Chapter 7

Conclusions and Recommendations

People in different sociocultural contexts respond differently to the use of contraceptive methods. Although many of the same effects occur with the use of the pill, DMPA, IUD, and condoms throughout the world, such as menstrual irregularities and amenorrhea, they are felt, understood, and acted on within particular sociocultural circumstances. The contraceptive experiences of women in Quirino are profoundly influenced by their understandings and practices related to menstruation and fertility derived from humoral assumptions about the natural body, health, and illness. Women's understanding of health, and the suitability of a method to a woman in particular is not simply a matter of the safety and efficacy of the method (although this is important) but also whether it fits or even improves the quality of their lives including their relationships. This is reflected in the concept of *hiyang* or suitability.

The study participants experienced a particular pattern of effects with hormonal method use, including decreased or absent menstruation, headache, dizziness, and hotheadedness. The pattern of effects correspond to humoral illnesses of "high" and "low blood" and women identified high and low blood as major health concerns related to using the hormonal methods. Women's speculation about accumulating menstrual blood or pills gives rise to health concerns such as high blood, tumors, and cancer that are voiced by women. Some of this could likely be alleviated by using the 100 mg dose of DMPA rather than 150 mg standard dose (Gray, 1981; Said 1986; Said, 1987). Although women report fewer effects from the IUD, they often do not choose the method due to the "open" and "slippery" nature of the uterus during menstruation and the expectation that it might easily fall out and also perhaps because providers are hesitant to promote the method. Although the women who use IUDs are less likely to discontinue them, some experienced the pattern of effects, such as cramping, dizziness, and abdominal pain, that were attributed to hot-cold imbalance related to IUD use.

Although women usually choose their own contraceptive method, men influence the use of contraceptive methods through negotiation about the wives experiences of the effects of the methods. Sexual side effects, including lowered libido and coital dryness with DMPA use was much higher than one would expect given the findings of clinical trials on American women. These effects were sometimes disruptive to the couples' relationship for a period of time, although the majority of women stopped the method before one year of use. Men, however, were generally not willing to prevent the discomfort and health effects of contraceptive use for their wife by using condoms. Providers and program planners also influenced women's contraceptive practices.

Cultural differences in the social construction of the humoral and biomedical body make the provider's job of communication and negotiation difficult. The key to competent "cross-cultural" care and counseling is to respect the diversity of experience among clients and community members, including their understandings related to the body, health, and illness. In direct opposition to biomedical common sense and much of the family planning literature that promotes a decrease in menstruation as an "advantage" of hormonal methods, an increase in

menstruation is considered healthier by Quirino women than a decrease in menstruation. In this study, midwives and even public health nurses were either not completely informed about the biomedical side effects of the methods or were taking a strong authoritative stance on the "realness," or conversely the fictitiousness or "psychological-ness," of side effects to the detriment of their clients. For example, midwives tended to avoid discussing sexual and weight gain side effects with clients. This dynamic is also the result of midwives not having a sufficient variety of contraceptive methods to satisfy those clients who cannot tolerate any of the methods currently offered through the government clinics. That some midwives are not treating side effects as real is troubling since good counseling on side effects of contraceptive methods is the linchpin of good-quality family planning care.

Even though the majority of women seem to be getting through the adjustment period when using a new method, they are less likely to get the kind of information or be provided the choices they need to develop a biologically sound, long-term strategy for preventing pregnancy. Because of the differences between the biomedical perspective and the humoral perspective of the body and the relations in the clinic, a significant number of women develop contraceptive strategies that expose them to the possibility of becoming pregnant long after an adjustment period has ended. For example, women sometimes took pills only when their husband was at home or used DMPA according to the body's menstrual response to the drug rather than every three months. Some women drop out of clinic service completely because their experience with side effects are not recognized as real or are ignored by midwives or because the clinics do not offer an acceptable method of birth control. The women who used a method for an extended period tended to report no change, a slight decrease or an increase in menstruation and few other accompanying side effects. This was true especially for long-term users of the pill and the IUD. The same sociocultural dynamics of the body, health, and illness that affect the experience and use of contraception in Quirino are likely to arise in other provinces of the Philippines. This will likely be true to the extent that humoral logic, experiences and practices related to the body, health and illness, and quality of care are similar.

This raises a central question: What are better ways to discuss and manage differences in the social construction of the body, illness, and medicine with clients? First of all, it appears that rather than teaching providers to value and make use of humoral knowledge in their clinical practice, nursing, midwifery, and perhaps medical schools are attempting to train local knowledge out of providers. This approach provides little in the way of cross-cultural insight or tools that might assist providers in coping with the very real cross-cultural issues that arise in their daily clinical practice. Thus, the following two recommendations are made for training providers.

- The training of midwives, doctors, and public health nurses might incorporate modules on alternative perspectives of the body, how to show respect for differences, and how to negotiate treatment options. This type of module would include, for example, discussions designed to sort out the differences between humoral and biological views of the body, health, and illness, and their significance in women's lives. The training might also include practical skills for eliciting the client's perspective on the body and identifying areas where their perspectives conflict and ways to negotiate treatment options.

- Training of midwives should include information on the incidence of biological side effects of the methods derived from clinical trials as well as the understanding that the incidence varies depending on the characteristics of the group serving as subjects in clinical trials. In other words, pharmaceuticals such as DMPA may have somewhat different effects on Filipinos than on Americans or Mexicans, for example.

Second, providers function best when they have the resources they need to provide good service. Without a sufficient variety of methods, midwives may feel more pressure to try to convince women to use those methods that are available although they may not be well suited or may even be intolerable to them.

- Consider providing diaphragms, several brands of oral contraceptives, and emergency contraception through government family planning clinics or partnering institutions.

- Consider using 100 mg dose of DMPA in this population rather than 150 mg. dose through government clinics.

- Consider providing biologically based information on the use of natural methods such as periodic abstinence and withdrawal since many couples use them (Tan, 2000).

Providers would also benefit from clinical standards references that are specifically geared to sociocultural understandings and practices surrounding contraceptive use in their country or local area and from health education pamphlets that fully reflect the experiences of women using the methods.

- The *Family Planning Clinical Standards Manual* should be modified to include counseling on sexual side effects and weight gain, to reflect an underlying respect for women's views on the body and how to communicate this respect to the client through actions, and how to negotiate the two sets of assumptions (humoral and biomedical) about the body and health.

- The health education pamphlets produced by UNFPA and distributed through government family planning clinics should add decreased libido and coital dryness as possible side effects of DMPA and oral contraceptives and should describe what to do if side effects are experienced.

Third, regarding counseling, ignoring the humoral view of the body and treating women's and men's views as "misconceptions" clearly is not a respectful or culturally sensitive strategy. In addition, it is not enough to tell a woman that amenorrhea will likely occur after injections or that menstruation will diminish with use of the pill and that this is normal, and leave it at that. An exclusively cognitive approach toward educating clients, such as using a biological model of the human body, does not work well with issues related to what people have physically experienced, for example, that a sluggish or absent menstruation causes headaches, dizziness, and hotheadedness. However, understanding the cognitive differences in the humoral and biomedical body allows providers to identify areas of chronic miscommunication, such as the meaning of high blood versus high blood pressure or that amenorrhea does not mean that one cannot get pregnant, and allows providers to address those misconceptions in routine clinical practice and

health education measures. Fortunately, it is not necessary for a provider and client to agree on the theories of the body or the cause of illness to find a solution that works for both parties. Both husbands and wives are involved and should be included in every aspect of health education efforts in this direction. Beyond this, good cross-cultural counseling skills in this setting would involve the following:

- Treating women's experiences as fact: If a woman says she has a side effect from a method, it does not matter whether it is biological, social, cultural, psychological, or political. It still needs to be heard, discussed, and addressed in the treatment plan.

- Understanding that switching is not a bad thing: Clients should be provided with the option of switching methods for side effects such as undesirable weight gain, sexual dysfunction, headaches, dizziness, or amenorrhea. By doing so, clients will more likely switch methods under the guidance of providers rather than on their own or under advice from friends and relatives who may not be trained in family planning method use. Switching methods early on in one's reproductive career may facilitate finding the most suitable and reliable method for long-term use.

- Ensuring that counseling on side effects is ongoing: Counseling on side effects prior to giving out a method is important. However, perhaps more important is talking to the client about the side effects after they begin a method and when they raise concerns about the side effects or become not *hiyang* to the method after using it for several months. After experiencing unwanted side effects, women are often more open to listening and learning.

- Focusing on manifest effects: Negotiation of method choice should take place in a context of consideration of the manifest effects of methods, such as menstrual bleeding. rather than according to which theory of the body is viewed as "correct."