client, illustrated in the following conversation:

> *MW: What are your problems in taking the pills?*
> *C: I become fat, and sometimes, I had spotting.*
> *MW: Maybe you need to control your diet.*
> *C: What other methods can you offer that I will not become fat?*
> *MW: IUD.*
> *C: But I don't want it. How about depo?*
> *MW: The more you will become fat.*
> *C: I'll just continue using the pills.*

Here the midwife does suggest the IUD when prompted by the client; however, the client says she does not want an IUD, raising the issue of how much the midwife should discuss the client's understanding of the IUD or should just allow the client to "choose" her own method. It is interesting that she does not suggest condoms in the encounter. It also demonstrates the bind that

midwives are in because they do not have enough alternative methods to offer clients who do not tolerate or do not prefer the two hormonal methods offered at government clinics.

Another midwife used the same tack, avoidance, as a midwife quoted earlier when a client raised her experience with sexual side effects of the methods. The following discussion took place between the midwife and a client receiving her third shot of DMPA:

> *MW: So this is your third shot? What do you feel since you stared using depo?*
> *C: I have a good appetite to eat, and sometimes I felt dizzy.*
> *MW: What else?*
> *C: If it's about our sexual contact with my husband, I have no urge, and I never respond.*
> *MW: You don't have urge; you did not feel anything?*
> *C: Yes, ma'am, even my husband, he's not contented.*
> *MW: By the way, how many children do you have?*

Again, the midwife, who has more control over the topics discussed in the interview, dismissed the issue of sexual problems and moved on to other matters and did not return to the issue raised by the client during the interview.

It was interesting that although the midwives interviewed generally thought women would tell them about all the side effects, including sexual ones, some participants said that they would not discuss sex with the midwives because they would not be able to do anything about it. For example, during an interview, Becky explained why she stopped mentioning sexual side effects to the midwives in the clinic:

> *"If it is about sex, when I am using depo, I experience dryness and that is one of my problems also. It is very painful during our contact with my husband. I shared it with my fellow mothers when we had discussions . . . Yes, [I discussed the effect] with the midwife, but she didn't explain it clearly. She just said it was normal. Even if I tell her that I felt really bad, she insists that it was normal, as if I'm just making an alibi."*

Becky went so far as to find some literature on DMPA.

> *"I read an article about depo, and sexual changes are not indicated there as a side effect. I didn't ask the midwife anymore because I'm sure she will not give me a good explanation."*

As discussed earlier sexual side effects occurred in 5 percent of the large sample of American women included in clinical trials of DMPA, whereas in the current study many more than 5 percent reported these side effects. In fact, the DMPA pamphlets by the United Nations Population Fund (UNFPA) that are given out in the clinic also do not mention sexual changes as a side effect of the method. Rather the pamphlet discusses "changes in menstruation" and mentions "increased weight due to increased appetite," "headaches," and "flatulent or bloated feelings" as the side effects of the methods (Philippines Family Planning Program [PFPP] in cooperation with UNFPA). From this, Becky surmises that midwives, whose work is based on

this type of information, will likely be of little help regarding women's experiences with the methods.

In the group discussions following the round table presentation of the study results, several groups of midwives and BHWs were asked to answer the following questions generated from the findings on weight gain and sexual side effects:

> *How do you counsel women on sexual side effects and weight gain? Is there anything that you can do about them? Are weight gain and sexual side effects good reasons to switch methods?*

The majority of midwives, BHWs, and nurses present at the round table reported that these were not "real" but rather "psychological" side effects of the methods. One midwife went on to tell the large group that she counsels her female clients by telling them that it "is normal that women lose interest in sex after a certain age" and that this "natural" tendency, rather than the method, is causing their loss of interest in sex. She also added that they counsel women on better eating habits when they report too much weight gain. She concluded by saying that neither weight gain nor sexual side effects were good reasons to switch to another method. When the facilitator asked the seven other members of the group whether they agree, they all shook their heads yes. This caused one 65-year-old female audience member to offer her own personal experience as testimony to demonstrate to the group that women do not necessarily loose interest in sex when they age. Midwives would benefit from training on the side effects identified in clinical trials and normal sexuality. Menstrual changes resulting from hormonal method use also presented a huge counseling challenge for midwives.

6.3 Counseling on Menstrual Changes

Midwives are aware of this difference in their perspective on the body and that of the client although they would probably not articulate it as differences in understanding of the body. In fact, it is a source of frustration for many of them. For example, one midwife said,

> *"They feel they are being poisoned if their period doesn't come . . . They come to ask us is there anything we can use to cause the menstruation? I usually tell them that is injectable depo; it is natural that you will loose your period . . . I tell them [when they get the shot the first time], but they insist on telling that no, it is not safe that we will lose our period."*

Midwives, many of whom come from similar backgrounds as the women they serve, draw on both humoral and biomedical knowledge in daily clinical practice. Some were not always managing changes in menstruation caused by the methods using a biomedical approach. This was evident in what clients said about how the midwife had advised them. For example, several said they were told by the midwife to stop using DMPA after a prolonged period of amenorrhea. It is not clear whether this is done to gain the confidence of women in the community who understand the menstrual changes caused by the methods to be unhealthy or whether some midwives themselves may feel menstrual loss is not a healthy sign. Most midwives do counsel

patients that the menstrual loss with DMPA is natural and harmless. Women work around the midwives when they disagree with their analysis of the situation, which happened frequently among the study participants. For example, Mary said she decided that since she was one of the women who did not have menstruation with the method, she just went in when she deemed it necessary:

> *"I used depo for around a year and stopped. For six months, I had no depo injection, and after that, I had my menstruation again. When I had depo injection, I did not menstruate, not even a single drop of blood; that's why I informed the midwife, and she told me that it's just the normal side effect of depo. Side effects vary for each woman. Some women experience heavy flow for a month, while others do not. That's why when I had amenorrhea, I did not ask the midwife again . . . I just stopped last September to let my menstruation go back to normal . . . Then I used depo again."*

A classic approach for addressing differences in understandings related to the body or "lack of knowledge" as it is often referred to by clinicians is to reeducate clients by instructing them on the biological body. One midwife used this technique in one client-provider interaction. In this instance, the client had decided to begin using DMPA, and the midwife went into greater biological detail while explaining the method and follow-up:

> *"In depo, you have to come back every three months. Depo contains progesterone; it prevents ovulation. Some women experience dryness because it thickens the vaginal mucus and thus it prevents the sperm cell from entering the uterus. If there were no meeting of egg cells and sperm cells, there will be no pregnancy because there will be no ovulation. You know what ovulation is?"*

To this question, the client responded,

> *"Yes, I know."*

It is possible but not probable that the client holds the same ideas about ovulation as the midwife. At this point, the midwife might have been wise to ask the client how ovulation works. However, she assumed the client had the same understanding of ovulation and went on to instruct the patient as follows:

> *"If you experience dizziness, severe headache, and bleeding, just come back here. But the side effects of depo are dizziness, mild headache, and spotting."*

When the client asked for clarification on the central practical issue, changes in menstruation, the following exchange took place:

> *C: Is it normal if I experience spotting?*
> *MW: Yes.*
> *C: How come that is normal?*
> *MW: Because you never ovulate.*
> *C: Ok, ma'am.*

The midwife's answer is not particularly direct, and the client probably does not understand what the midwife is talking about, but she does not push the issue. The client's observations or thoughts on spotting and menstruation are not even discussed. The biological explanation works better when a model of the body is used and such models were available in the study clinics, although this approach has clear limitations. BHWs receive more education on family planning methods than the average woman in the province, although as illustrated below, they do not necessarily incorporate these ideas totally.

Barangay Health Workers

Interviews with barangay health workers as discussed in the last chapter, illustrate that they hold assumptions about the body that are closer to the average woman in Quirino Province. For example, two excerpts from interviews with barangay health workers illustrate the ways that humoral and biomedical knowledge are combined during counseling of clients. When asked why one of her clients stopped taking DMPA to get her menstruation back, Georgia, a barangay health worker, said,

> *"It's like the car; it needs a change of oil. In menstruation, it will cleanse the uterus and it is better to have menstruation every month."*

Although she uses the classic biomedical machine-body analogy, the common-sense assumption is that a woman needs to have her menstruation every month to be healthy. Another barangay health worker, uses the lifespan of the average red blood cell to explain why women need to menstruate:

> *"Our blood has lifespan for 120 days after which it will be changed to another blood. The matured blood will go to the uterus as menstrual blood if it is not fertilized by sperm cells."*

Again, the biological information is combined with common sense derived from a different kind of body to rationalize why a woman needs to have her menstruation to be healthy. It was interesting that BHWs incorporated bits of what they learned about biology to rationalize why decreased menstruation was unhealthy and also why a slight increase in menstruation with the IUD could actually be healthy. Whereas a few midwives may be recommending that clients stop using a method when they become amenorrheic, it is likely that many of the BHWs hold this view and advise their neighbors as such.

6.4 Reading the Blood Pressure: High and Low Blood

Besides having different common sense about the importance of menstruation for good health, clients and providers also held somewhat different assumptions about what constituted the illnesses of "high blood" and "low blood" and the potential effects of the contraceptive methods. Many Filipinos have experienced high blood and know the symptoms.

For example, when asked what the symptoms of high blood were, a midwife responded,

> *"Headache, neck pain, dizziness, and feeling nausea. Then we have to get the blood pressure. Usually, they can feel it [the blood pressure]."*

When asked,

> *"Do you get it yourself?"*

She said,

> *"Yes."*

This is commonly translated as hypertension, a biomedical-illness category. Cardiovascular disease is the leading cause of death in the Philippines. Hypertension is often called "the silent killer" because although hypertension threatens the health of an individual, many people do not know they have it because they cannot feel it. The question of whether a person can feel high blood pressure gets varied responses from biomedical doctors. Some say yes, some say no, and some say that certain people who are more sensitive can feel it and others do not. Women in Quirino can feel high blood and know what leads to it. High blood and low blood are opposites in humoral terms, so one has either an excess or a deficit but not both.

The client provider interactions and home interviews suggest that clients regularly read a different meaning into the blood pressure checks performed routinely by midwives in the clinic. For example, during a home interview, Josephine a barangay health worker, said,

> *"I always have my blood pressure checked because I'm afraid. I am thinking that my blood pressure is getting high, but it's just normal, 120/80."*

When asked whether she had experienced high blood pressure in the past, she responded,

> *"No, but when I was not yet using depo before, my blood pressure was 90/60. When I used depo, my blood pressure was good . . . 120/80."*

It is interesting that women found so much significance in the reading of the blood pressure, something of little interest to patients in many other clinical settings who are not diagnosed with hypertension. Not only does Josephine purposely go to get her blood pressure checked at the clinic even though she has not been diagnosed with hypertension, but she also finds the minor differences in the readings significant to her health. Neither of the readings would be considered significant from a clinical perspective since they are both "normal." The client, however, in this case, a barangay health worker, finds them significant and takes the slightly higher reading 120/80 to mean that her blood is more in balance perhaps, neither high nor low, and she takes the normal lower reading to mean that she was slightly low blood before she took DMPA. In other words, DMPA is improving her health to some degree. Georgia was not alone in her concern about blood pressure that was "too low."

A low blood pressure reading, understood either as one that is lower than 120/80 (the standard biomedical "normal" reading) or one that is lower than the last reading, was at times understood as a confirmation of low blood or anemia. Following from this, when one's blood pressure reading is a bit higher, it could be confirmation that the anemia has abated. For example, Elizabeth, a barangay health worker, explained that her anemia was indeed improved by using DMPA:

> *"Yes, I became fat [while taking DMPA] and besides what I know before is that I am anemic. But upon using DMPA my blood pressure became normal."*

Clients expressed some doubt about whether their blood pressure was indeed normal in the clinic. In another client-midwife interview, when the midwife told the client,

> *"Your blood pressure is normal, 90/70."*

The client responded,

> *"Is it, midwife?"*

Appropriately, the midwife responded,

> *"Yes, as long as you don't feel dizzy and other negative feelings."*

Clarifying the symptoms of high blood versus low blood according to clients' reports, one physician said,

> *"They say headache and dizziness with anemia. [With high blood pressure], they say the symptoms are 'just the same, but the symptoms are more profound.' With anemia, one symptom is insomnia."*

The following exchange took place in an interview with a participant, Valentina:

> *V: My blood pressure was 90/80. After taking the pills, my blood pressure lowered to 70/60. That is why I can't sleep well at night.*
> *I: So your blood pressure was low?*
> *V: Yes.*
> *I: Do you consider this as a side effect?*
> *V: Yes, and until now I am experiencing it.*
> *I: What did you do to remedy this?*
> *V: I took multivitamins.*

Ferrous sulfate tablets, sometimes referred to as "vitamins," were given to clients with low hemoglobin readings or those who said they had profuse menstruation. Sometimes, clients reporting dizziness, thinness, or a poor appetite were also supplied with "vitamins." What is interesting is that giving ferrous sulfate, or vitamins, is often thought to "increase the blood" or the blood pressure since these terms are used interchangeably. This came out in both home and

clinic interviews. For example, a woman who wanted to continue pills but was being taken off the pill by the midwife had the following exchange:

> *MW: No. You cannot continue the pills because your blood pressure is getting high.*
> *C: Because the pills contain vitamins?*

It is not clear that the midwife even heard the question, but she went on to prescribe another contraceptive method as a substitute for the pill. It is possible that if the patient thinks the "vitamins" in the packet of 28 pills (that is the 7 ferrous sulfate filler tablets) are causing the high blood pressure, she might continue pills but avoid taking the ferrous sulfate tablets while possibly having hypertension.

One perceptive physician we spoke with is well aware of the translation problems related to high and low blood, anemia, and hypertension in the clinic, since patients with high blood pressure readings are referred to him for evaluation. He said,

> *"When the blood pressure is down, they think it's anemia already for them. But I keep telling them that diagnosis of anemia is based on hemoglobin. I've been telling them this. But some segment of clients are still confused about the high blood, anemia and/or the low blood . . . Yes, I've been telling them that they could have high blood and anemia at the same time because they are different things because if you have high blood, the pressure of your blood is very high, and then you have anemia because the hemoglobin is very low. So you can have them both. But then it's a contradiction for them. [They might say], 'how can you have anemia and high blood?' something like that. But I'm telling them they are different things."*

The picture of a person with both anemia and hypertension hits the heart of the theoretical differences between the humoral and biomedical body and seems to be an excellent strategy to stimulate dialogue with clients on their differences in perspective.

6.5 Counseling on the IUD

Suggesting the IUD is perhaps one way to avoid the problems related to menstrual changes resulting from the hormonal methods. This strategy was used by one midwife who reflected as follows:

> *"For some, they missed, they long for their menstruation. I usually advise IUD [to those women]."*

Of course, the woman has to choose the method and of course there are several reasons already mentioned for why they do not choose it, one being that it is not very practical for working women and could cause the uterus unnecessary exposure to cold. One midwife asked the patient what she heard about the IUD. She responded,

> *"They were telling that if you carry heavy things, the IUD might come out."*

She then went ahead and advised,

> *"No, it's not easy for the IUD to come out without any cause. To avoid any problem, better if you will not carry heavy things if you have your menstruation."*

When asked whether she would prescribe an IUD to a hard-working woman, a midwife reflected on the practice of telling women to avoid carrying heavy things when menstruating.

> *"They [those who do heavy work] can [get an IUD], yes. But we tell them that during menstruation, we tell them not to lift heavy things or it will be expelled . . . We tell them so that they will use the IUD. If you will not have problems, don't carry heavy things during your menstruation so that you don't have problems. We also say things like that so they will use it . . . That is only our strategy . . . We also tell them, before injecting the IUD, we have to measure the depth. Then we can tell them it's not low."*

The utility of using this as a strategy is questionable. Honesty is often the best policy although allowing the client to talk about her own perspective and agreeing with her need to avoid heavy work while menstruating may leave more room for presenting a different perspective later.

These findings illustrate some of the difficulties encountered in the clinic when counseling on side effects of the contraceptive methods. To varying degrees, midwives and barangay health workers work with two kinds of knowledge about the body, health, and illness on the job—one humoral, the other biomedical. One is promoted through midwifery schooling and BHW training and is supported by biomedical knowledge of the body and pharmaceuticals, and the other is cultivated through the experiences of women, hilots, and other community members in Quirino Province. The two kinds of knowledge neither agree on the meaning of the physical signs of menstruation and its impact on health nor on the type or frequency of side effects of pharmaceutical contraceptive methods. The provider's job often entails translating, interpreting, and negotiating these two kinds of knowledge and experience as they provide services to women.

Daily clinic practices such as conducting precounseling and follow-up counseling on the "adjustment period" are reflected in women's understandings of contraceptive methods, especially the pill. The use of a passive or an authoritative approach when advising on side effects sometimes caused women to stop going to the government clinic for family planning services or to stop telling the midwives about particular effects of the methods such as the sexual side effects. The passive approach was exemplified in avoiding or ignoring women's reports of side effects deemed "psychological" by midwives, such as weight gain or loss of sexual interest. The authoritative approach involves being overly confident that one can predict the side effects that will be experienced by an individual client. Misunderstandings between providers and clients, for example, about the meaning of high and low blood pressure and the reasons for prescribing or discontinuing methods, occur on a daily basis in the clinic. For example, practices such as screening women for high blood pressure before prescribing the hormonal methods and taking some women off the medication because of an increase in blood pressure, may support women's hypothesis about the connection between high blood and high blood pressure. Midwives encounter situations where they do not have enough alternative methods to offer to women who are not able to tolerate a method or who do not like the effects of the methods

available at the clinic. Offering a client a different method is the obvious option for addressing the weight gain, headache, or sexual side effects of the methods. Additionally, midwives are not teaching clients ways to counteract the sexual side effects of contraceptive methods, such as the use of artificial lubrication to make intercourse more comfortable. It is quite possible that the strong position taken by midwives on the "psychological" nature of the side effects reported by their clients, such as weight gain and sexual dysfunction, reflects their biomedical orientation. They may not be sure how to improvise explanations to patients using the logic of the humoral body, or they may simply feel the need to assert more authoritatively the biomedical position on menstruation in a context where women learn the a different logic about health and menstruation at home.