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**FACTORS AFFECTING THE
ACCEPTANCE AND CONTINUATION
OF IUD A COMPARATIVE STUDY**

PHILIPPINES

Final Report

**ASIA & NEAR EAST OPERATIONS RESEARCH AND
TECHNICAL ASSISTANCE PROJECT
FAMILY PLANNING OPERATIONS RESEARCH
AND TRAINING (FPORT) PROGRAM**

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

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EXECUTIVE SUMMARY

Interest in a study of IUD use in the Philippines stems from two major observations. First, findings from the 1997 cluster surveys indicate that, while IUD use is low in the country as a whole, there are nonetheless a few regions with fairly high levels of acceptance and continued use for this method (LPP-MICS, 1997). This suggests that there may be some program-level variables which account for these differentials. Areal differences in population composition or in beliefs and rumors relating to IUD may also be involved.

A second reason for this interest in the study of IUD use lies in the felt need to improve quality of care in the provision of FP services in the country. A recently concluded study on RTI integration revealed an association between IUD use and the incidence of RTIs (Population Council, Manila, 1998). This study will explore this relationship further and examine the role of clinic practices in this regard. More generally, it has been argued that improved quality of care, as shown by increased technical competence, adherence to clinical standards in terms of information and follow-up, upgraded infrastructures, can help to improve method mix and raise overall levels of FP acceptance.

Data show a steady decrease in IUD use over the past few years, even as oral contraceptives continue to gain in popularity. In 1994 more than 175,000 IUDs were inserted, as compared to only a little more than 127,000 in 1997. This decline is something of an anomaly, given the advantages of the method and the fact that IUD use remains popular in several other countries of Asia and the Near East.

The overall objective of the study then, is to investigate factors affecting IUD use in the Philippines. By knowing the reasons why some areas of the country reveal high IUD prevalence and others are quite low, program managers should be better able to design more effective strategies for improving program performance through increased IUD acceptance and higher continuation rates.

For this study, Misamis Oriental province in Northern Mindanao was purposively chosen as the high prevalence study site while Iloilo province in the Western Visayas served as the low prevalence comparison area. Specifically, the study addresses the following questions:

1. What are the levels of readiness of the SDPs in the low IUD prevalence (Iloilo) and high IUD prevalence (Misamis Oriental) areas?
2. Are there differences in quality of care being provided in Misamis Oriental and Iloilo? Are these differences associated with program performance, particularly concerning IUD use?
3. What are the factors associated with clients that may affect acceptance and continuation of IUD in Iloilo and Misamis Oriental?

The study utilized a modified situation analysis (SA) and Focus Group Discussions (FGDs) approach for data collection. **Four basic SA instruments** were used: **Inventory of facilities, equipment and supplies** (especially those needed to provide IUD services), **Staff interviews** (focussing on their technical competence to provide IUD), **Client-provider interactions** (includes all FP clients, with a few observations of IUD being inserted with the consent of the clients), and **Clients' exit interviews**.

The two study sites, Iloilo and Misamis Oriental, have 51 and 26 main service delivery points (SDPs) or Rural Health Units (RHUs), respectively. All of these SDPs were visited by the SA study teams consisting of a person with clinical training and a social science trained researcher. Both teams underwent training in conducting situation analysis arranged and facilitated by Population Council.

Thirty-two FGD sessions (16 sessions in each study site) were conducted with the different subgroups of women users in selected municipalities of the two provinces. Instruments for FGDs consisted of guide questions designed to elicit insights about women's attitude toward IUD use, experiences related to acceptance or dropout, perception of the community norms about family planning (with emphasis on IUD) and other IUD-relevant information.

Study results showed that when the two study sites (representing a high performance and a low performing area) were compared on three dimensions of readiness, Misamis Oriental came out to be clearly and consistently better than Iloilo. Misamis Oriental has more SDPs with adequate and clean water supply, working toilets, separate examination room (thus affording privacy), and have more IUD equipment and supplies than its counterparts in Iloilo. In fact, stock-outs of IUD in SDPs of Iloilo were almost three times higher than in Misamis Oriental. SPs in Misamis Oriental show a higher average in terms of years of family planning service. Misamis Oriental has almost 35% more SPs providing IUD services, specifically IUD insertions. It also has a performance mean of almost twice that of Iloilo. More importantly, one hundred percent of all certified SPs are providing IUD services. In Iloilo 60% of SPs are trained in IUD insertion but only 55% are actually providing IUD services.

In terms of availability of services, the SDPs of Misamis Oriental clearly have a wider array of FP/RH services offered than those of Iloilo. IUD services is one of the four services that is universally provided in Misamis Oriental, while this is being provided only by 82% of SDPs in Iloilo. Furthermore, and perhaps more importantly, only 40 out of 51 (78%) of SDPs offer IUD services in Iloilo while all 24 SDPs in Misamis Oriental offer IUD services every day.

Several program-related factors are found to be associated with the low IUD performance of Iloilo. While contraceptive methods are generally available in all fifty-one RHUs, the IUD, however, is not available in 9 out of 51 service delivery points. Iloilo also has fewer IEC materials on IUD. Moreover, 10 out of 51 service delivery points are not giving IUD services in any day of the week.

In terms of manpower, almost all (95%) of Misamis Oriental FP providers are certified IUD providers in contrast to only one-third of Iloilo's health providers. Although their doctors are mostly (91%) trained in IUD insertion and removal, Iloilo's middle-level providers (nurse and midwife), however, are deficient in training compared with their Misamis Oriental counterparts. Training is therefore not maximized because a significant proportion of the trained doctors are not performing IUD insertions.

The health and sanitation aspect of the clinics in Iloilo is poor. Lighting, adequate clean water supply, and hygienic conditions need to be improved. Adequate and clean water supply is especially crucial in maintaining a hygienic environment for IUD services.

What exacerbates these inadequacies is the lack of basic equipment for IUD insertion and removals in six percent of Iloilo RHUs. This problem is compounded by incidence of stock-outs in up to thirty-five percent (35%) of all RHUs. This makes the goal of improving IUD performance a difficult challenge for the Iloilo FP Program.

Another set of program-related factors posing roadblocks to IUD acceptance relate to management barriers, medical procedures and tests, restrictions imposed based on the woman's health-related conditions, incompetency barriers, and provider's bias. The **management obstacles** take the form of unskilled personnel and inadequacy of training. The low IUD performance of Iloilo can be partly explained by its lower percentage of providers who are certified, and lower service availability (with only 78% of its SDPs providing IUD services every day). Furthermore, 34% of SPs in Iloilo have not been trained in IUD insertion and removal. Interestingly, four out of every five providers in Iloilo underwent counseling training. This means that health providers in Iloilo have been upgraded on some aspect of FP service but not for IUD services.

The **medical barriers** consist of procedures and tests to be followed. Again, Misamis Oriental providers compared with their Iloilo counterparts felt that adherence to these procedures and tasks is essential. Providers from both places, however, do not consider RTI/STD screening as an important procedure in FP service delivery. This means that SPs have not appreciated the importance of RTIs/STDs and are not fully aware of the link that exist between IUD and RTIs. It is possible that the signs and symptoms of RTIs/STDs may have been present prior to an IUD insertion but because no screening was conducted (coupled by lack of training), RTI cases were missed.

A substantial number (majority) of providers in the two study sites put **restrictions** on IUD acceptance on the basis of age and number of children ("a woman must have at least one child").

Competency of providers is measured in terms of their knowledge on 1) when to perform an IUD insertion, 2) on medical conditions that rule out IUD use, and 3) knowledge of side effects. Providers from both Misamis Oriental and Iloilo are highly knowledgeable on when to do IUD insertion and on conditions which make it unacceptable. The Iloilo providers demonstrate poor knowledgeability of side effects especially with regard to conditions that warrant immediate medical attention.

Certain **biases of service providers** came out in the study which resulted from their experiences as IUD acceptors themselves, or previous cases handled which created problems and complications. Researchers found that some providers, because of their religious convictions, refuse to offer IUD services themselves. They delegate IUD insertions to others providers. This observation also came out in Misamis Oriental. It is interesting to note, however, that a majority of providers interviewed in both places claim that religion should not be a restriction to IUD provision and use.

The level of client satisfaction is high in both places. Providers are viewed as friendly and accommodating. Clients do not pay for the health services, however, giving of donations is encouraged. These range from ten (P10) to twenty (P20) pesos. The donation amount is the same for IUD insertion. It is interesting to note that women voiced willingness to give donations and even agreed to pay for the cost of family planning methods if these are for sale.

Knowledge of FGD participants on advantages and disadvantages of IUD as a method were obtained as a result of their own vicarious and actual experiences. An advantage viewed by some women can be viewed as a disadvantage by another group of women. For instance, pelvic examinations that are given regularly for IUD users are welcomed by some women because they are getting a free check-up. On the other hand, other women with strong inhibitions view this as a hassle and an embarrassing situation.

Factors that induced discontinuation include husbands objections due to experienced pain during contact and side effects. Among a substantial number of dropouts, the main reason for removal was infection, specifically abnormal and foul discharges, pus in the uterus, and lower abdominal pain coupled with fever and chill. Other women experienced allergy/rashes in their vagina, and painful intercourse, these experiences led them to request for IUD removal from the service provider. Husbands' objections due to the painful sensation during intercourse also figure in IUD discontinuation. Similarly, women report discomforts which they tend to ignore because according to them, the pain later diminish or eventually disappear.

In Iloilo, it seems that a certain amount of "anti-contraceptive culture" pervades among providers and clients alike. Cases about IUD failure and complications that were described earlier spread to other places. Interviewers heard the same stories repeated in other towns that they visited. However, this situation is more pronounced in places where these cases were known to have happened.

Program Recommendations

The scenario described above necessitates certain program interventions. Based on the findings the following sets of activities are recommended:

To upgrade facilities and physical clinic condition and hygiene in SDPs. This involves providing a continuous supply of clean water and lighting in the different facilities, including providing a separate room for consultation and counseling. Assessment of client's needs, and counseling should be integral parts of service delivery.

Conduct of refresher training. As has been shown by the data, providers were asking for training on management of side effects. Refresher trainings on contraceptive technology and sexuality are needed, given the prevalence of misconceptions about the IUD and inadequacies in knowledge that have been identified. Training on the management of RTIs should also be considered.

Rumors about the IUD abound in some places which necessitate interventions to change the negative image of IUD. Training and information campaigns to counteract rumors should be directed not only to clients but also to providers. Leaflets, media campaigns with testimonials from satisfied users, and endorsements from known personalities including NGOs and women's health advocates can be tested.

Husbands or partners must be drawn into the program by addressing their reproductive health concerns. The side effects experienced by husbands regarding IUD must be addressed before they can be expected to be more supportive of their wives' use of IUD.

Finally, something ought to be done to increase the availability of services and continuous contraceptive supply in the SDPs. That a number of SDPs (RHUs) do not provide IUD services and not every certified user is doing IUD insertions are certainly affecting IUD prevalence in Iloilo. The same is true for contraceptive stock outs. Program managers need to address these problems and exert stronger efforts to improve the elements of quality of care that have been found wanting in the SDPs covered by the study.

FACTORS AFFECTING THE ACCEPTANCE AND CONTINUATION OF IUD: A COMPARATIVE STUDY

INTRODUCTION

The interest in a study of IUD use in the Philippines stems from two major observations. First, findings from the 1997 cluster surveys indicate that, while IUD use is low in the country as a whole, there are nonetheless a few regions with fairly high levels of acceptance and continued use of this method (LPP-MICS, 1997). This suggests that there may be some program-level variables which account for these differentials. Areal differences in population composition or in beliefs and rumors relating to IUD may also be involved.

A second reason for this interest in the study of IUD use lies in the felt need to improve quality of care in the provision of FP services in the country. A recently concluded study on RTI integration revealed an association between IUD use and the incidence of RTIs (Population Council, Manila, 1998). It will be interesting to explore this relationship further and likewise examine the role of clinic practices in this regard. More generally, it has been argued that improved quality of care, as shown by increased technical competence, adherence to clinical standards in terms of information and follow-up, upgraded infrastructures, can help to improve method mix and raise overall levels of FP acceptance. This suggests that areas with high levels of IUD acceptance/continuation might be characterized as well by enhanced quality of care. Further study is therefore needed to see how these factors are interrelated.

Justification of the Study

While the IUD has already played an important role in the Philippine Family Planning Program for more than twenty years, there is a clear need to take a second look at this method. To begin with, the IUD offers several important advantages. It is long lasting, non-hormonal, and highly suitable for breast-feeding mothers. In the Philippines it rates considerably higher than oral contraceptives in terms of use effectiveness. (Indeed, birth interval data from the 1993 National Demographic Survey indicate that the use of oral contraceptives has only a slight impact at best upon spacing patterns.) The IUD is also a cost-effective method, since it requires only a single insertion on the part of the service provider.

Nonetheless, data show a steady decrease in IUD use over the past few years, even as oral contraceptives continue to gain in popularity. In 1994 more than 175,000 IUDs were inserted, as compared to only a little more than 127,000 in 1997. This decline is something of an anomaly, given the advantages of the method and the fact that IUD use remains popular in several other countries of Asia and the Near East.

Objectives of the Study

The overall objective of the study, therefore, is to investigate factors affecting IUD use in the Philippines. By identifying the reasons why some areas of the country reveal high IUD prevalence and others are low, program managers should be better able to design more effective strategies for improving IUD program performance through increased acceptance and higher continuation rates.

The specific objectives of the study are as follows:

- 1 To determine the readiness of the SDPs in specific local government units (LGUs) to provide quality FP/RH services focussing on IUD as one of the FP methods being provided,
- 2 To identify programmatic factors that affect both the prevalence and continuation of IUD, as well as an FP method, and
- 3 To study the knowledge, attitudes and practice of both providers and clients (IUD acceptors, IUD drop-outs, and users of other FP methods) with regard to IUD as a family planning method.

RESEARCH METHODOLOGY

The 1997 cluster surveys reported IUD acceptance rates to be much higher in some regions than others. For example, the 1997 Family Planning Survey found 11.0 percent of all eligible women from Northern Mindanao to be using this method as compared to only 1.9 percent in Eastern Visayas. Provincial variations are higher still. The cluster surveys of 1997 (Local Government Performance Program (LPP) Multi-Indicator Cluster Survey) thus show acceptance rates of 19 percent in Misamis Oriental, as compared to much lower levels for some of the other provinces of Region 10.

Study Design and Setting

Misamis Oriental province in Northern Mindanao was therefore purposively chosen as the high prevalence study site while Iloilo province in the Western Visayas served as the low prevalence comparison area. The choice of these two provinces was based upon the following criteria on the contraceptive prevalence:

1. **Contraceptive Prevalence Rates** The contraceptive prevalence rates for any method and for IUD are as follows for the two provinces:

Province	Overall CPR	IUD Prevalence
1 Iloilo	58.1	2.8
2 Misamis Oriental	60.6	30.5

2. **Ease of communication** The medium of communication in Misamis Oriental and Iloilo provinces is the Visayan language (i.e., Cebuano for Misamis Oriental and Ilonggo for Iloilo) and the interviewers from the Research Institute for Mindanao Culture who served as interviewers for the study have excellent abilities to speak and understand both dialects.

Study Sites

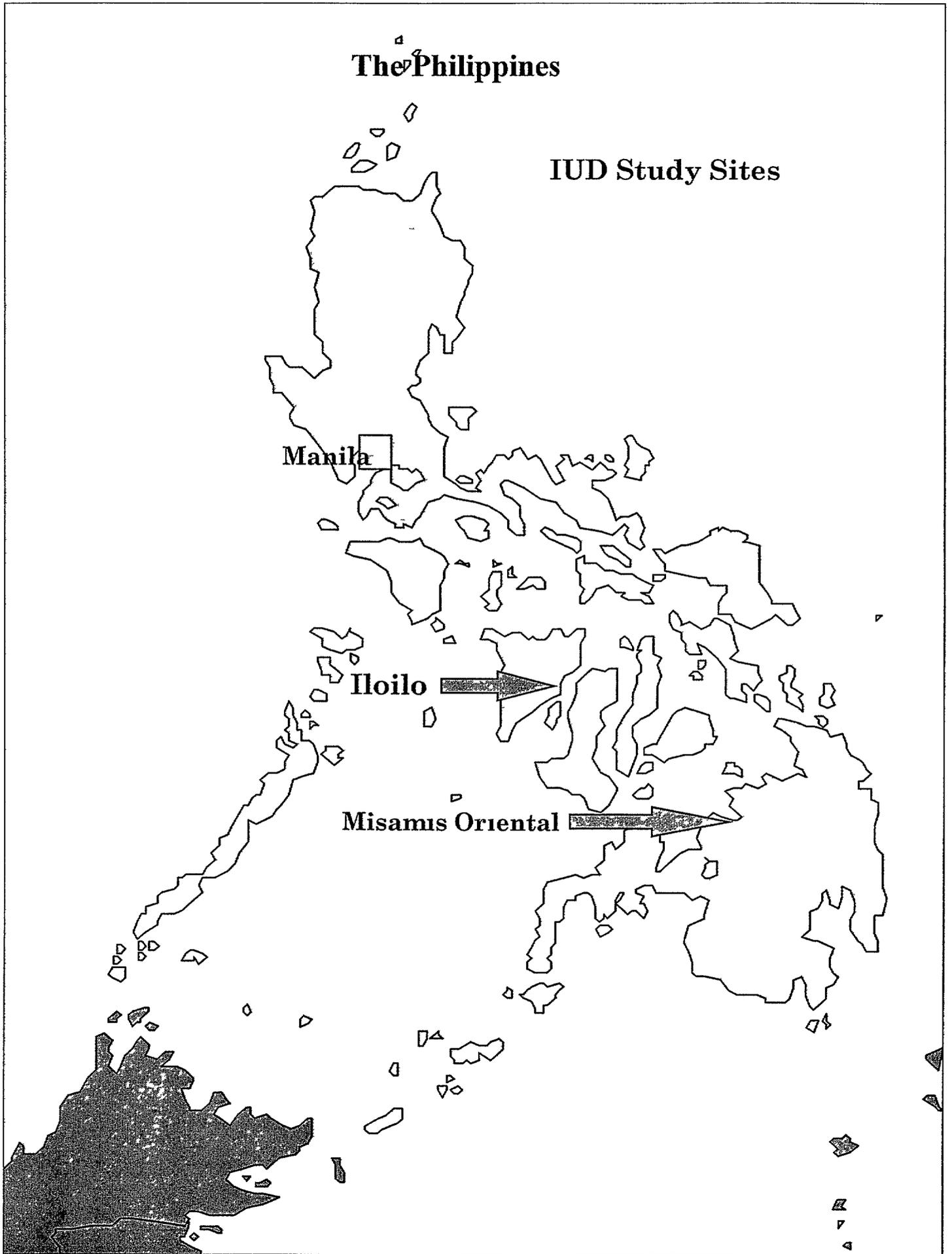
A comparison of the two provinces in terms of basic demographic and socio-economic characteristics are given in Annex 1. Iloilo had been an area of out-migration for the past four decades while Misamis Oriental had been an area of in-migration, until the recent decade when the movement to Mindanao has slowed down. Iloilo has a population of 1,749,558 reported in the 1995 census comprising 43 municipalities and one city. Misamis Oriental has a population of 1,015,865 with 24 municipalities and two cities. **Figure 1** shows the location of these provinces in the Philippine Map.

Data Collection

The study utilized the rapid assessment approach through the use of a modified situation analysis (SA) and Focus Group Discussions (FGDs). Four basic SA instruments were used: **Inventory of facilities, equipment and supplies** (especially those needed to provide IUD services), **Staff interviews** (focussing on their technical competence to provide IUD), **Client-provider interactions** (includes all FP clients, with a few observations of IUD being inserted with the consent of the clients), and **Clients' exit interviews**.

Instruments for FGDs consisted of **guide questions** designed to elicit insights about women's attitude toward IUD use, experiences related to use or dropout, perception of the community norms about family planning (with emphasis on IUD) and other relevant information.

Figure 1



The Situation Analysis The two study sites, Iloilo and Misamis Oriental, have 51 and 26 main service delivery points (SDPs) or Rural Health Units (RHUs), respectively. The maps of these provinces are shown in **Figures 2 and 3**. Generally, there is a one to one correspondence in the number of municipalities and the number of RHUs. However, in Iloilo there is one municipality which has two RHUs. Furthermore, the city's seven districts have one health unit each, hence, there is a total of 51 service delivery points in this province. Misamis Oriental, on the other hand, has 24 RHUs and two Main (City) Health Centers. All of these SDPs were visited by the study teams consisting of a person with clinical training and a social science trained researcher. Both teams underwent training in conducting situation analysis arranged and facilitated by Population Council, Manila staff. The project director was hired from RIMCU to act as overall field supervisor. She directed the data collection in both areas, staying in the field during the whole duration of the data gathering phase. She was also responsible for transcription and write-up of the FGD reports and the analysis of the SA data. Data were coded and entered in the computer of RIMCU using the SPSS program. Interviewers were hired in the study sites, with RIMCU, Xavier University and SSRI, Central Philippine University in Iloilo serving as collaborators in this activity. Field work for data collection started in April and finished in June 1998.

Focus Group Discussions Prior to the conduct of the FGD sessions, the participants were asked to fill out a 3-page questionnaire to elicit socio-demographic information from each of them. The selection of participants for each group turned out to be a challenging activity because many drop-outs from IUD often had already switched to other methods. Switchers were then categorized and were allowed to participate in the discussions under their current FP status grouping. A total of 32 FGD sessions (16 sessions in each study site) were conducted with the different subgroups of women users.

The findings on the acceptability of different FP methods derived from the service statistics of the SA inventory instrument confirmed the results of the 1997 cluster survey. IUD performance is shown to be much higher in Misamis Oriental compared to Iloilo (**Table 1**). The pill is the method that is most popular for both areas, although this is more true in Iloilo than in Misamis Oriental. In Misamis Oriental the third most popular method is IUD, while this was only the sixth most accepted method in Iloilo.

FIGURE 2 PROVINCIAL MAP OF MISAMIS ORIENTAL



LEGEND

- | | |
|------------------------------|---|
| Areas shaded in red - | low IUD performing RHUs
(20 or less new IUD acceptors) |
| Areas shaded in blue- | high IUD performing RHUs
(151 or more new IUD acceptors) |

Table 1 -- Percent Distribution of New Acceptors According to Types of FP Methods Used, Misamis Oriental and Iloilo, January-December, 1997

FP Methods	Misamis Oriental		Iloilo	
	Percent	Number	Percent	Number
IUD	19 0	3299	3 4	810
Pill	30 0	5203	35 8	8464
Condom	10 6	1835	23 8	5642
Injectable	24 2	4184	12 7	3000
Ligation	0 3	61	0 0	0
Vasectomy	0 6	100	0 0	0
NFP	3 6	631	7 9	1885
LAM	11 6	2003	16 3	3867
Total	99 9	17316	99 9	23668

DATA ANALYSIS: FINDINGS FROM THE SITUATION ANALYSIS

1 Readiness To Provide Services

Readiness to provide quality services is considered in three levels. The first level refers to the capacity to provide quality services and involves the **physical infrastructure** (facility, equipment and supplies) of the SDP. The second relates to the characteristics of the service providers which indicate their **technical capability** to provide IUD services (training attended, level of knowledge, etc), and the third component pertains to the **availability of services** (IUD, in particular) present in the SDP. The two provinces, Misamis Oriental and Iloilo, will be compared along these three dimensions of readiness.

Physical infrastructure The situation analysis study made a complete inventory of the facilities, equipment and materials that are required for providing quality family planning services. **Table 2** indicates that in Misamis Oriental there are more SDPs with adequate and clean water, working toilets, adequate light, separate exam room, auditory privacy compared to Iloilo. Although higher in Misamis Oriental, availability of clean water is problematic in both areas. This finding is particularly important when providing IUD services because availability of safe and clean water is critical in maintaining septic conditions during the IUD insertion procedure. There are more SDPs that are found to be fully clean in Misamis Oriental.

Table 2 -- Selected Indicators Related to Facilities and Infrastructure

Selected Indicators	Study Areas	
	Misamis Oriental (N=26)	Iloilo (N=51)
Percent of SDP with		
Adequate and Clean Water	62	49
Electricity	96	98
A waiting Room/Area	96	96
Working Toilet for Clients	89	75
Adequate Light	100	83
Percent of SDPs with Physical Structure		
A Separate Examination Room	100	92
-with Auditory Privacy	85	83
-with Visual Privacy	89	90
SDP Fully Clean	69	46

The capacity of the SDP to provide IUD services is enhanced if the necessary equipment are available **Table 3** shows that except for scissors and uterine hook and retriever, the SDPs in Misamis Oriental have generally higher number of IUD equipment

**Table 3 -- Mean Number of Various Equipment Available at SDPs
by Province, 1998**

Equipment	Misamis Oriental (N=26)	Iloilo (N=51)
IUD Kit	2 2	1 6
Instrument tray	4 0	2 1
Ovum forceps	5 9	1 7
Scissors	2 9	3 0
Speculum	11 5	5 8
Tenaculum forceps	4 7	1 6
Uterine sound	5 1	2 3
Uterine hook and retriever	1 0	1 5

After an examination of **Table 4** one is struck by the deficiencies of health centers in Iloilo. The overall pattern of possession of IUD equipments shows the disadvantaged position of Iloilo RHUs where six percent or more have **no** ovum forceps, scissors, speculum, tenaculum forceps. Although one-third of Misamis Oriental health centers have no uterine hook and retriever compared to only 12% in Iloilo, overall, its service delivery points are better-equipped compared with its Iloilo counterparts.

Table 4 -- Percent of SDPs without Equipment by Province, 1998

Equipment	Misamis Oriental (N=26)	Iloilo (N=51)
IUD Kit	8	12
Instrument tray	4	4
Ovum forceps	0	6
Scissors	4	6
Speculum	0	2
Tenaculum forceps	0	8
Uterine sound	0	2
uterine hook and retriever	35	12

Another aspect of readiness to provide services is the availability of supplies in the SDPs. There is apparently a difficulty in ensuring a continuous supply of contraceptives in the facilities as both provinces experienced stock-outs in contraceptive and laboratory needs. However, as shown by **Table 5**, stock outs are higher in SDPs of Iloilo, especially on IUD supplies and injectable. There are, however, slightly less stock-outs of stains and reagents in Iloilo.

Table 5 -- Percent of SDPs with Stock-outs of Contraceptives and Supplies During the Last Six Months, by Province, 1998

Contraceptive/Supplies	Misamis Oriental (N=23)	Iloilo (N=48)
IUD	12	35
Oral Pills	12	8
Condoms	12	2
Injectable	15	26
Stains/Reagents	69	57

Technical capability of providers A second dimension of readiness pertains to the technical capabilities of service providers. In the Philippines, many doctors are found only in RHUs (or main health centers) and only visit the BHSs once a month. The midwives are the “front liners” who provide FP/RH services in most facilities in the country.

Table 6 shows that the percentage distribution of different types of SPs does not vary greatly between the study areas. It is clear, though, that midwives are the majority of service providers, followed by nurses and doctors. The study areas show that the average number of providers per SDP is lower in Misamis Oriental compared to Iloilo. There are more doctors in Misamis Oriental, but this is balanced by a higher percentage of nurses in Iloilo.

With regard to the length of experience in providing FP services, Misamis Oriental SPs show a higher average years of service, (13.7 years vs. 12.7 years), with the median of 13.5 years for Misamis Oriental and 9.5 years only for Iloilo.

Sections D and E of the same table show the percent of SPs who have been providing IUD and are certified for IUD insertion. Overall, a much greater proportion (87%) of all types of SPs in Misamis Oriental are providing IUD services compared to SPs in Iloilo (55%). What these data further reveal is the fact that a greater proportion of midwives compared to doctors are providing IUD insertions in Misamis Oriental. The reverse is true in Iloilo where a higher proportion of doctors than midwives are providing IUD insertions.

Interestingly, those who are certified IUD providers in Misamis Oriental are all providing IUD services. However, this is not true for Iloilo. It appears that not all of the doctors and nurses there who are certified are providing IUD services except for the certified midwives who are all providing IUD services.

The last item in the table shows the number of IUD insertions and removals during the last three months. It indicates that the SPs in Misamis Oriental show a higher performance than the SPs in Iloilo for IUD insertions and removals.

Table 6 -- Selected Provider Characteristics by Study Areas, 1998

Selected Indicators	Study Areas			
	Misamis Oriental (N=85)		Iloilo (N=217)	
A Percent of Service Provider (N) by Type				
Doctor	27		22	
Nurse	29		34	
Midwife	44		44	
Total	100		100	
B Average Number of Providers per SDP	3.3		4.2	
C Number of Years Providing FP Services				
Mean	13.7 years		12.7 years	
Median	13.5 years		9.5 years	
Range	1-32 years		0-42 years	
D Percent of Service Providers who have been Providing IUD Insertion by type	87		55	
Doctor	87		71	
Nurse	80		50	
Midwife	92		52	
E Percent of Service Providers who have already been certified IUD providers by type	87		60	
Doctor	87		90	
Nurse	80		53	
Midwife	92		52	
F Number of IUD Insertions and Removals in the last 3 months	Insertion	Removal	Insertion	Removal
Mean	3.3	1.9	1.9	0.8
Median	1.5	1.5	5.5	2
Range	0-26*	0-20**	0-21***	0-13****
SD	6.09	2.94	3.49	1.6

*51% of 73 providers did not have any insertions during the last three months

**41% of 73 providers did not have any removals during the last three months

***58% of 120 providers did not have any insertions during the last three months

****66% of 120 providers did not have any removals during the last three months

Section F of the same table shows that a higher percent of providers (58% and 66%) in Iloilo did not have any insertions and removals during the last three months, compared to 51% and 41% in Misamis Oriental

Table 7 shows the percent of SPs who were trained in providing FP/RH services by study areas. The data clearly show that, except for counseling and RTIs/STDs, Misamis Oriental has more providers trained in IUD insertion than providers in Iloilo (94% vs 66%), IUD removal (87% vs 66%), Minitlap/Laparotomy (8% vs 1%), and Vasectomy (6% vs 2%). The data on percent attending practicum and didactic trainings, however, show Iloilo to be at an advantage.

Table 7 -- Percent of Providers Who Attended Training by Province, 1998

Type of Training	% Attended Training	Mean Duration of Training	% Attended Practicum and Didactic
A Misamis Oriental (N=85)			
IUD Insertion	94	34.6	92
IUD Removal	87	36.1	85
Minitlap	8	14.8	67
Surgical Vasectomy	6	15.8	60
Counseling	66	10.1	56
Infection Prevention	29	17.1	46
Diagnoses and Treatment of RTIs/STDs	34	7.5	35
B Iloilo (N=217)			
IUD insertion	66	34.6	96
IUD removal	66	34.6	97
Minitlap/Laparotomy	1	14.4	67
Surgical Vasectomy	2	9.5	40
Counseling	80	16	57
Infection	34	21.1	51
Diagnoses and Treatment of RTIs/STDs	36	17.3	55

Availability of FP/RH services Table 8 presents the results on the availability of FP/RH services. Five of the ten FP/RH services are universally being provided in SDPs of Misamis Oriental: the oral pill, condom, IUD, injectable and NFP. Only 2 out of 10 of these services are universally provided in SDPs of Iloilo (oral pill and condom). IUD is provided in only 82% of SDPs in Iloilo. Female sterilization and vasectomy are hardly being provided at all in both areas, although the situation is a bit better in Misamis Oriental.

Table 8 -- Selected Indicators Related to Availability of Services, By Province

Percent of SDPs Where the following FP/RH Services are Available	Misamis Oriental	Iloilo
Oral Pill	100	100
Condom	100	100
IUD	100	82
Injectable	100	98
Female Sterilization	23	2
Vasectomy	23	8
NFP	100	96
LAM	92	96
Diagnosis for RTIs	46	18
Treatment for RTIs	46	16

Having FP/RH services offered more frequently during the week improves availability and accessibility. Table 9 gives the frequency of service provision in the SDPs per week. What is noteworthy in this table is the finding that a significant percent of SDPs (20%) in Iloilo do not offer IUD services at all. Almost every day of the week, IUD services are offered in Misamis Oriental, while only 78% of SDPs do the same in Iloilo.

Table 9 -- Percent Distribution of SDPs Providing IUD Services Per Week

No of Days IUD Services are Offered	Misamis Oriental (N=26)	Iloilo (N=51)
0 days	0	20
1-4 Days a week	4	2
5 days a week	96	78
Total	100	100
Mean	5 Days	4 Days

In sum, the picture that emerges in this section is one of clear advantage of SDPs in Misamis Oriental over Iloilo in terms of readiness to provide quality FP/RH services. The SDPs in Misamis Oriental tended to have better facilities and equipment, lower stock-outs of supplies and greater availability of FP services, particularly for IUD. In terms of capability and technical competence of SPs, the midwives in Misamis Oriental have longer average years of service in family planning. More of them are also trained in IUD insertion and removal. Although a fewer proportion of their doctors are trained in FP services, this is made up by a higher proportion of the midwives who are trained in Misamis Oriental. Furthermore, the certified midwives are more likely to be providing IUD services consistently in both study areas rather than the doctors. In view of these findings, the program should consider adopting the general policy to prioritize midwives for training rather than doctors (since the former are the ones more likely to be providing FP services anyway).

2 Quality of Services

Quality of services can be measured by a program's ability to serve clients competently, to provide a wide range of choices with full information on each option, and to provide follow-up and other related services. It is often hypothesized that providing good quality services to FP/RH clients will increase contraceptive prevalence by attracting new users, increasing continuation rates, reducing morbidity associated with contraceptive use, and by increasing client satisfaction.

Several indicators of quality of care will be examined in this section to determine whether these bear any relationship to the acceptance and prevalence of IUD use observed in both study areas.

Client-Provider communication The capacity to provide effective information, counseling and privacy is enhanced if the physical facilities are conducive to such consultation. **Table 10** shows some selected indicators related to information exchange. Based on client-provider interaction (CPI) observation, there is no clear difference between the two areas on the indicators of information exchange, and if anything, the SDPs in Iloilo have a slight advantage over Misamis Oriental SDPs. The providers and/or client are more likely to mention more general questions ("if client has any question," "if client has concern about her own health") as observed during the client-provider interaction. The "date of last menstrual period" is often mentioned and this is true for providers from both study areas.

SPs in Misamis Oriental are more likely to elicit information regarding abnormal vaginal bleeding and lower abdominal pain. Other than these few differences, the overall picture is that, as far as communication on specific aspect of service provision is concerned, the two study areas, Misamis Oriental and Iloilo which represent a high IUD prevalence and a low prevalence areas do not differ significantly on the communication indicators.

Table 10 -- Selected Indicators Related to Information Exchange

Selected Indicator (Client-Provider Interaction Observation)	Study Area	
	Misamis Oriental (N=10) No of Cases	Iloilo Province (N=11) No Of Cases
1 SP asking about or client spontaneously mentioning the following (observation)		
a Whether the client wanted more children in the future	2	3
b Age of youngest child	3	4
c Whether the client is breast-feeding	1	4
d Client's marital status	4	4
e If client has more than one sexual partner	0	0
f If client has any question	5	7
g If client has concern about her own health	4	8
h If client has concern about using any method	3	6
I If client has any concern about STD or HIV/AIDS	0	0
J If client has previous symptoms/signs/treatment suggestive of STDs	0	0
k If client has discussed FP with husband	4	2
2 SP asking about or did the client spontaneously mentioning the following subjects (observation)		
a Any medical/family history	3	7
b Date of last menstrual period	8	10
c Abnormal vaginal bleeding	3	1
d Abnormal vaginal discharge	2	2
e Genital itching	0	0
f Lower abdominal pain	2	1

Misamis Oriental SDPs stand out in terms of availability of IEC materials as shown in **Table 11** Iloilo has a fairly high percent of SDPs with IEC materials but shows a lack of RTI materials (with only 45% of SDPs having these) and materials on HIV/AIDS

Table 11 --Percent of SDPs with Available IEC Materials, by Province

Type of IEC materials	Misamis Oriental (N=26)	Iloilo (N=51)
IUD materials	96.0	88.0
Oral Pills materials	100.0	90.0
Condom materials	96.0	94.0
Injectable materials	89.0	86.0
RTI materials	62.0	45.0
HIV/AIDS materials	85.0	59.0

Technical competence A few indicators on this variable were explored in the earlier section on readiness to provide services. **Table 12** assessed the training they received. Very few SPs rated the training they received as inadequate. More SPs in Misamis Oriental seem to feel that they require refresher training, though. The areas they identified a need for refresher training is on how to deal with side effects and infection prevention.

Table 12 -- Percent of Providers who Felt IUD Training is Inadequate and type of Refresher Training Needed

	Misamis Oriental N	Iloilo N
Training inadequate	6 (85)	5 (217)
Required refresher training	61 (52)	42 (217)
Didactic	42	39
Insertion practicum	34	50
Removal practicum	35	45
Side effects	60	53
Screening	42	50
Infection prevention	54	76
Training adequate to manage RTIs/STDs cases	21	28

Table 13 shows a list of conditions when IUD is contraindicated. SPs in both areas do not differ in their responses on 11 out of 12 of these conditions. In one condition on restrictions to insert IUD “between 48 hours and 4 weeks of post partum” a difference in responses was shown with only 55% of SPs in Iloilo knowing this as compared to 81% of SP’s in Misamis Oriental.

Table 13 --Percent of Providers Who Knew that an IUD Should Not Be Inserted to Women Having Certain Conditions

Condition	Misamis Oriental	Iloilo
1 High risks for STDs	87	88
2 Heavy menstrual bleeding with clinical signs of anemia	91	93
3 Between 48 hours and 4 weeks of post partum	91	55
4 High risk of HIV or HIV/AIDS infected	90	91
5 Benign trophoblasa disease	94	93
6 Pregnancy	99	100
7 Active STD or PID within past 3 months	99	99
8 Sepsis following child birth or abortion	98	98
9 Abnormal vaginal bleeding	99	100
10 Severely distorted uterine cavity	100	99
11 Cervical-endometrial or ovarian cancer	100	100
12 Pelvic tuberculosis	100	98

In terms of IUD knowledge, Table 14 show that there are wide variations about knowledge on when is the best time to insert IUD. This observation is true for both areas. The most popular responses are “anytime during the menstrual cycle” (82% in Misamis Oriental and 86% in Iloilo) and “anytime as long as the woman is not pregnant” (74% in Misamis Oriental and 78% in Iloilo). Seven out of ten respondents gave the more specific response “if size of uterus is 6 4 cm ” to this question.

Table 14 --Percent of providers possessing knowledge when to insert an IUD

Condition	Misamis Oriental	Iloilo
<u>An IUD can be inserted.</u>		
1 Any time as long as the woman is not pregnant	74	78
2 Any time during the menstrual cycle	82	86
3 Within 48 hours of delivery	3	3
4 4-6 weeks or 6-8 weeks postpartum	8	5
5 If size of uterus is 6 5 cm	67	10
6 No abnormalities during physical exam	4	9

Table 15 shows the knowledge of SPs of conditions or side effects that would necessitate a visit to the clinic or not. The providers in Misamis Oriental are better at judging these situations. In only one out of six conditions was Iloilo higher in percentage compared to Misamis Oriental, this pointing to the fact that more Misamis Oriental SPs recognize the conditions or warning signs needing a visit with the clinic than is the case for Iloilo. For cases that do not require a visit to the clinic, Misamis Oriental again is higher than Iloilo in four out of six indicators.

Table 15 --Percent of providers with knowledge of common side effects which require no visit to the clinic and side effects which require immediate attention of the provider

Condition	Misamis Oriental	Iloilo
Side effects that do not require a visit to the clinic		
1 Increased menstrual cramps	57	39
2 Longer and heavy periods	49	45
3 Mild backache/headache	70	71
4 Feeling of heavy hypogastrum	24	26
5 Once-in-a-while hypogastrum pain/abdominal	24	5
6 Spotting/intermenstrual bleeding	16	1
Side-effects that require immediate attention of SPs and visit to the clinic		
1 Late period	55	13
2 Abnormal spotting/bleeding	82	85
3 Abnormal pain during intercourse	62	50
4 Infection or abnormal discharge	70	37
5 Not feeling well, has fever or chill	49	36
6 String is missing or has become shorter or longer	73	61

Information was elicited from clients as to their knowledge of the availability of specific FP/RH services in the SDPs. The extent of client knowledge of these information is reflective of the ability of the program to reach its potential clients. **Table 16** shows that all clients in the SDPs of Misamis Oriental who were interviewed are aware of IUD services being available in the SDPs of Misamis Oriental. However, only 73 % of client (8 out of 11 clients) in Iloilo knew that these services are available. In general, oral pill availability is known by 100% of clients in SDPs of both areas. The availability of DMPA is not well known in Iloilo (only 54.5% knew of its availability compared to 90% in Misamis Oriental). In the study of the Population Council on the DMPA reintroduction program in 1994, Iloilo was one of the least performing of the pilot LGUs as far as this method is concerned. On the whole, awareness of available services is higher among Misamis Oriental clients than Iloilo clients.

Table 16 --Percent of FP Clients Who Knew of FP/RH Services that are Available at the SDP

Percent of SPs who knew the following are available at the SDP	Misamis Oriental (N=10)	Iloilo (N=11)
IUD	100.0	72.7
Oral pills	100.0	100.0
Condom	70.0	81.8
Injectable	90.0	54.5
Vasectomy	0.0	0.0
NFP	0.0	9.1
LAM	0.0	0.0
Diagnosis for RTIs/STDs	0.0	0.0
Treatment for RTIs/STDs	0.0	0.0
Female Sterilization	10.0	0.0

Appropriateness and Accessibility There is no difference shown in Table 17 between Misamis Oriental and Iloilo in terms of client satisfaction with services provided them and the responses given by providers to their questions during consultations. Iloilo clients think that the consultation time given to them by providers is “about right”. Almost all claimed to have been satisfied with services received. They also tend to be similar on these two indicators: (1) clinic hours are convenient to them and (2) the average walking time from their residence to the clinic to (16.2 and 16.3 minutes on the average). The two areas differed widely on the “waiting time”. Whereas the waiting time in Misamis Oriental is only 9.9 minutes on the average, Iloilo clients report an average of 19 minutes in waiting time.

Table 17 --Selected Indicators Related to Appropriateness and Acceptability of Services

Selected Indicators	Misamis Oriental (N=10)	Iloilo Province (N=11)
1. FP Clients satisfied with -services during visit -answers to their questions	10 8	11 8
2. Time given to FP Clients -was too long -too short -about right	3 1 6	0 1 10
3. FP clients feel they would have wanted to know more about IUD	3	4
4. Clinic hours are convenient	10	11
5. Average waiting time (in minutes)	9.9	19.1
6. Average walking time from residence to SDP (minutes)	16.2	16.3
7. FP clients claim that during consultation the provider took or performed any of the following -assess weight -took blood pressure -perform/refer for pregnancy test -perform physical exam -perform/request/refer for a blood test -perform a breast exam -perform pap smear -perform syndromic analysis of RTI/STDs	8 9 0 3 0 2 0 0	8 9 0 1 0 1 0 0

3 Barriers to IUD Service Provision

Three categories of barriers may be considered restrictions barriers, medical barriers, incompetency barriers, management barriers and provider-related barriers

Restriction barriers Providers were asked to indicate whether they considered certain medical procedures or examinations as prerequisites to providing IUD insertions **Table 18** shows the percent of providers who put restrictions on providing IUD services Forty-nine and 38% of providers from Misamis Oriental and Iloilo respectively place limits on IUD use on the basis of age Four out of every ten providers in both places restrict IUD provision for women with no children, they should have at least one child before they can use the IUD In addition, 18% of SPs in Misamis Oriental reported that they must restrict IUD provision "highly" because of religious reasons, as compared to only 14% of Iloilo SPs adopting this position In fact 68% of SPs in Iloilo reported that they did not place restrictions on IUD provision because of religion, and only 62% of those in Misamis Oriental reported the same But what is more disturbing for the program is the restrictions placed by SPs in Iloilo (12%) and Misamis (4%) on breast-feeding, considering that a key advantage of IUD over other methods is that it can be used without any effect on breast-feeding This misconception of providers needs to be addressed

Table 18 --Percent of Providers Who Put Restriction on Providing IUD Services

Condition	Misamis Oriental	Iloilo
1 Must reach certain age	49	38
2 Must have at least one child	47	43
3 Must not be breast-feeding	4	12
4 Must not restrict the use at all because of religion (scale 1-3)	62	68
5 Must restrict the use highly because of religion (scale 8-10)	18	14

Medical Barriers

Table 19 shows that a high percentage of providers in Misamis Oriental than in Iloilo believe that various procedures and test have to be done prior to offering an IUD. These include medical history, blood pressure check-up, pelvic examination, and breast examination. RTI/STD screening is considered not important by providers in both areas with only twenty-five percent in Misamis Oriental and eleven percent in Iloilo affirming that such procedure is a must. Viewed in the context of barriers to services Misamis Oriental SPs are more likely to put medical barriers to IUD provision compared to Iloilo SPs.

Table 19 --Percent of providers who felt that procedures and tests must be followed before offering an IUD

Procedures	Misamis Oriental	Iloilo
1 Medical history must be taken	90	69
2 Blood pressure must be checked	80	42
3 Pelvic examination must be done	84	72
4 Breast examination must be done	86	54
5 Lab tests Urine/blood/pregnancy must be done	33	18
6 RTI/STD Screening	25	11
7 Sepsis/Anti-sepsis examination	11	25
8 Pap smear/gram staining	8	28
9 Uterus exam	6	16
10 Speculum exam/vaginal exam	11	19
11 Complete physical exam	13	4
12 weights and other exam	6	2

Incompetency Barriers Incompetency barriers consist of low percentages of providers in both Misamis Oriental and Iloilo who know that IUD insertion can be done within forty-eight hours of delivery, 4 - 6 weeks or 6 - 8 weeks postpartum or when no abnormalities during physical examination are ascertained. Only ten percent of Iloilo

providers know that the size of the uterus determines the right timing for IUD insertion. Deficient knowledge when to insert IUD translates to incompetency in the insertion timing and in certain conditions which IUD insertion is not warranted. These data are shown in Table 13 earlier.

Management Barriers In an earlier discussion on technical competence (Table 6) it was observed that 87% of Misamis Oriental providers who are certified to perform IUD are actually doing IUD insertions. In contrast, only 60% of providers in Iloilo are certified to perform IUD insertions, however, five percent (5%) of these certified providers are not giving IUD services. The average number of insertions and removal done by those who are performing IUD services indicate that providers in Misamis Oriental have a higher performance record than providers in Iloilo.

Although the training duration is the same for service providers of the two provinces, attendance of this training differs. Only two-thirds of Iloilo service providers attended training in IUD insertion and removal. In comparison, ninety-four and ninety-eight percent of providers in Misamis Oriental underwent both trainings. Providers from both areas are deficient in trainings related to infection prevention and diagnosis and treatment of RTIs/STDs.

Provider-related Barriers This type of barriers stem from providers' bias for or against particular methods. In interviews with providers, and from accounts of FGD participants, several cases connected with IUD complications were cited that created an impression on both clients and providers. One case that was cited was about a doctor who had to cover the expenses connected with the surgical removal of a piece of an IUD that remained in the uterus of a client when a midwife tried to remove it unsuccessfully. This story was told by a doctor in Iloilo and was repeated in a few more instances in other SDPs visited by the research team. The doctor claimed she never recommended the method again, because the program does not provide financial support for these types of complications. Other stories gathered include a case of hemorrhage when the woman tried to remove the IUD herself after a fight with the husband, and another one pertains to IUD failure which resulted in pregnancy.

As a result, some providers inhibit themselves from inserting IUD or refer cases to other providers who are more willing to insert. These hesitations are caught by clients when they come to ask for the method, and soon rumors about the IUD spread to other places. The interviewers noted that this has been the case because the same stories were repeated to them in the next towns that they visited.

DATA ANALYSIS: FINDINGS FROM THE FOCUS GROUP DISCUSSIONS

The data from Focus Group Discussions (FGDs) with women provide insights to reproductive behavior and experiences of women. Other observations and information from both structured and informal interviews with clients and providers supplemented this analysis.

A total of 244 women (141 from Misamis Oriental and 103 from Iloilo) participated in 32 FGD sessions conducted in two high and two low IUD performing RHUs in each of the study area. As mentioned in previous sections, 32 FGD sessions were conducted in the two provinces. The distribution of participants is as follows:

	Mis Oriental	Mean Number Per Session	Iloilo	Mean Number per session
IUD Dropouts	22	5.5	17	4.3
IUD Users	37	9.3	24	6.0
Other Method				
Acceptors	45	11.3	45	10.8
Non-user of Any Modern Method	37	9.3	19	4.8
Total	141		103	

IUD dropout participants were difficult to identify. Moreover, many of them have already switched to other methods. Switchers were categorized under their current FP status and participated in the discussions.

Socio-demographic Profile of FGD Participants Prior to undertaking the FGD basic socio-demographic data were obtained from participants. This is presented in **Table 20**. Participants are generally in their thirties, are either a high school graduate or had spent one year in college, and have 3 to 4 children. The IUD users and drop-outs have used a method for an average of about four years, but acceptors of other methods from Iloilo had an average of nine years of contraceptive use. When asked if they will be able to pay for IUD services if they can no longer be provided for free, all IUD users and dropout participants from Misamis Oriental said “yes” and the average amount that they can afford to pay range from P42 to P45. The respondents who are “other users” reported a much lower amount on the average (P13). These findings can mean that either IUD insertion is viewed as being more “complicated” and therefore deserving higher fees or that IUD users represent a select group who are economically better off and can afford to pay a higher fee. It is interesting to note that these two groups (IUD users and IUD drop-outs) exhibit a higher educational attainment compared to “users of other methods”.

Table 20 Demographic Characteristics of FGD Participants, Iloilo and Misamis Oriental Provinces, 1998

Demographic Variables	IUD Users	IUD Dropouts	Other Users (other modern and traditional method acceptors)
A Misamis Oriental			
No. of participants	37	22	82
Average Age	34	34	31
Highest grade obtained	11	10.5	9.3
Average number of children	3.5	3.5	3.3
Average duration of use (in years)	4	4.5	3.8
Amount respondents can afford to pay for IUD insertion	P45.00	P42.00	P13.40
B Iloilo			
No. of participants	24	17	64
Mean Age	33	36	36
Highest grade obtained	9.5	10.5	11.0
Average number of children	3.5	3.0	3.5
Average duration of use (in years)	3.5	3.0	8.8
Amount respondents can pay for IUD insertion	P37.50	34.20	P41.20

The Iloilo participants did not differ much in characteristics except that “other users” tend to be older, have longer years of contraceptive use, have higher educational attainment, and can afford a higher amount to pay for FP method compared to IUD users and dropouts. The latter findings is the opposite of the situation in Misamis Oriental.

Awareness of and Access to Health Services Offered at SDPs One of the quality of health care indicators is information given to users, not only on family planning methods but also on the whole range of reproductive health services. Are women aware of services which they can avail of?

FGD participants reported that were all aware of the different types of services offered in their health centers, a wide array of services were enumerated by them including special services like surgical operation, sanitation, eye consultation, and others. Aside from family planning, the most mentioned was child-related health assistance.

In Misamis Oriental, the role of the outreach workers in promoting family planning use was highlighted by the FGD participants. According to one woman, “*we are always reminded by the Barangay Health Workers (BHWs) about services in the RHUs. For instance, during immunization day, they checked who among our children are not yet immunized. They also know who are not practicing family planning, they try to encourage women to practice family planning.*”

The BHWs are quite active in Misamis Oriental, from the reports of the participants. Four participants in Misamis Oriental related how BHWs conduct house-to-house visits to announce that IUD insertions are being scheduled on a specific date. That this did not come out as much in Iloilo is surprising, considering that the province has been known for its strong network of outreach workers. It seems, however, that outreach workers do not provide adequate information or counseling to women. The same observation was reported for midwives. Some of their comments reflect this observation.

“Walay explain-explain, diretso-diretso man” (There is no explanation, they just go right ahead and start { to do it} ’)

“The midwife told me: Balik inig kahuman nimo panganak kay IUDhon ta ka (Come back after delivery and I will insert the IUD on you)”

“The midwife told me that I should try IUD but my husband did not like it.”

FGD participants who are current IUD acceptors or dropouts were asked what made them decide to accept IUD. The primary reasons given for using IUD is to space or limit the number of children, and because of health-related reasons. Many of the switchers were formerly using pills. Participants with more than four (4) children and are of age forty (40) years or over chose the IUD for various reasons.

“I am using IUD because it is a temporary method. When I reach my menopausal stage, I will have it removed.”

“I suffered from a mild stroke, and the doctor advised me to shift to IUD especially since I’m getting older.”

Quite a number of participants shifted from the pills to IUD. Reasons given include

“I became so quarrelsome and irritable.”

“I often feel faint when I was using the pill.”

“I had intensely dry skin when I was using pills, so I shifted to IUD.”

“I developed high blood pressure when I was using pills, so I tried IUD.”

There were also women who made up their mind to use the IUD after having been given lectures during a seminar-workshop or during a premarriage counseling. Some women cited practical reasons for their IUD preference.

“IUD is convenient, we don’t need to take it everyday, (like the pill).”

“We considered it more natural since it is placed in the uterus, and can be removed anytime.”

“IUD is okay, I always get examined by a midwife.”

It seems that using an IUD is often discussed with husbands or at least they were informed and persuaded by the wives. There are also women participants who related that their partner's choice was the IUD. Oftentimes, they go ahead to have the insertion before discussing this with their husbands.

A few admitted that even though the decision was jointly made, their husbands later urged them to have it removed because they experience discomfort during sexual intercourse, which husbands describe as a pricking sensation.

Knowledge of IUD All four groups of women (IUD users, IUD dropouts, users of any modern method, and non-users of any modern method) were asked to explain how IUD works. Moreover, they were requested to draw how the IUD looks like. A significant number of women indicated knowledge of the physical appearance of IUD Copper T380A. The outline drawn resembles closely to a Copper T with a string attached to it.

Women have general ideas on how the IUD works--"it prevents the meeting of the sperm and egg cells." Some examples of their responses include "*the IUD acts like a traffic policeman,*" "*it is more like a soldier,*" "*acts as a barrier*."

Several IUD advantages and disadvantages were enumerated by women:

"Flexibility. If a mother wants a baby anytime, she can have the IUD removed and reinserted again."

"I can breast-feed while using IUD."

"It has fewer side effects."

"It is safe as long as the woman has regular check-up."

"I can have peace of mind."

"With IUD, I'll stay healthy. It is localized, unlike pills, which are absorbed by the body."

"A woman need not worry if she and her husband have frequent sex. A woman is ready for her husband anytime."

Despite the advantages cited about IUD use, women are also aware of its disadvantages. Majority of cited complaints are heavy menstrual flow, hypogastric pain, longer period of menstruation, and pain during the first two weeks after insertion.

Participants from both study sites mentioned their husbands' complaints about IUD. As mentioned earlier, they experienced "*pricking pain*" during the sexual act especially during the first few months after insertion. Women IUD users also confirmed that they too experienced pain during intercourse.

The husbands also complained of longer menstrual period which prevents them from having sex with their wives. One participant revealed that the "*pricking pain*" and/ or long menstrual period are the source of frequent quarrels with her husband.

Expulsion is another cited disadvantage by IUD users especially among women who work hard or who lift heavy things. That someone can get pregnant while on IUD is in place causes apprehension. In Iloilo, where this was reported to have occurred, women mentioned this as their concern regarding the IUD.

Knowledge of women concerning the appropriate timing of IUD insertion is generally consistent with the prescribed period during menstruation, after delivery, or after caesarian section. However, they cited different number of days from the beginning of menstruation. 2, 3, or 4 days were commonly mentioned. Varied answers were also given such as 3 weeks, 4 weeks, or 6 weeks postpartum.

Why do women refuse to have IUD insertion? FGD participants pinpointed the following factors: religion, husband, side effects, and personal reasons. Religion and husband's wishes are still strong reasons as perceived by Iloilo participants, although this was not borne out by the SA data. According to David's report (1994) in Iloilo "*wives cannot decide on family planning matters without consulting their husbands,*" and that, "*when husbands object to FP practice, their decision usually prevailed*"

A participant who shifted use of the pill says she disliked to be examined. She has a strong inhibition to present herself and be poked in her intimate parts. "*I'm embarrassed to spread out my legs during examinations*"

A provider in Misamis Oriental claimed that she did not want “to prescribe the IUD because she knows her parish priest is against it

Experiences of Side Effects The most mentioned complaint was pain in the pelvic region. Pain was described in various terms: numbing of flank area, dull and throbbing pain, and pricking/ painful sensation. In some instances, women related that the pain extended to limbs, and tremors were observed to occur.

Heavy menstrual flow was another side effect cited. Other participants reportedly experienced having menstruation twice a month. The majority of dropouts had infections which prompted their decision to have their IUD removed. Abnormal and foul-smelling discharges were reported as well as pain in the lower abdominal region.

A woman told the researchers about her experience when she had high fever and pelvic pain. She went to the center and a check-up of her IUD revealed the presence of pus. This is one documented RTI case. Upon removal, the pain and fever subsided. Another reported side effect was loss of sexual appetite. The woman claimed that both she and her husband no longer enjoyed sexual intercourse when she was using the IUD. Upon the husband’s insistence, the wife had the IUD removed.

Women’s usual response to side effects was to seek medical assistance. Upon presenting and describing their experiences, providers usually give pain reliever (paracetamol) for pelvic pain, caladryl for itchiness, and ferrous tablets for heavy menstrual flow. For infections and symptoms/signs of reproductive tract infections, removal of the IUD was indicated.

Most of the reasons given by IUD drop-outs fall under health-related events like cervicitis, infections, pain during intercourse, allergy to copper, and lower abdominal pain. Expulsion was the reason given by those who allegedly lifted heavy objects and who engaged in strenuous work. About three participants in the FGD claimed that they dropped out of IUD use because they considered frequent check-up a hassle and an embarrassment.

Dropouts vividly described how they managed side effects. Massage by a traditional birth attendant (TBA) was the usual recourse for pelvic or lower abdominal pain. However, the relief is temporary. Allergies and infections (most probably reproductive tract infections based upon the description of signs and symptoms such as itchiness of the vagina, foul and

abnormal discharges and fever) were treated by providers with anti-allergy ointments and paracetamol. Some resorted to use of herbs. However, regardless of the temporary relief that they experienced, all confirmed that after two to three months, they experienced the same pain and side effects again.

Health-seeking behavior is basically similar for both IUD users and dropouts. The first thing they do is to go to the RHUs. If the symptoms persist, clients generally go to a private practitioner in the city. They claim that the prescription of these medical specialists are more effective than those given by RHU doctors.

The women said they intend to remain IUD users as long as no pain is experienced, as long as IUD is in place or until they reach the menopausal stage. Others specified the number of years of use ranging from four to eight years.

Women from both areas are aware of the different services offered by the health centers. Most popular are family planning and children-related services. The main sources of information on the type and schedule of services are the Barangay Health Workers (BHWs). Advocacy on family planning use is included as one of the roles of a BHW.

Satisfaction with services rendered by service providers were cited by both clients from Misamis Oriental and Iloilo. This was supported by the findings in the SA. In both places, the average travel time from residence to clinics is 16 minutes. Providers in the two areas were observed to be friendly and accommodating.

Concerns about sexual behavior and vulnerability of clients to STDs or HIV/AIDS were not discussed according to the clients. Privacy in the clinics is cited by Misamis Oriental clients as being poor. Often it is only a thin curtain that separates the examining room from the waiting room. On a busy day, it is difficult to maintain any privacy in counseling or physical examination in the health center.

The primary reason cited for IUD acceptance is to limit and space the number of children. Older women considered the IUD because they can have it removed during or after menopause. Reasons given by those who shifted to IUD use are mostly because of the side effects of previous methods used. Convenience is also a reason given by other women in both areas.

SUMMARY DISCUSSION AND PROGRAM IMPLICATIONS

Comparing the two study sites representing a high performance and a low performing area on three dimensions of readiness physical infrastructure, technical capability of personnel, and availability of services, Misamis Oriental came out to be clearly and consistently better than Iloilo. More SDPs in Misamis Oriental were found to have adequate supply of clean water, have working toilets, a separate examination room (thus affording privacy), and were also better supplied with IUD equipment and supplies. In fact, stock-outs of IUD in SDPs in Iloilo were almost three times higher than in Misamis Oriental. SPs in Misamis Oriental show a higher average in terms of years of family planning service. Misamis Oriental has almost 35% more SPs providing IUD services, specifically IUD insertions. It also has a performance mean of almost twice that of Iloilo, and has a higher proportion of practicing certified providers. One hundred percent of all certified SPs offer IUD services, whereas in Iloilo where 60% of their SPs are trained in IUD insertion, only 55% are actually offering IUD services.

In terms of availability of services, the SDPs of Misamis Oriental clearly have a wider array of FP/RH services than those of Iloilo. Provision of IUD services is one of the four services that is universally offered in Misamis Oriental, while this is being offered by only 82% of SDPs in Iloilo. Furthermore, and perhaps more importantly, all 24 SDPs in Misamis Oriental offer IUD services every day, while only 40 out of 51 (78%) of SDPs do the same in Iloilo.

The client-provider communications observations yielded no significant difference in the results between SDPs of both areas. Aside from this, however, other indicators of quality of care showed wide variations between areas. In terms of technical competence, more SPs in Misamis Oriental expressed the need for a refresher training course. This may be indicative of providers' genuine desire to improve the quality of their service provision, especially since they proved to already have greater procedural knowledge of FP services. They also proved more knowledgeable in areas of screening for IUD insertion, in dealing with side effects and optimal time for IUD insertion.

Along the lines of appropriateness and acceptability of services, Misamis Oriental and Iloilo showed no significant differences. There was a general degree of client satisfaction in both areas and only they differ in the indicator of "waiting time". Misamis Oriental clients wait for an average of 9.9 minutes for service while Iloilo clients wait for about 19 minutes.

In general, there are no big differences between the number of SPs in both areas who knew the special conditions when an IUD is contraindicated. With the exception of the finding that only about half of the SPs in Iloilo knew that an IUD should not be inserted between 48 hours and 4 weeks postpartum as compared to 81% of Misamis Oriental SPs, providers from both areas have almost equal knowledge of IUD contraindications. It is interesting to note, however, that the SPs of Misamis Oriental actually seem to place a greater number of restrictions on IUD as compared to Iloilo. More SPs in Misamis Oriental place restrictions on the basis of clients' age and number of children. In addition to this, a greater number of SPs in Misamis Oriental reported placing high restrictions on IUD provision because of religion, as compared to Iloilo. Conversely, there were more SPs in Iloilo that said that they did not restrict IUD acceptance because of religious reasons. These findings are interesting because Iloilo has a much lower acceptance rate in comparison to Misamis Oriental. Finally, it was also noted that Iloilo providers place restrictions on breast-feeding women, when in fact one of IUD's selling points is the fact that it is actually ideal for women who are breast-feeding.

A mixture of program-related factors are seen to be associated with low IUD performance of Iloilo. While contraceptive methods are generally available in all the fifty-one RHUs, the IUD, however, is not available at all in 9 out of 51 service delivery points. Compared to Misamis Oriental clinics, Iloilo has less IEC materials on IUD. Moreover, 10 out of 51 service delivery points are not giving IUD services in **any** day of the week.

Almost all (95%) of Misamis Oriental FP providers are certified IUD providers in contrast to only one-third of Iloilo's health providers. Although their doctors are mostly (91%) trained in IUD insertion and removal, Iloilo's middle-level providers (nurse and midwife) are deficient in training compared with their Misamis Oriental counterparts.

The SDPs in Iloilo suffer from poor lighting and inadequate supply of clean water. These are both crucial in providing the proper environment for providing IUD services.

What exacerbates these inadequacies is the lack of equipment in six percent of Iloilo RHUs, for indeed how can providers perform IUD insertion without the basic essential equipment? Compounded by IUD stock-outs in 35% of RHUs, the goal of increasing high IUD performance becomes a difficult task to undertake in Iloilo

Other program-related factors pose additional roadblocks to IUD acceptance. These consist of management barriers, medical procedures and tests, restriction on conditions of women, incompetency barriers, and provider's bias. The **management obstacles** take the form of unskilled personnel and inadequate training. The low IUD performance of Iloilo can be partly explained by its low percentage of certified IUD providers, and limited service availability (with IUD insertion being available everyday in only 78% of its SDP)

Training of Iloilo service providers is needed considering that one-third of them have never been trained in IUD insertion and removal. Interestingly, four out of every five providers in Iloilo underwent counseling training which shows that health providers in Iloilo have been upgraded on other aspects of FP service, but not in the area of providing IUD services.

Training in managing infections, diagnosis and treatment of RTIs and STDs is also desirable in both places, considering that several women mentioned having experienced RTI-related symptoms. Moreover, service providers claimed that the training they received were inadequate and that they need refresher courses to update their knowledge and upgrade their skills in service provision.

The **medical barriers** consist of procedures and tests to be followed. Again, the Misamis Oriental providers compared with their Iloilo counterparts felt that adherence to these procedures and tasks is essential. Providers from both places do not consider RTI/STD screening as an important procedure. It is possible that women experienced signs and symptoms of RTIs/STDs prior to IUD insertion but because no screening was conducted and providers have not been trained to recognize these symptoms, these conditions remain untreated.

A substantial number (majority) of providers in the two study sites put **restrictions** on IUD acceptance on the basis of age and number of children ("a woman must have at least one child" before she can be given IUD)

Competency of providers is measured in terms of knowledge of providers' on when is the best time to perform IUD insertion, on medical conditions that rule out IUD use and knowledge of side effects. Providers from both Misamis Oriental and Iloilo are highly knowledgeable on when to provide IUD insertion and on what conditions make it unacceptable. The Iloilo providers demonstrate poor knowledgeability of side effects especially in their unawareness about symptoms that warrant immediate medical attention.

The **biases of service providers** that were observed resulted from negative experiences of both IUD providers and acceptors. It has been reported by some providers that because of their religious convictions, they do not offer IUD services. Sometimes they delegate the performance of IUD insertion to others providers. To a certain extent this sentiment was also voiced out in Misamis Oriental. However, a majority of providers did claim in the SA that religion should not be a restriction to IUD provision and use.

The level of client satisfaction is high in both places. Providers are viewed as friendly and accommodating. Clients do not pay for the health services, however, giving of donations is encouraged. These range from ten (P10) to twenty (P20) pesos. The donation amount is the same for IUD insertion. It is interesting to note that women voice their willingness to give donations and even agree to pay for the cost of family planning methods if these are for sale.

Knowledge of FGD participants on advantages and disadvantages of IUD originate mainly from their own vicarious and actual experiences with the method. An advantage viewed by some women can be viewed as a disadvantage by another group of women. For instance, the pelvic examinations are welcomed by some women as an advantage because they are getting a free check-up. On the other hand, other women with strong inhibitions view this as a hassle and an embarrassing situation.

The clinical procedures being followed are deficient in both places. Women reported that these procedures/guidelines are not performed, however, they were unaware that these should be done prior to an IUD insertion.

Factors that induced discontinuation include objections raised by the husbands, pain during contact and other various side effects. Among a substantial number of dropouts, the main reason for removal was infection, specifically abnormal and foul discharges, pus in the uterus, and lower abdominal pain coupled with fever and chill. Other women experienced

allergy/rashes in their vagina and painful intercourse, these experiences led them to request for IUD removal from the service provider. Husbands' objections due to the painful sensation during intercourse also figure in IUD discontinuation. Similarly, women report discomforts which they tend to ignore because according to them, the pain later diminish or eventually disappear.

In Iloilo, it seems that a certain degree of "anti-contraceptive culture" pervades among providers and clients alike. The cases that were described earlier have spread to other towns visited by interviewers. However, this situation is more pronounced in places where these events are known to have happened.

Program Recommendations

The scenario described above necessitates program interventions. Based on the findings the following sets of activities are recommended:

To upgrade facilities and physical clinic condition and hygiene. This may involve providing a continuous supply of clean water and lighting in the different facilities, including providing a separate room for consultation and counseling. Assessment of client's needs, and counseling should be an integral part of service delivery.

Conduct refresher trainings. As has been shown by the data, providers are clamoring for training on management of side effects. Refresher training on basic understanding of contraceptive technology is needed, given misconceptions and inadequacy in knowledge that have been identified.

The situation regarding the spread of rumors demands an intervention designed to improve the negative image of IUD. This should be directed not only to clients, but also to providers, given that particular provider-related biases affect IUD services. Leaflets, media campaigns with testimonials from satisfied users, and endorsements from known personalities including NGOs and women's health advocates are strategies that can be tested.

Husbands or partners must be drawn into the program by addressing their concerns about the method, and including them in counseling. Some way of addressing the side effects issues of husbands must be made before any headway in this direction can be expected.

Finally, something should be done to increase the availability of services. The fact that a number of SDPs (RHUs) do not provide IUD insertions and not all certified users are providing the method are significant indicators which are associated with low IUD performance. Program managers need to look at these aspects, along with efforts to address other elements of quality of care that have been found wanting in the SDPs covered by the study.

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ANNEXES

MISOR XLS

MISAMIS ORIENTAL 1995 CENSUS OF POPULATION				
PLACE	TOTAL	Estimated Currently Married Women (15% of Total Pop)	TOTAL OF IUD	IUD
	POPULATION		ACCEPTORS	Prevalence
1 Alubijid	21 765	3 265	99	3
2 Balingasag	46 018	6 903	30	0 4
3 Balingoan	7 548	1 132	11	0 9
4 Binauan	5 374	806	2	0 2
5 Cagayan de Oro	428 314	64 297	515	0 8
6 Clavena	39 020	5 853	214	3 7
7 El Salvador	31 500	4 725	217	4 6
8 Gingoog City	87 530	13 130	594	4 5
9 Gitagum	11 327	1 699	32	1 9
10 Initao	23 340	3 501	111	3 2
11 Jasaan	33 598	5 040	113	2 2
12 Kinoguitan	10 406	1 561	8	0 5
13 Lagonglong	15 258	2 289	9	0 4
14 Laguindingan	16 521	2 478	22	0 9
15 Libertad	9 258	1 389	17	1 2
16 Lugar	13 012	1 952	31	1 6
17 Magsaysay	23 730	3 560	17	0 5
18 Manticao	22 630	3 395	108	3 2
19 Medina	17 330	2 600	438	16 8
20 Naawan	14 578	2 187	56	2 6
21 Opol	23 958	3 594	232	6 4
22 Salay	18 923	2 838	95	3 3
23 Sugbongcogon	6 957	1 044	17	1 6
24 Tagoloan	40 929	6 139	173	2 8
25 Talisayan	19 742	2,961	39	1 3
26 Villanueva	21 310	3 197	93	2 9
Total Population	1 015 865	152 380		

ILOILO XLS

ILOILO PROVINCE 1995 CENSUS OF POPULATION				
PLACE	TOTAL	Estimated Currently	Total	IUD
	POPULATION	Women	IUD	Prevalence
		15% of total pop'n	Acceptors	
1 Ajuy	38 415	5 762	12	0 2
2 Alimodian	29 179	4 377	0	0
3 Anilao	20 711	3 107	8	0 257483103
4 Badiangan	22 795	3 419	0	0
5 Balasan	22,949	3,442	42	1 2
6 Banate	24 976	3 746	7	0 2
7 Barotac Nuevo	40 968	6 145		0
8 Barotac Viejo	33 652	5,048	0	0
9 Batad	15 345	2,302	4	0 2
10 Bingawan	11 494	1 724	0	0
11 Cabatuan	42 264	6 340	11	0 2
12 Calinog	45 452	6 818	56	0 8
13 Carles	46 218	6,933	3	0
14 Concepcion	30 111	4,517	0	0
15 Dingle	35 639	5 346	0	0
16 Duenas	28,945	4 343	0	0
17 Dumangas	51 092	7 664	2	0
18 Estancia	30 673	4 601	29	0 6
19 Guimbal	26 316	3 947	12	0 3
20 Igbaras	25 960	3 894	26	0 7
21 Iloilo City	334 539	50 181	79	0 1
22 Januay	50 066	7 510	7	0 1
23 Lambunao	58,792	8 819	0	0
24 Leganes	19 235	2 885	2	0 1
25 Lemery	20 860	3 129	163	5 2
26 Leon	41 043	6 156	0	0
27 Maasin	29 364	4,405		0
28 Miag-ao	52 276	7 841	5	0 1
29 Mina	16 419	2 463	18	0 7
30 New Lucena	16 873	2 531	14	0 5
31 Oton	56 821	8 523	20	0 2
32 Passi	59,539	8,931	4	0
33 Pavia	26 756	4 013	146	3 6
34 Pototan	56 340	8 451	1	0
35 San Dionisio	25 263	3,789	3	0 1
36 San Enrique	25 576	3 836	0	0
37 San Joaquin	44 368	6,655	0	0
38 San Miguel	18 819	2 823	4	0 1
39 San Rafael	12 000	1 800	9	0 5
40 Santa Barbara	39 667	5 950	5	0 1
41 Sara	38 652	5,798	0	0
42 Tigbauan	47 158	7 074	0	0
43 Tubungan	18 450	2 768	16	0 6
44 Zarraga	17 519	2 628	84	3 2
Total Population	1 749 549	262 434	329	0 1

New IUD Acceptors for Misamis Oriental

Municipalities	# of IUD Acceptors for 1997	Municipalities	# of IUD Acceptors for 1997
1 Opol	232	15 Balingasag	36
2 El Salvador	217	16 Salay	95
3 Alubijid	99	17 Lagonglong	9
4 Laguindingan	22	18 Binuangan	2
5 Gitagum	32	19 Sugbongcogon	17
6 Libertad	17	20 Kinogutan	8
7 Initao	111	21 Balingoan	11
8 Naawan	56	22 Talisayan	39
9 Manticao	108	23 Medina	438
10 Lugait	31	24 Gingoog City	594
11 Villanueva	93	25 Magsaysay	17
12 Claveria	214	26 Cagayan de Oro City	515
13 Tagoloan	173		
14 Jasaan	113		

New IUD Acceptors for Iloilo Province

A RHU with 0 IUD acceptors in 1997	B High Acceptance RHUs	# of IUD Acceptors	C Low Acceptance RHUs	# of IUD Acceptors
			Group 1 (10 and above acceptors)	
1 Barotac Nuevo	1 Balasan	42	1 Ajuy	12
2 Dingle	2 Iloilo City	79	2 Cabatuan	11
3 Lambunao	3 Lemery	163	3 Gumbal	12
4 Sara	4 Calinog	56	4 Mina	18
5 San Joaquin	5 Pavia*	146	5 Oton (2 RHUs)*	20
6 Alimodian	6 Zarraga*	84	6 Tubungan	16
7 Badiangan			7 Estancia	29
8 Barotac Viejo			8 Igaras	26
9 Bingawan			9 New Lucena*	14
10 Concepcion			Group 2 (9 and below Acceptors)	
11 Duenas			1 Anilao	8
12 Leon			2 Batad	4
13 San Enrique			3 Carles	3
14 Tigbauan			4 Dumangas	2
			5 San Dionesio	3
			6 San Rafael	9
			7 Banate	7
			8 Januay	7
			9 Leganes	2
			10 Miagao	5
			11 Passi City	4
			12 Pototan	1
			13 San Miguel	4
			14 Santa Barbara	5

*FGD areas