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# Postpartum Family Planning Services in the Philippines: An Assessment of Current Service Provision and Future Program Requirements

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**Abstract.** The 1998 Philippine Survey of Postpartum Family Planning Services documents the range and quality of family planning services offered to new mothers in the Philippines. The survey assesses the nature and completeness of information supplied by service providers to mothers concerning the initiation and use of individual contraceptive methods. It also reports on postpartum family planning practice, as reported by mothers, in order to determine compliance with protocols of use. The study is divided into two principal components: (1) interviews with 338 providers regarding family planning postpartum care; and (2) interviews with 3,452 mothers who gave birth between January 1994 and December 1997 and who accepted a family planning method within six months of delivery. Information was obtained from 86 clinics in 28 provinces across the Philippines.

Results indicate that the percentage of mothers accepting family planning during the six-month period following delivery is quite low (only 6.7 percent between January 1996 and July 1997 in the clinics covered in this study). The main methods accepted by postpartum clients are IUDs, DMPA, and oral pills.

The study found that the level of provider and client knowledge pertaining to postpartum family planning services is often inadequate. For example, many providers believe erroneously that combination (estrogen-progesterone) pills are safe for breastfeeding women within six months following delivery. Many providers are also unclear about proper compliance in the use of LAM (lactational amenorrhea method) as a method of pregnancy limitation. Interviews with clients suggest that pills (principally estrogen-progesterone combinations) and DMPA may sometimes be initiated too soon following delivery. Client misconceptions regarding LAM include the belief that women can use the method if they are not fully breastfeeding, if their infants are more than six months of age, and after their menses have resumed. Slightly more than one-quarter of LAM users have experienced return of menses less than six months after childbirth but maintain that LAM offers effective contraceptive protection for six months or longer. Clearly, there is considerable potential for unwanted pregnancies.

While clients reported few provider restrictions, medical procedures were not usually followed or explained to clients. Likewise, test results were not clearly reported nor used in selection of a method. Information given to clients was rather minimal, particularly in terms of mode of use. While the primary health care system is supposed to provide a constellation of services, knowledge of their availability is limited. The lack of congruence between provider and client responses on the provision of most service components is noteworthy. The study provides recommendations for (1) more actively promoting postpartum services as essential elements of maternal and child health care in the Philippines; (2) clarifying and disseminating guidelines for the provision of postpartum family planning services to providers and clients; and (3) enhancing training in postpartum family planning care.

# **Postpartum Family Planning Services in the Philippines: An Assessment of Current Service Provision and Future Program Requirements**

## **Introduction**

The International Conference on Population and Development held in Cairo in 1994 underscored the need for a comprehensive approach to reproductive health. Unfortunately, in many countries, postpartum family planning services have not been well integrated into existing health services. Strategies to improve reproductive health care for women after pregnancy have become a high priority.

The provision of quality family planning services in the postpartum period can contribute significantly to reducing the risk of poorly timed or unwanted pregnancies. Closely spaced pregnancies pose greater health risks for mothers and their infants, while unwanted pregnancies often result in unsafe abortions. Studies show that a large proportion of women interviewed in the postpartum period wish to regulate their fertility, either by spacing or preventing future pregnancies. However, in many settings, new mothers often do not have access to contraception<sup>1</sup>.

Many women who deliver in health facilities do not receive contraceptive counseling while they are there. Women typically do not return to the hospital for postnatal checkups unless they are feeling ill or have complications. This suggests that family planning counseling during prenatal visits is an important opportunity to encourage more extensive postnatal follow-up care.

Counseling on family planning is a crucial component in the range of services women need after pregnancy. In countries where a low proportion of births occur in institutional settings, proven strategies of community education - such as the use of traditional birth attendants to provide postpartum contraception - should also be utilized. Other factors inhibiting utilization include cultural barriers to family planning among providers and clients, provider biases in postpartum family planning, a lack of adequately trained personnel and updated service delivery guidelines, legal barriers, and inadequate attention to the development of client-centered services. In addition, inadequate facilities, equipment and commodities are major limiting factors to family planning services for women after pregnancy.

The 1990 International Conference on Postpartum Contraception in Mexico and the 1993 International Workshop on Postpartum and Postabortion Family Planning in Ecuador listed numerous recommendations for improving FP options following delivery, including the need to integrate reproductive health services<sup>2</sup>. Other recommendations called for evaluating contraceptive

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<sup>1</sup> Roberto Rivera and Jose Antonio Solis. *Improve Family Planning After Pregnancy*. FHI Network, Vol. 17, No. 4. Summer 1997, pp. 4-6.

<sup>2</sup> R. Rivera, Kennedy K., Rosman A., et al. *Identification of Clinical and Programmatic Needs for Postpartum Contraception. Report on the International Conference on Postpartum Contraception, Mexico City, 17-19 September 1990*. Research Triangle Park, NC: Family Health International, 1991.

methods used in the postpartum and postabortion period; giving more attention to clients' perspectives, expectations, and needs; and extending postpartum services to non-hospital and non-urban settings. Improving the choice of methods available; evaluating the effectiveness of postpartum and postabortion counseling and family planning services; and identifying barriers, both medical and non-medical, to postpartum family planning were other important recommendations from these conferences.

It was also noted that postpartum family planning should be included in medical and nursing school curricula, especially where medical services emphasize curative rather than preventive care. In some countries, family planning is either not included in nursing and medical school curricula, or the information presented is inadequate. Training needs may also lie in specific areas, such as the need for better counseling techniques to ensure adequate method choice and informed consent.

Unfortunately, many program managers equate postpartum contraception with IUD insertion or voluntary surgical sterilization and may not provide other appropriate methods. National service delivery guidelines should be reviewed and, if need be, revised to include the most recent scientific information on both clinical and programmatic aspects of care.

### **The Need For A Client-Centered Postpartum Program**

After a woman gives birth, she faces the task of caring for a newborn (an especially challenging experience for first-time mothers), and recovering from the rigors of pregnancy and child birth. Following delivery, many women want to space or limit their childbearing in order to protect their own health and that of their children.

Despite these special needs, service providers tend to pay little attention to postpartum care, including the need to begin contraception when menstruation returns. In Ecuador, for example, three-quarters of women go for prenatal checkups, but only one-third obtain postpartum care.<sup>3</sup> In a study in two Kenyan hospitals, 92 percent of postpartum women reported that they wanted to use family planning, but only 2 percent left the hospital with a method after delivery<sup>4</sup>. Worldwide, about a third of all women with an unmet need for family planning are pregnant or have recently given birth<sup>5</sup>.

What is the best way to serve postpartum women? The International Planned Parenthood Federation (IPPF) encourages its affiliates to integrate family planning with other services. This

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<sup>3</sup> Pan American Health Organization/Family Health International. *Postpartum and Postabortion Family Planning in Latin America: Interviews with Health Providers, Policy-Makers and Women's Advocates in Ecuador, Honduras and Mexico WP97-02*. (Research Triangle Park: Family Health International, 1997).

<sup>4</sup> J. Bradley, Lynam P, Gachara M, et al. "Unmet family planning demand: evidence from two sites in Kenya". *Four Obst Gyn East Cent Afr* 1993; 11:20-23.

<sup>5</sup> B. Robey, Ross J, Bhushan I. "Meeting unmet need: new strategies". *Population Reports 1996; Series J, No. 43:18*.

approach prevents duplication of services and expertise, reduces costs, and responds to the call of the 1994 International Conference on Population and Development in Cairo for integrated services<sup>6</sup>.

The World Health Organization (WHO) is moving in a similar direction. WHO convened a panel of experts to determine how to address the needs of postpartum women and their infants. The group's report recommends appropriate postpartum care for mothers and their infants, including family planning, nutrition, social support and HIV/AIDS prevention.

Providers in the Philippines, Mexico, Chile, Zambia, and elsewhere are developing integrated postpartum services that include family planning. Many link maternal and child care with contraceptive provision; others emphasize breastfeeding to enhance maternal and infant health while offering contraceptive protection; and still others link prenatal services and family planning to postpartum follow-up. Offering a variety of services can seem overwhelming to providers who often face limited resources, time, and technical capabilities. The results, however, may include more satisfied clients, better follow-up and improved health care.

### **Common Perceptions of Postpartum Contraception**

Postpartum women have particular health needs, including specific contraceptive requirements. IUDs, barrier methods and certain hormonal contraceptives can all be appropriate for the postpartum period. However, even where postpartum and postabortion family planning programs are available, many factors can limit their success. Primary among these are a lack of institutional or official support and poor integration of services into existing programs.

Advice on family planning use for postpartum women may be different from regular use, especially for breastfeeding women. Providers must be aware of restrictions and inform clients about them in order to ensure effective contraceptive coverage. For example, the IUD is a good option for most women after pregnancy, including those who are breastfeeding. However, IUDs should be inserted within 48 hours or delayed six weeks to reduce the risk of expulsion (during the 48 hours after delivery, risk of expulsion is lowest for immediate insertions, especially those done within 10 minutes of delivery). Barrier methods that require fitting, such as the diaphragm, should be delayed six weeks. While sterilizations can be performed any time, some experts believe that it is preferable to delay this procedure until at least four weeks postpartum in order to reduce the risk of infection.

Progesterone-only hormonal methods (DMPA, Norplant and progestin-only pills) may be started immediately by mothers who are not breastfeeding, but should be delayed six weeks by breastfeeding mothers, since hormones are transferred from mothers to infants through breast milk. Although no adverse effects have been reported among children exposed to synthetic hormones during breastfeeding, most experts recommend delaying use as a precaution against theoretical concerns.

Combined hormonal methods (those that contain estrogen and progesterone), including oral contraceptives and certain injectables, should normally be delayed six months for breastfeeding women. In general, combined hormonal methods are not recommended for breastfeeding mothers unless other acceptable choices are unavailable, since estrogen can diminish the production of breast

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<sup>6</sup> M. Potts, Thapa S. *Child Survival: The Role of Family Planning*. Research Triangle Park, NC: Family Health International, 1991.

milk. Some experts recommend that non-breastfeeding women delay combined hormonal methods until three weeks after delivery, although there are no significant problems stemming from immediate use other than a very slight risk of blood clotting. Another contraceptive option for postpartum women is the lactational amenorrhea method (LAM). Correct use of LAM entails that a woman's menses has not resumed, that she is fully or nearly fully breastfeeding, and that her baby is less than six months old.

Establishing LAM education and promotion can be an effective way to provide integrated postpartum care. By promoting full breastfeeding for six months, LAM education leads to other health benefits for both the mother and baby. Infants who are breastfed get immune protection from infections, and they receive good nutrition as well. Breastfeeding also speeds involution of the uterus after delivery, decreases postpartum bleeding and may protect against breast cancer. Women using LAM should be prepared to use a different contraceptive method when conditions for LAM no longer apply.

Health and family planning services in the Philippines, Ecuador, Zambia and other countries have begun promoting LAM to improve health and contraception. In Zambia, for example, women who have prenatal or postpartum checkups at government health clinics can see counselors from the Family Life Movement, a non-governmental organization, for advice on proper breastfeeding techniques and LAM. Some providers worry that women who use LAM will not move on to other family planning methods. However, in Zambia, as in other countries, there is evidence that LAM encouraged women to begin using modern methods of contraception at six months postpartum.

### **Integrating Postpartum Information in Prenatal Services**

Many experts recommend that family planning counseling for postpartum contraception should take place as part of prenatal care and during the postpartum period. Prenatal counseling for postpartum contraception - especially for permanent and long-term methods such as surgical sterilization and IUDs - allows women to make more informed choices without time pressure. Prenatal counseling can also help educate women about their reproductive physiology. For example, many women use the return of their menstrual periods, not the end of pregnancy, as a signal to begin using contraception. Yet the return of menses may actually indicate that fecundity returned weeks before.

Research shows that women's needs and sense of timing may differ from that of providers. For example, a study by the Institute of Child Health in Istanbul, Turkey found that a majority of the 184 postpartum women interviewed had wanted to receive family planning information during prenatal visits, while others preferred the period immediately after delivery, or 40 days postpartum<sup>7</sup>. Many women who wanted contraceptive information did not receive any at all. Providers, on the other hand, thought that postpartum family planning information should be given primarily to women at high risk of difficult pregnancies. An essential step to improve or establish postpartum services is training, both on postpartum use of contraception and on linking reproductive health services to child care.

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<sup>7</sup> A. Bulut. "Postpartum service delivery, Istanbul, Turkey". In *Rethinking Postpartum Health Care, Proceedings of a Seminar, December 10-11, 1992*. (New York: Population Council, 1993) 8-10.

## **Client-Focused Postpartum Family Planning Services**

In providing care for postpartum women, service providers must consider the client's needs for accurate information, empathetic counseling, and accessible services. Workers also must consider how service delivery systems, provider attitudes and client perspectives can affect postpartum and postabortion access to contraception and other reproductive health services. Providers must consider women's needs for related reproductive health services. For example, postpartum women also need information about breastfeeding, infant care and nutrition. Women undergoing treatment for incomplete abortions, whether spontaneous (miscarriage) or induced, need emergency treatment for complications.

Counseling is an important element of service quality. For postpartum women, counseling should begin by helping women discuss past contraceptive experiences and identify future reproductive health needs. Providers should ask clients about their planned future pregnancies and offer information on contraceptive methods if they choose to delay or space births. Providers should help women understand the effects of individual contraceptive methods and assist in assessing the practicality of using a particular method. For example, condoms will require a male partner's knowledge and consent and must be used during every act of intercourse. Progestin-only methods may cause bleeding between menstrual periods and women need to consider how that will affect their work and family life. Oral contraceptives are highly effective at preventing pregnancy, but offer no protection for women at risk of sexually transmitted diseases.

In addition to information about family planning methods, postpartum women need to know what they should expect during their recovery and how to care for themselves. Providers should also offer information about (1) signs and symptoms of health problems indicating if mothers need to return for additional care; (2) how mothers can take care of their health to prevent future problems; (3) when mothers can return to usual work and household activities; and (4) when women can resume sexual intercourse.

Providers should not offer women information about family planning while they are under stress. It is considered unethical to discuss contraception while women are in the physical and emotional pangs of labor. Counseling during this time of anxiety may also be ineffective. When planning postpartum care, program managers should consider who will be responsible for providing information, counseling and services. Often, when busy staff are not assigned specific responsibilities, family planning may be ignored as other duties take precedence. Program managers must look at the whole system of service delivery to make sure procedures are in place for postpartum and postabortion clients to receive family planning services.

### **The Philippine Situation**

The Philippine Family Planning Program (PFPP) defines the demand for family planning in terms of the expressed desire of couples to space or limit their children and the need to reduce risks to the health of mothers and children due to pregnancy and childbirth. The Program relies on voluntary acceptance and compliance among service users. The PFPP provides information and services related to family planning. Information consists of factual explanations of health and other benefits of family planning, descriptions of various family planning methods included in the program, and other materials that couples need in order to make fully informed choices.

The program makes available the following contraceptive methods: (a) low dose combination pills and progestin-only pills, intrauterine devices (IUDs), injectable hormonal

contraception (Depo Provera), male and female voluntary surgical contraception, condoms, natural family planning (NFP), and the lactational amenorrhea method (LAM). In 1995, the program maintained a network of 10,865 DOH/LGU facilities and 1,975 NGO clinics that provided family planning information and services to an estimated 2.13 million current users. In addition, around 355 natural family planning (NFP) centers have been established nationwide.

An important component of the Philippine program that has not received much attention in recent years is the provision of family planning services to women who have recently had a child. Little is currently known about the range of reproductive health services provided to postpartum mothers, the type of counseling offered at clinics, the range of FP methods on offer, and medical eligibility protocols established by providers for the initiation of contraceptive use postpartum. For example, are clinics waiting for the first postpartum menses, adopting fixed duration strategies, or employing mixed timing initiations of contraceptive use based upon the general health status of mothers? In addition, there is little client information focusing directly on satisfaction with postpartum FP services as well as the methods provided.

Of particular concern in the Philippines, and in many other country programs, is the extent to which providers are adhering to protocols for determining client eligibility in initiating use of specific methods. For example, are estrogen-based oral contraceptives being prescribed to mothers too soon following childbirth (e.g., to fully breastfeeding mothers within three months postpartum) thereby reducing breast milk flow and transmitting estrogen hormones to the newly-born? Are non-hormonal forms of contraception (e.g., IUDs and barrier methods) being systematically withheld from mothers who have recently given birth? Are mothers obtaining accurate information about LAM and other natural family planning methods commonly utilized soon after the birth of a child?

Informed knowledge about LAM is especially crucial for ensuring effective protection from unwanted conceptions. Since this method is now being widely introduced in the Philippines, it is important to consider whether providers and clients are familiar with the three preconditions for effective LAM use (full or nearly full breastfeeding, no return of menses, and infant's age less than six months) and whether proper compliance is being followed by LAM users. Identifying field-level problems that may be associated with the introduction of LAM in the Philippines could be highly instructive to other countries considering the introduction of LAM as a formal postpartum family planning method.

### **The Research**

The general objective of this research is to document the range and quality of postpartum family planning services in the Philippines. The nature and completeness of information supplied by service providers to mothers concerning the initiation and use of individual contraceptive methods is assessed. Postpartum family planning practice as reported by mothers is also studied in order to determine compliance with protocols of use.

The study is divided into two principal components:

1. Interviews of 338 providers regarding family planning postpartum care including screening procedures, information, counseling, and the provision of suitable postpartum methods;
2. Interviews of 3,452 mothers giving birth between January, 1994 and December, 1997 regarding postpartum family planning acceptance, reproductive intentions, reasons for method selection, side effects, pregnancy, and the range of services obtained by clients.

Information was obtained from 86 clinics in 28 provinces across the Philippines. The distribution of providers and clients interviewed in this study by province and clinic affiliation is presented in Appendices 1-2.

Specifically, the objectives of the study are:

1. Assess current provider policies and practices regarding postpartum family planning services in the Philippines and evaluate the current status of provider knowledge regarding the provision of postpartum family planning services;
2. Document the content of family planning counseling and information typically provided to mothers. For example,
  - a. How are postpartum women recruited into the program?
  - b. Are mothers told that they cannot use a contraceptive method owing to age, parity, breastfeeding status, pre-existing health conditions, or other criteria?
  - c. What medical procedures are recommended by providers before mothers can accept specific methods and are these laboratory examinations/tests adequately explained to clients? To what extent have the results been used as the basis for the methods provided?
  - d. What are clinic policies and provider's perceptions regarding provision of contraceptives to ensure the continuation of lactation?
3. Identify patterns of method use among mothers accepting contraception postpartum and assess levels of satisfaction with the method (or methods) adopted. More specifically, what are the practices affecting the initiation of non-hormonal and hormonal-based contraception?
4. Specify when the use of contraception is initiated postpartum (e.g., immediately following delivery, after cessation of breastfeeding, at first postpartum menses, or after a fixed period of time);
5. Determine what follow-up care is given to mothers who adopt contraception soon after the birth of a child (e.g., number of return visits and how side-effects are managed);
6. Assess the overall quality of clinic services associated with greater client satisfaction and use of postpartum family planning services;
7. Document recent experience with LAM and other natural family planning methods in ensuring use-continuation and preventing unwanted pregnancies.

## **Methodology**

The centerpiece of this study is the client survey of mothers who gave birth within the 48 month period between January, 1994 and December 30, 1997 and obtained postpartum family planning services (excluding sterilization) from 86 clinics, including those studied in the 1996 De La Salle Quality of Care Practicum (QCP) and Quality of Care Survey (QCS). This study provides national-level information on the provision and utilization of postpartum family planning services

in 28 provinces. Particular attention is paid to qualitative elements of postpartum family planning services such as screening, content of counseling and information, the choice of appropriate methods for limiting and spacing, the timing of contraceptive adoption, and the management of side effects. In addition, follow-up mechanisms and socio-cultural barriers affecting the utilization and provision of postpartum family planning care are assessed.

## **The Provider Survey**

### **Profile**

There were 338 providers interviewed for the study - 144 from Luzon, 114 from Visayas, and 80 from Mindanao. Providers interviewed were mainly from government service delivery points, primarily rural health units and municipal health offices. Slightly more than a tenth (10.7 percent) came from NGO clinics and private hospitals. The majority of the respondents were midwives (65.4 percent), followed by nurses (20.7 percent) and physicians (11.0 percent).

More than half of the providers (51.2 percent) have been supplying family planning services for 10 years or more, with slightly more than a fourth (25.7 percent) having been in service for less than 5 years. The average duration of service was 12 years. Most of the providers (88.2 percent) underwent training for postpartum service delivery. On average, about three training courses of varying durations have been attended. Despite this, only 66.7 percent of the respondents felt that their family planning training was adequate. A slightly higher percentage (70.3 percent) reported that their postpartum training was sufficient. The percentage who had training on LAM and NFP was relatively low - 41 to 43 percent. For those who underwent this training, the duration of training was usually around 1 to 2 weeks (see Table 1).

### **Specific Service Delivery Practices**

Most providers interviewed for this study report that they recommend family planning methods as part of their postpartum services. As can be seen in Table 2, 98.9 percent of providers recommend that mothers begin using some form of contraception within six months of delivery. Within one month of delivery, 77.8 percent of providers say that they recommend the initiation of contraception. There is not much regional variation in provider recommendations for initiating family planning use in the postpartum period (see Table 3). However, private sector providers appear to recommend somewhat later initiation of contraceptive use (an average of 2.6 months postpartum) than public sector providers (1.9 months following delivery).

Many providers recommend that mothers begin using contraception following the cessation of breastfeeding (45.8 percent). The conclusion of full breastfeeding is seen as the point at which family planning use should begin by 22.7 percent of providers, while the ending of partial breastfeeding is cited by 6.2 percent of providers. As can be seen in Table 4, a significant number of providers (33.0 percent) only recommend that mothers begin using contraception following the resumption of menses.

Tables 5, 5a and 5b show the range of methods recommended by providers for up to six months postpartum for women who either want to space (delay) or limit (terminate) their childbearing. As might be expected, providers generally recommend short-term methods for women wishing to space their next child and long-term and permanent methods for women interested in limiting their fertility. IUDs (25.4 percent), LAM (23.4 percent), and DMPA (19.2 percent) are the

main spacing methods recommended by providers, while female sterilization (46.3 percent) and IUDs (9.3 percent) are most commonly recommended for limiting. Nearly all providers report giving advice on contraception to women wishing to space, but a surprisingly large number (20.3 percent) did not provide any advice on contraception to women interested in limiting methods (see Tables 5a and 5b). This finding suggests that providers may not be as knowledgeable about long-term and permanent methods (which require clinic provision and backup) as they are about more commonly used non-clinical methods (e.g., pills, condoms, and NFP).

For those who want to delay childbearing, the method most commonly recommended within 6 weeks after delivery is the IUD (31.0 percent), followed by DMPA (18.1 percent) and LAM (17.7 percent). Within three months postpartum, the IUD is again the main method of choice (24.3 percent), followed by DMPA (20.1 percent), pills (17.1 percent), and LAM (10.9 percent). From four to six months after delivery, pills emerge as the major method recommended (26.1 percent) followed by the IUD (23.6 percent), DMPA (20.4 percent) and LAM (8.8 percent). The fact that a significant percentage of providers continue to recommend LAM at four-six months following delivery suggests that there is inadequate knowledge about the method in some service outlets. Many women may be ending full breastfeeding and experiencing return menses at four-six months postpartum, which are events that should dictate the cessation rather than the initiation of LAM use.

For pregnancy termination, female sterilization is the predominant method recommended within six weeks, three months, and four-six months postpartum. The IUD is a distant second in all three time periods. These results suggest that many providers have a reasonable understanding of effective methods that can be employed to limit childbearing. However, it is worth noting that male sterilization continues to be substantially under-emphasized relative to female sterilization.

In terms of methods actually provided, LAM is the method of choice within the first week of delivery (see Table 6). Nearly half of all providers (42.3 percent) are supplying LAM at one week postpartum, followed by the IUD (10.7 percent). Within six weeks after delivery, the IUD ranked first (30.5 percent) followed by DMPA (21.3 percent). It is worth noting that Family Health International (FHI) recommends that IUDs be inserted within 48 hours or after 6 weeks to avert expulsion. In addition, DMPA is recommended only after six weeks postpartum. According to providers, sterilization is not a major postpartum family planning method in the Philippines. Only 5.1 percent of providers (mainly hospital based) provided female sterilizations within one week of delivery, and an insignificant percentage of providers performed sterilizations at longer durations following delivery.

Within three months postpartum, IUDs and DMPA were the preferred methods (19.6 percent for each method) followed by pills and condoms (17.5 and 17.0 percent respectively). From four to six months after delivery, pills are the main methods of choice among providers (26.0 percent) followed by DMPA (20.6 percent) and IUDs (17.0 percent). The high level of pill acceptance within three months and between 4-6 months postpartum is somewhat disconcerting in that the vast majority of pills being used by Philippine women are combination (estrogen-progesterone) pills that are generally not recommended for breastfeeding mothers until six months postpartum.

Additional information on the nature of postpartum services can be seen from information on when providers believe that family planning methods can be safely initiated for breastfeeding mothers. Results provided in Table 7 show that the overwhelming majority of providers (86.3 percent) maintain that the IUD can be inserted within one month following delivery. It is not clear from these findings whether most providers know that IUDs are best inserted within 48 hours of delivery or after six weeks. In addition, 20.7 percent of providers believe that combination pills

are safe for breastfeeding women within five months following delivery. As noted previously, it is generally recommended that combination pills not be prescribed to breastfeeding women until six months postpartum. It is also worth noting that a significant number of providers believe that progesterone-based hormonal contraceptives (progestin-only pills and DMPA) are not safe for breastfeeding women between three and six months postpartum. These methods are generally recommended for breastfeeding women from as early as six weeks postpartum. Clearly, there is some confusion among providers concerning the protocols for recommending specific methods in the postpartum period.

Results from the provider survey indicate that Logentrol (60.1 percent), Exluton (23.2 percent), and Marvelon (7.9 percent) are the most commonly recommended oral pills for postpartum mothers in the Philippines family planning program. Both Logentrol and Marvelon are combination pills while Exluton is a progestin-only pill. However, recent evidence suggests that the vast majority of oral pills currently being used in the Philippines are combination pills. In terms of commercial sales, the main brands in circulation are Femenal (a high dose monophasic oral contraceptive), Nordette, Trinordiol, Logynon, Trust, and Noridol<sup>8</sup>. Exluton is not widely available at the present time. Logentrol, the most widely used oral pill in the Philippines and the main government pill brand.

Table 8 presents information on provider perceptions of breastfeeding and LAM use among postpartum women. Most providers (61.8 percent) mentioned that their facility allows the mother and infant to stay together following delivery and for mothers to breast feed on demand. Exclusive breastfeeding in the first days of life is encouraged by 85.5 percent of providers. Inadequate knowledge of certain reproductive health issues is reflected by the fact that only slightly more than half of all providers (53.0 percent) know that AIDS infected mothers can pass the HIV virus to infants through breast milk and only 27.2 percent believe that pregnancy risk is reduced with full breastfeeding.

Almost all of the respondents (96.4 percent) reported that their service delivery points promote the use of LAM and a majority feel that LAM can be used for both breastfeeding and family planning (82.5 percent). A small but not insignificant number of providers (10.7 percent) think that a woman can use LAM even if she is partially breastfeeding. More than a fifth (20.1 percent) reported that LAM can still be used even if the child is older than 6 months and 21.0 percent indicated that a woman can still use LAM once her menses resumes. Clearly, many service providers are still unclear about proper compliance and the mode of action for LAM as a method of pregnancy limitation.

Results shown in Table 8 also show that most providers (62.1 percent) would advise women to use LAM if they are malnourished and 29.6 percent feel that postpartum clients can use LAM even if they are taking prescription medicines. Slightly less than one-third of all providers (30.8 percent) think that LAM can be prescribed to mothers with AIDS and 42.3 percent indicated that LAM can be used by women with tuberculosis.

At the present time there are no clear guidelines for whether LAM should be used by women with AIDS, which in part reflects uncertainty within the professional community about the relative

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<sup>8</sup> Edelweiss Balbin Mallari. *Commercial Contraceptive Marketing in the Philippines*. Draft. The Policy Project in collaboration with Research Triangle Institute and The Center for Development and Population Activities, 1998.

risks of these conditions for breastfeeding mothers. For example, despite evidence that HIV transmission can occur through breast milk, UNICEF still recommends breastfeeding as "the best possible way of feeding young children". An advisory issued by UNICEF and UNAIDS on March, 11, 1998 concluded that "studies indicate that one-quarter to one-third of infants born worldwide to HIV-infected mothers contract the disease; most of these infections occur during late pregnancy and delivery, but preliminary studies indicate that over one-third of the infants who contract HIV do so through breastfeeding"<sup>9</sup>

An infant born to a mother with untreated pulmonary tuberculosis should be advised not to breast feed. Mothers with treated TB that is no longer infectious can generally breast feed, although if ethambutol (an antibiotic commonly used to treat TB) is being prescribed, mothers should still refrain from breastfeeding<sup>10</sup>. Adding to potential provider confusion is the fact that in many resource poor clinical settings, it is not always easy to clearly distinguish between contagious (active) and non-contagious TB.

Finally, characteristics of natural family service provision by postpartum service provider are presented in Table 9. Most providers reported supplying NFP in their facilities. The most common NFP procedure provided is the calendar or cycle calculation method (59.2 percent) followed by cervical mucus assessment (40.9 percent) and the basal body temperature system (20.7 percent). However, only 55.9 percent mentioned that women can engage in sexual activity without the risk of becoming pregnant from the fourth day of temperature increase to the end of the cycle. Just 22.8 percent mentioned that mucus is sticky and pasty if the woman is fertile. Nearly half (46.2 percent) of the respondents reported a difference in mucus observation and menstrual cycle between contraceptive and non-contraceptive users. Only 22.5 percent recommend that NFP users track their menstrual cycles and a mere 3.0 percent suggest the use of back-up methods. These findings suggest a need for more training and information about NFP methods among service providers in the Philippine family planning program.

### Restrictions in Service Delivery

Table 10 provides details on specific provider restrictions in prescribing family planning methods to clients. Results indicate that 41.1 percent of providers will not give combined pills to women aged 35 years and over. Also, 11.5 percent of providers require that female sterilization acceptors be at least 35 years of age. In terms of the number of children, 10.9 percent of providers who prescribe DMPA require mothers to have had at least one child and 13.9 percent require a woman to have at least 3 children before accepting sterilization. Marital restrictions are highest for IUD and DMPA acceptors, with 30.8 and 30.2 percent of providers saying that women must be married to obtain these methods. In addition, spousal consent is often required by providers in the provision of IUDs (48.8 percent), DMPA (42.9 percent), female sterilization (39.6 percent), and combined pills (30.2 percent).

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<sup>9</sup> International Pediatric Society, Public Policy News Update, "Children: UNICEF backs breastfeeding over AIDS threat", March 11, 1998. Recent global evidence on maternal transmission of HIV to infants is also provided in UNAIDS, *Report on the Global HIV/AIDS Epidemic*, December, 1997.

<sup>10</sup> Breastfeeding recommendations for TB-infected mothers are provided in Canadian Pediatric Society, "Breastfeeding by infected mothers", Position Paper released by the CPS Infectious Diseases and Immunization Committee, 1983.

In general, these findings suggest substantial levels of provider restriction in the use of family planning services (especially true in the case of marital status and spousal approval criteria). It is therefore curious to note that clients tend not to report such high levels of provider restriction when obtaining services. This may be largely due to the fact that they are unaware of the judgements made by providers, supposedly on their behalf.

### **Information Given to Clients**

Table 11 provides information supplied to postpartum clients about individual family planning methods. While providers commonly mention pills, condoms, IUDs and DMPA, the level of presentation for other methods is lower (LAM, 76.9 percent; NFP, 66.0 percent; female sterilization, 62.7 percent; and vasectomy, 32.2 percent). The advantages and disadvantages of most methods were also commonly discussed with mothers.

Information presented in Table 11 shows that compliance in the proper use of methods appears to be less readily discussed by providers. It is worth noting that less than fifty percent of all providers say that they discuss the proper use of LAM (44.4 percent) and NFP (37.9 percent) with postpartum clients. However, providers report that contraindications and potential side effects for most modern methods (pills, IUDs, and DMPA) were usually discussed with clients.

Somewhat less attention is given to reviewing treatments for specific side effects. For example, side effect treatments for pill users are only discussed by 55.3 percent of providers, IUDs by 52.1 percent, and DMPA by 49.4 percent. Some may argue that it is not obvious whether clients need to be fully informed about the full range of side effect treatment protocols (e.g., this might greatly lengthen provider/client consultation times and reduce the number of clients that can be accommodated by providers). However, to the extent that clients need to be educated about potential side effects in order to make informed choices in selecting family planning methods, it may be useful to upgrade client knowledge of treatments for common side effects.

### **Screening Procedures**

Screening procedures employed by providers for individual methods are presented in Table 12. For pills, IUDs, and DMPA, providers commonly record medical histories, take blood pressure and weight check measurements, and conduct physical examinations. However, very few LAM and NFP users undergo these screening procedures. Pelvic examinations are also not given for most methods, the only exception being for the IUD. Less than six percent of all providers report conducting blood test hemoglobin (to test for the presence of anemia) and sexually transmitted disease (STD) lab screening for postpartum family planning acceptors. These screening components, which are often considered to be essential elements of a comprehensive reproductive health service, appear to be largely lacking in the current range of services offered to postpartum family planning clients in the Philippines.

Providers indicated that reasons for conducting screening procedures and examination results relevant for selecting methods are usually transmitted to clients. Providers also report that checklists are available in the clinic for method options, proper use of methods, advantages and contraindications of methods, side effects, sources of assistance and supply, and information appropriate for switching methods. Providers also note that checklists are commonly available for the identification of client needs based on such criteria as age and number of children, desire for more children, breastfeeding experience, method preference, health status, follow-up visits, and resupply sources.

### **Constellation of Services**

Table 13 presents the constellation of services that are provided in the service delivery points (SDPs) surveyed in this study. Child health services tend to be given most attention by providers. For example, over 90 percent of all providers report offering child immunization and growth monitoring services. Oral rehydration therapy (ORT) and acute respiratory infection (ARI) care are only provided by approximately 75 percent of all providers.

Maternal and reproductive health services are generally less well represented in the constellation of services offered by providers to postpartum family planning clients. Reproductive tract infection/STD diagnosis and treatment services appear to be especially under-represented, with only around one-third of all providers stating that these elements are offered at their facilities. In addition, roughly one-third of all providers say that treatments for family planning side effects are not available as part of their service offerings. These results indicate that there are still gaps in the range of services that should be offered to mothers wishing to use family planning in the postpartum period.

### **Emphasis on Quality**

The provider survey also employed a scaling procedure to assess provider orientations on the quality of care. The scale employs a range from 1 for no emphasis to 4 for considerable emphasis. These results are presented in Table 14. Quality of care items considered are contraceptive choice, side effect information, assistance in the selection of most appropriate methods, possibility of switching, effectiveness of different methods, information on the mode of action, source of supply, cleanliness at the clinic, waiting time, respect, and privacy. Elements accorded considerable emphasis by providers are respect for clients (89.6 percent), the provision of side effect information (85.2 percent); privacy (84 percent); promotion of family planning method choice (82.8 percent), and effectiveness of methods (81.7 percent). Less emphasis is given to reducing client waiting times (63.6 percent) and providing information on alternative sources of family planning services (67.0 percent).

**Table 1: Percentage Distribution of Postpartum Service Providers by Selected Characteristics (N=338)**

Type	Number	Percentage
<b>1. Geographical Base</b>		
Luzon	144	42.6
Visayas	114	33.7
Mindanao	80	23.7
<b>2. Type of Service Delivery Point</b>		
Government	302	89.3
NGO	36	10.7
<b>3. Type of Clinic</b>		
RHU/MHO	252	74.6
NGO Clinic	33	9.8
Government Hospital	15	4.4
City Health Office	35	10.4
Private Hospital	3	.9
<b>4. Designation</b>		
MD	37	10.9
Nurse	70	20.7
Midwife	221	65.4
Others	10	3.0
<b>5. Length of Service at the Service Delivery Point (Years)</b>		
< 5	87	25.7
5 - 9	78	23.1
10 - 19	91	26.9
20 +	82	24.3
Mean Duration of Service	11.9 years	
Median Duration of Service	9 Years	
Percentage with Family Planning Training	94.7	
Percentage With Postpartum Training	88.2	
Percentage Perceiving FP Training Adequate	66.9	
Percentage Perceiving PP Training Adequate	70.3	
Percentage With Training on LAM	42.9	
Percentage With Training on NFP	41.1	
Average Duration of LAM Training	1.9 Weeks	
Average Duration of NFP Training	2.3 Weeks	

**Table 2: Time Following Delivery When Provider Recommends Initiation of Family Planning Use for Postpartum Mothers**

Time Following Delivery	Number	Percentage
Within 1 Month	203	77.8
Within 3 Months	213	81.6
Within 6 Months	258	98.9
More than 6 Months	3	1.1

**Table 3: Mean Number of Months Before Providers Recommend Initiation of Family Planning Use for Postpartum Mothers by Region and Source of Supply**

	Number	Mean Number of Months
<b>Region</b>		
Luzon	113	2.1
Visayas	80	2.0
Mindanao	72	1.9
<b>Source of Supply</b>		
Public Sector	237	1.9
Private Sector	28	2.6

**Table 4: When Do Providers Advise Mothers to Use Family Planning (Based Upon Single and Multiple Response Patterns)**

	Number	Percentage
Following All Breastfeeding	112	16.9
Only After Full Breastfeeding	151	22.7
Only After Partial Breastfeeding	41	6.2
After Resumption of Menses	219	33.0
After Fixed Duration of Lactation	39	5.9
Depends on General Health of Mother	79	11.9
Other	23	3.5
<b>Total</b>	<b>664</b>	<b>100.0</b>

**Table 5: Family Planning Methods Recommended by Providers for Women Wishing to Space and Limit their Childbearing (Based Upon Single and Multiple Response Patterns)**

Method	Advice for Women Who Want to Delay Childbearing (N=714)	Advice for Women Who Want to Limit Childbearing (N=443)
Pills	8.4	1.1
IUD	25.4	9.3
DMPA	19.2	5.9
Female Sterilization	.6	46.3
Male Sterilization	.3	7.2
Condom	12.5	2.9
NFP	7.1	2.0
LAM	23.4	4.1
Other	.6	.7
None	2.7	20.3
<b>Total</b>	100.0	100.0

**Table 5a: Family Planning Methods Recommended by Providers at Different Periods Following Delivery for Women Wishing to Space their Childbearing (Based Upon Single and Multiple Response Patterns)**

Method	Within Six Weeks (N=733)	Within Three Months (N=741)	Within Four-Six Months (N=793)
Pills	9.7	17.1	26.1
IUD	31.0	24.3	23.6
DMPA	18.1	20.1	20.4
Female Sterilization	1.0	.9	1.3
Male Sterilization	.4	.4	.6
Condom	9.8	10.8	7.1
NFP	6.5	5.8	4.9
LAM	17.7	10.9	8.8
Other	.8	.6	.3
None	4.9	9.0	6.9
<b>Total</b>	100.0	100.0	100.0

**Table 5b: Family Planning Methods Recommended by Providers at Different Periods Following Delivery for Women Wishing to Limit their Childbearing (Based Upon Single and Multiple Response Patterns)**

Method	Within Six Weeks (N=446)	Within Three Months (N=433)	Within Four-Six Months (N=450)
Pills	3.8	4.2	6.0
IUD	10.3	7.9	8.2
DMPA	6.7	6.2	6.2
Female Sterilization	52.0	47.8	45.3
Male Sterilization	6.7	6.2	6.0
Condom	1.8	1.4	.9
NFP	1.1	.9	1.3
LAM	1.6	.7	1.8
Other	.6	.7	.5
None	15.2	24.0	23.3
<b>Total</b>	<b>100.0</b>	<b>100.0</b>	<b>100.0</b>

**Table 6: Family Planning Methods Provided at Different Periods Following Delivery (Based Upon Single and Multiple Response Patterns)**

Method	Within One Week (N=449)	Within Six Weeks (N=727)	Within Three Months (N=765)	Within Four-Six Months (N=880)
Pills	2.0	10.6	17.5	26.0
IUD	10.7	30.5	19.6	17.0
DMPA	4.9	21.3	19.6	20.6
Female Sterilization	5.1	1.2	1.0	1.0
Male Sterilization	1.3	.4	.4	.5
Condom	7.6	14.0	17.0	15.6
NFP	5.8	4.3	5.4	6.0
LAM	42.3	13.2	10.5	8.1
Other	.2	.7	.7	1.0
None	20.0	3.7	8.4	4.2
<b>Total</b>	<b>100.0</b>	<b>100.0</b>	<b>100.0</b>	<b>100.0</b>

**Table 7: Percentage of Providers Who State that Family Planning Methods can be Safely Initiated at Different Postpartum Periods for Breastfeeding Women (N=338)**

	Combination Pills	Progestin-Only Pills	IUDs	DMPA
Within 1 Month	7.7	27.0	86.3	56.9
Within 3 Months	14.8	39.9	94.3	69.3
Within 5 Months	20.7	44.8	96.7	72.7
6 or More Months	79.3	55.2	3.3	27.3

**Table 8: Provider Perceptions of Breastfeeding and LAM Use Among Postpartum Women (N=338)**

	Number	Percentage
1. Facility Allows Mother and Infant Together Immediately after Delivery	209	61.8
2. Facility Encourages Breastfeeding on Demand	209	61.8
3. Facility Encourages Exclusive Breastfeeding	289	85.5
4. Infected Mother Can Pass AIDS Through Breast Milk	179	53.0
5. Breastfeeding can Inhibit Pregnancy Risk as long as Full Breastfeeding Ongoing	92	27.2
6. Facility Promoting the Use of LAM	326	96.4
7. Can LAM be Used for Breastfeeding and FP	279	82.5
8. Women Can Use LAM When Not Fully Breastfeeding	36	10.7
9. Woman Can Use LAM When Child is Older than Six Months	68	20.1
10. Woman Can Use LAM Once Her Menses Resumes	71	21.0
11. Woman is Advised to Use LAM If She Is Malnourished	210	62.1
12. Woman is Advised to Use LAM If She Is Using Prescription Medicines	100	29.6
13. Woman Can Use LAM If She Has AIDS	104	30.8
14. Woman Can Use LAM If She Has TB	143	42.3

**Table 9: Characteristics of Provider Provision of Natural Family Planning Methods, and NFP Services, (N=338)**

NFP Services	Number	Percentage
1. Percentage Providing NFP in Facilities		
Methods Provided:		
Cycle Calculation	200	59.2
Cervical Mucus Assessment	130	40.9
Sympto-Thermal	49	14.5
BBT	70	20.7
LAM	40	11.8
2. When Woman Can Engage in Sexual Activity Without Risk of Becoming Pregnant		
4th Day of Temperature Increase to End Cycle	189	55.9
3. Changes in Texture and Color of Mucus to Indicate Fertility		
When Mucus is Sticky and Pasty	77	22.8
4. Differences in Mucus Observation and Menstrual Cycle Between Contraceptive and Non-Contraceptives Users		
Yes	156	46.2
5. Advice Before Using NFP		
Observe Menstruation	76	22.5
Use of Back-Up Method	10	3.0

**Table 10: Percentage Distribution of Postpartum FP Providers by Presence of Restrictions on FP Service Provision (N=338)**

Restrictions	Number	Percentage
<b>1. With Age Restrictions</b>		
Combined Pills	139	41.1
Progesterone Only Pills	14	4.1
IUD	19	5.6
DMPA	38	11.2
NFP	1	.2
Female Sterilization	39	11.5
Male Sterilization	4	1.1
<b>2. Number of Children</b>		
Combined Pills	24	7.1
Progesterone Only Pills	5	1.5
IUD	29	8.6
DMPA	37	10.9
Female Sterilization	47	13.9
Male Sterilization	8	2.4
<b>3. Marital Status</b>		
Combined Pills	81	2.4
POP	6	1.8
IUD	104	30.8
DMPA	102	30.2
NFP	23	6.8
LAM	18	5.3
Female Sterilization	62	18.3
Male Sterilization	15	4.4
<b>4. Spousal Consent</b>		
Combined Pills	102	30.2
POP	12	3.6
IUD	165	48.8
DMPA	145	42.9
NFP	23	6.8
LAM	17	5.0
Female Sterilization	134	39.6
Male Sterilization	22	6.5

**Table 11: Percentage Distribution of Postpartum FP Service Providers by Information Given to Clients (N=338)**

Information	Pills	IUD	DMPA	Female Sterilization	Male Sterilization	Condom	LAM	NFP
Method Mentioned	96.4	95.9	94.1	62.7	32.2	93.2	76.9	66.0
Advantages/ Disadvantages	92.6	88.5	87.9	55.0	29.0	83.1	68.9	56.5
Compliance of Use	69.8	64.8	63.9	38.5	25.4	61.5	44.4	37.9
Contra-indications	79.9	76.3	73.1	46.7	26.6	64.2	46.2	40.2
Side Effects	82.0	77.5	75.1	44.1	25.4	66.9	41.7	36.1
Treatment of Side Effects	55.3	52.1	49.4	26.9	15.4	41.1	27.2	20.4

**Table 12 : Percentage Distribution of Postpartum FP Services Providers by Procedures Routinely Conducted for Postpartum Clients (N=388)**

Procedures	Pills	IUD	DMPA	Condom	LAM	NFP
Medical History	97.6	88.2	92.6	37.3	34.9	29.6
Blood Pressure	97.9	87.0	92.9	31.7	23.4	19.2
Weight Check	95.9	85.5	91.1	30.8	21.6	17.8
Physical Examination	96.7	86.7	91.4	18.6	15.7	9.2
Pelvic Examination	45.6	80.8	41.1	8.0	5.5	3.3
Blood Test Hemoglobin	4.7	5.9	4.7	.9	1.5	.9
STD Lab Screening	3.3	3.8	2.7	1.2	.6	.6
2. Reason for Test Discussed				99.1		
3. Examination Result Used to Chose Method				98.8		
4. Procedures or Checklists Utilized for:						
Method Options				95.6		
Proper Use of Methods				94.4		
Advantages of Methods				95.0		
Contraindications				95.6		
Side Effects				95.0		
Where to Get Help				93.5		
Possibility of Switching				89.6		
Where to Get Method				87.9		

**Table 13: Percentage Distribution of Postpartum Service Providers by Constellation of Services Offered (N=338)**

Constellation of Services	Percentage
<b>1. Child Health</b>	
Immunization	91.1
Growth Monitoring	90.2
Instruction on Breastfeeding	77.8
ORT	72.2
ARI Therapy	74.3
Child Nutrition Counseling	81.7
Vitamin A Supplementation	84.6
<b>2. Maternal Health</b>	
Delivery Follow-Up	79.0
Tetanus Toxoid Immunization	84.9
Maternal Nutrition Counseling	77.8
Iron-Deficiency Supplementation	76.6
<b>3. Reproductive Health</b>	
Diagnosis of RTI/STD	37.6
Treatment of STD	34.3
Screening of FP Contraindications	74.0
Treatment of FP Side Effects	65.4

**Table 14: Percentage Distribution of Postpartum Family Planning Service Providers by Emphasis on Quality of Services (N=338)**

Emphasis on Quality Services	Percentage with Considerable Emphasis
Providing Choice of Contraceptive Methods	82.8
Side Effects	85.2
Advice Selection of Methods	80.2
Switching of Methods	71.6
Effectiveness of Methods	81.7
Mode of Action	79.0
Source of Methods	66.9
Cleanliness at Clinics	73.1
Reduction of Waiting Time	63.6
Treatment With Respect	89.6
Privacy	84.0

## The Client Survey

The Client Survey covered 3,452 postpartum women who accepted a family planning method between January 1994 to December, 1997. Postpartum family planning acceptance in this study is defined as contraceptive adoption within six months of delivery. The distribution of clients by family planning acceptance date is as follows:

Year	Number	Percentage
1994	136	3.9
1995	482	14.0
1996	1072	31.1
1997	1762	51.0
Total	3452	100.0

Between January 1996 and July, 1997 postpartum family planning acceptors constituted only 6.7 percent of all mothers obtaining postpartum care at the clinics covered in this study.

Most postpartum acceptors were drawn from the most recent years - 1996 and 1997. Nearly half (43.8 percent) were from Luzon, a third (30.7 percent) from Visayas and a fourth (25.5 percent) from Mindanao (see Table 16). The mean age at acceptance was 28.2 years. Most women delivered at home (63.9 percent) and a more than a fourth (27.0 percent) gave birth in hospitals. Those who delivered at home were either attended by traditional birth attendants or midwives. Hospital and private clinic deliveries were attended by physicians. Clients had an average of 3 live births when they adopted family planning. About half of the respondents had 1 to 2 children and only 16.8 percent had 5 or more children.

Most clients obtained postpartum family planning services from public sector outlets, primarily Rural Health Units (RHUs), Municipal Health Offices (MHOs), government hospitals and city health offices (78.7 percent). Midwives (71.0 percent) were the front line providers. The major promoters of postpartum family planning adoption were the midwife, barangay health workers, and community based distributors. The majority of postpartum FP services are provided in government service delivery points (see Table 15).

### Timing of Postpartum Family Planning Adoption

Table 16 provides information on the timing and choice of method by clients during the postpartum period. Many postpartum family planning clients report adopting contraception within the first month after delivery (42.0 percent). The mean number of months from delivery to family planning adoption was 2.4 months. The IUD (35.3 percent), DMPA (30.6 percent), and pills (24.4 percent) were the main postpartum methods reported by clients. There were also 229 LAM acceptors, which constitutes 6.6 percent of all postpartum clients.

The Client Survey did not record information from postpartum sterilization users owing to the low level of provision noted in the Provider Survey. In the seven hospitals included in this study that provided sterilization services (from a total of ten hospitals surveyed), only 8.4 percent of all postpartum family planning clients were sterilization acceptors. In order to provide additional detail

on the characteristics of postpartum sterilization clients, recent information on deliveries and subsequent family planning acceptance (including sterilization) from one large maternity hospital (the Philippine General Hospital in Quezon City) is presented in Appendix 3.

Within the first month following delivery, mothers report that they are most likely to accept IUDs (47.7 percent), followed by DMPA (24.1 percent), LAM (13.8 percent) and pills (12.0 percent). As noted previously, DMPA and pill use within one month of delivery is not advisable for breastfeeding mothers. As can be seen in Table 17, pills and DMPA are also commonly adopted between two and six months following delivery. IUD use is still significant in these later periods, but at six months following delivery only 18.3 percent of mothers report adopting IUDs compared to 42.1 percent for pills. These results suggest that pills (principally combination estrogen-progesterone brands) and DMPA (a progesterone-only hormonal contraceptive) may sometimes be initiated too soon following delivery and DMPA may be somewhat underutilized by mothers after six weeks postpartum.

Tables 17a and 17b show the initial timing of postpartum use by method for breastfeeding and never-breastfeeding mothers. Mothers who breast feed are far less likely to use pills than mothers who never breast feed, but the percentage of breastfeeding mothers adopting pills at 2-5 months postpartum is still substantial. Among all postpartum pill users who breastfed their children, 86.4 percent began using pills less than six months following delivery. Mothers were not asked to identify the pill brands they were using in the Client Survey, but social marketing data indicates that the overwhelming majority of pills being used by Philippine women are combination pills (estrogen-progesterone based), with Logentrol being the most common brand.

Method-specific FP initiation patterns by region, age of mother, and source of supply are presented in Table 17c. Among the results to be noted are that pill use begins somewhat later in Luzon than in Visayas and Mindanao. IUD and DMPA use is greater in Visayas than other regions within the first month following delivery. In general, the time at which family planning methods are adopted in the six month postpartum period does not vary substantially by age of mother. Also, pill use tends to begin somewhat sooner in private sector clinics, but other methods show little timing variation in relation to source of supply.

### **Characteristics of Lactation and Amenorrhea**

Results from the Client Survey on breastfeeding and menses resumption (shown in Tables 18-19) indicate that 12.7 percent of all respondents did not breast feed. Among those who did, 54.6 percent breastfed for up to 6 months and 9.8 percent claimed to have lactated for more than a year. The average duration of breastfeeding was 6.2 months. Full breastfeeding extended to 4.2 months and partial breastfeeding was 2.0 months. The average resumption of menses was 4.4 months following delivery, with 61.6 percent of mothers reporting the inception of bleeding within the first 3 months postpartum. Resumption of menses beyond one year was reported by 5.6 percent of the clients. The average interval between delivery and resumption of sexual relations was 2.4 months.

As can also be seen in Table 18, there is a clear association between lactation and amenorrhea. For mothers who did not breast feed, postpartum infecundity only lasted for 1-2 months. For those who breastfed for only one month, the average amenorrhea period is not much different from women who did not breast feed. With progression of lactation, menses resumed later. Pill clients experienced resumption of menses sooner than other acceptors, largely since women who do not breast feed tend to use pills rather than other methods. The average resumption of menses

occurs much later for LAM users since these users tend to breast feed longer than mothers using other family planning methods.

Mean breastfeeding durations, intervals between delivery and menses, and intervals between delivery and resumption of sexual activity by time of FP adoption are shown in Table 19. For most methods, women who breast feed longer tend to delay the adoption of contraception. This pattern is not unexceptional since many women wait to use family planning until after they have stopped breastfeeding (or are only partially breastfeeding). In general, women who start using contraception sooner (owing in part to shorter breastfeeding durations) experience resumption of menses earlier than women who adopt later. Somewhat surprisingly, there is no clear association between the resumption of sexual activity and the initiation of contraception during the postpartum period.

These results clearly point to the importance of strengthening postpartum family planning care for Philippine women. With many mothers resuming sexual relations around 2.5 months following delivery, and with the mean interval of menses resumption at 4.4 months, many postpartum women will be at risk of unwanted pregnancies if some form of contraception is not practiced within 2-3 months following delivery (and even sooner for mothers who do not breast feed).

### **Postpartum Family Planning Use Effectiveness**

Of the initial 3,452 postpartum family planning acceptors interviewed in the Client Survey, 88.7 percent reported currently using a method while only 70.6 percent of all current users were still using the method initially accepted following delivery. Therefore, 18.1 percent of mothers switched methods and 11.3 percent stopped using (see Table 20). In terms of individual methods, Table 21 shows that initial users were most likely to switch from LAM (35.4 percent), DMPA (25.4 percent), and condoms (23.2 percent). Mothers discontinuing the use of family planning (dropouts) were most likely to have been initial users of LAM (24.9 percent), condoms (23.2 percent), and DMPA (13.1 percent). High levels of switching from LAM are not unexpected since mothers are advised to change methods once they are no longer fully (or nearly fully) breastfeeding, experience return menses, or are more than six months from their time of delivery. However, the high percentage of LAM users who drop out rather than switch methods is a cause for concern.

Table 22 shows the patterns of method switching by comparing the distribution of methods initially and currently used. Many women who initially accepted IUDs, DMPA, and LAM switched to pills, condoms, NFP, and withdrawal; in other words, often from more effective to less effective methods. Among mothers who discontinued the use of pills, 45.6 percent switched to the use of condoms, NFP and withdrawal. For initial IUD acceptors who changed methods, the shift to the same methods was 25.8 percent and for DMPA, 30.2 percent. The increase in NFP and withdrawal among postpartum acceptors who switched methods is especially striking. Among mothers reporting an initial method of use, 0.7 percent used NFP and none reported using withdrawal. However, among mothers who switched methods, 8.5 percent selected NFP and 15.2 percent resorted to withdrawal (see Table 20). This transition to less effective contraception among postpartum family planning clients should probably receive priority attention from FP program managers and service providers.

Among initial postpartum acceptors, there were 131 women who eventually became pregnant (which represents 3.8 percent of total initial acceptors). The mean interval between postpartum family planning acceptance and subsequent pregnancy is 14 months. Of these, 31 (24 percent of all those who became pregnant) occurred while they were using a family planning

method. Of the 31 accidental pregnancies (method failure), 36 percent were LAM users. However, given the small number of cases underlying this estimate, it is not possible to draw definitive conclusions about the relative use effectiveness of LAM compared to other methods.

The major reason cited for the discontinuation of the initial method was the occurrence of side effects (see Table 20). Pill users said that headache, nausea/dizziness, and weight change were their most common complaints; for the IUD, the more usual complaints were abdominal cramps, bleeding, and backache; and for DMPA, amenorrhea, spotting, and weight change. About 15 percent felt that the method they accepted, particularly LAM and NFP, was not effective or convenient to use. These findings call for more information about family planning methods, particularly their side effects and management, in order to reduce client dissatisfaction and discontinuation.

### **The Clinic Situation: Information Given to Clients**

According to clients, only 54.7 percent of their providers mentioned a wide range of methods (see Table 23). The methods that were most often mentioned were pills, IUDs and injectables. Likewise, only slightly over half (59.4 percent) of the clients were informed that they can switch methods. The main methods recommended for switching were pills, IUD and injectables (however, as noted above, pills and less effective methods were most often adopted by mothers changing methods). Nearly two-thirds (64.5) of all mothers in the Client Survey reported that the provider usually emphasized one method. The most common methods cited were IUD (36.6 percent); injectables (29.7 percent) and pills (23.0 percent).

Evidence that the service delivery point is often accessible is suggested by the fact that 47.4 percent of the clients surveyed used a tricycle or walked (34.9 percent) in order to travel to their service delivery point. As can be seen in Table 24, average travel time to the SDP - most often a Rural Health Unit - was 10-14 minutes. About a third (33.0 percent) of all postpartum clients mentioned that they waited before receiving attention. The average waiting time was about 30 minutes, although 26 percent waited more than half an hour before receiving attention.

Most of the wives (83.1 percent) reported that a health talk was given in the service delivery point where they obtained services (see Table 24). The health talk was usually given by the midwife. Mothers report that most service providers offered family planning information as part of their postpartum service (76.8 percent). The main topics discussed in the provider health talk were the effectiveness of methods and potential side effects (63.3 percent).

Information on family planning was given to 76.8 percent of all clients. However, very few (34.1 percent) were informed about when in the menstrual cycle they are at greatest risk of becoming pregnant. Of those who received this instruction, 43.9 percent knew the time at which they were most likely to become pregnant during their menstrual cycles. The benefits of child spacing were included in the health talk, which may partially account for the fact that the 61.8 percent of all postpartum family planning acceptors wanted to wait four years before having another child.

### **Knowledge of Postpartum Family Planning Methods**

Findings on knowledge of individual methods (presented in Table 25) reveal gaps in information given to clients in terms of advantages and disadvantages of methods, modality of use, contraindications, side effects, management, and sources of supply. The situation is particularly notable for sterilization, NFP, and LAM users, where information pertaining to the method was given to fewer than 10 percent of all clients. However, most mothers report that providers discussed

such topics as breastfeeding knowledge, previous use of contraception, attitudes toward family planning, method preference, and follow-up procedures when adopting a method of family planning.

The Client Survey also evaluated knowledge concerning the modality of use. In general, most postpartum acceptors had good understanding of proper compliance in the use of modern methods (pills, IUDs, and DMPA). For example, 94.2 percent of all pill users knew when to begin using pills (within 1-5 days of menstruation), and that pills should be taken everyday (98.3 percent). However, there was some uncertainty about what to do if pills were not taken on schedule. Most IUD users reported that they were asked to return to their SDP for follow-up care (80.0 percent) within 1-2 months. Mothers also noted that IUDs could be worn for an average of 6.6 years. Finally, 98.6 percent of DMPA acceptors knew that they should obtain an injection every three months.

Knowledge of LAM was considerably less impressive. Table 26 presents information on LAM adoption and knowledge. Client misconceptions regarding LAM are borne out by the fact that 29.0 percent of LAM users believe that the method can be used if they are not fully breastfeeding; 58.5 percent believe that LAM can be used when their infant is beyond 6 months of age; and 47.9 percent maintain that LAM can be used when menses has resumed. LAM users also think that breastfeeding can inhibit pregnancy without using any method of contraception for an average of 11 months (return menses for LAM users was 7.6 months in the Client Survey).

Equally troubling is the fact that 82.4 percent of LAM users believe that LAM can protect against unwanted pregnancies for six months or longer even though 35.6 percent experience return menses in less than six months following delivery. Slightly more than one-quarter of LAM users (26.4 percent) have experienced return menses at less than six months and maintain that LAM offers effective contraceptive protection for six months or longer. Clearly, there would appear to be considerable potential for unwanted pregnancies to occur given the current level of LAM knowledge among mothers.

### **Policies and Restrictions Regarding FP Services Provision**

Restrictions in the use of family planning services were reported by 34.7 percent of all clients. However, when assessed for individual methods (see Table 27), few clients reported the existence of provider restrictions. The only exception was in the case of spousal consent, where clients noted that 7.5 percent of providers asked for husband approval for an IUD insertion and 4.4 percent for DMPA adoption. As noted previously, providers reported far higher levels of socio-cultural restrictions on the adoption of contraception in the postpartum period. These inconsistent results may simply reflect the fact that providers often do not inform mothers about decisions that are being made on their behalf. If services are to be truly client-based, mothers need to know whether and in what manner providers are passing judgement on eligibility criteria for adopting contraception.

### **Constellation of Services**

Compared to provider responses, clients generally report that fewer medical procedures were performed before accepting a family planning method. As is noted in Table 28, blood pressure and weight checks were conducted for most clients, but other procedures (e.g. physical examination, pelvic examinations, blood analysis for anemia, and STD screening) were undertaken far less often. According to mothers, specific procedures were often not adequately explained or the results used in method selection. Very few mothers mentioned that some family planning methods can protect from STD infection (only 9.7 percent). In addition, only 33.3 percent of all clients reported that they

had been told about the protective abilities of condoms in preventing STD infections. Enhanced provider counseling skills would appear to be needed in these areas.

Other child, maternal, and reproductive health services offered as part of postpartum care are presented in Table 29. As was true in the case of provider responses, mothers report greater attention given to child and maternal health care than reproductive health services. However, in general, mothers report lower availability of specific services than was commonly mentioned by providers. Among the interventions most commonly supplied were child immunizations (72.2 percent), tetanus toxoid immunization (68.2 percent), iron deficiency supplementation (66.3 percent), child growth monitoring (65.4 percent), and vitamin A supplementation (62.7 percent). Except in the case of screening for family planning contraindications (60.3 percent), other reproductive health services were not widely available. For example, only 8.1 percent of postpartum mothers report that RTI/STD diagnosis and treatment facilities were available at their service point.

### **Emphasis on Quality**

The overwhelming majority of mothers interviewed in the Client Survey said they were satisfied with the quality of services obtained from their SDP (96.1 percent). This high degree of satisfaction was due primarily to the perceived technical competence of the SDP (cited by 56.0 percent of mothers) and good interpersonal relations with the care giver (32.4 percent). Nearly all clients (96.3 percent) said they would recommend their SDP to others.

Despite these high levels of overall satisfaction, clients generally said less emphasis was given to high quality standards than commonly reported by providers (see Table 30). A small majority of mothers said considerable emphasis was given to being treated with respect (54.1 percent) at their SDP. However, fewer than 50 percent of clients said that considerable emphasis was given to other elements of service quality (e.g., cleanliness, 43.2 percent; privacy in provision of services, 42.7 percent; reduction in waiting time, 41.1 percent; choice of methods, 34.8 percent; assistance in method selection, 30 percent; and information on side effects, 27.3 percent). These findings suggest that there is still much to be done in upgrading the quality of care in the provision of postpartum family planning services in the Philippines.

**Table 15: Percentage Distribution of Postpartum Family Planning Clients by Selected Background Characteristics**

Selected Characteristics	Number	Percentage
<b>1. Geographical Area</b> (N=3452)		
Luzon	1512	43.8
Visayas	1059	30.7
Mindanao	881	25.5
<b>2. Age of Respondent</b> (N=3189)		
15 - 19	125	3.9
20 - 24	807	25.3
25 - 29	1103	34.6
30 - 34	666	20.9
35 - 39	356	11.2
40 - 44	123	3.9
45 - 49	9	0.3
Mean Age = 28.2 years		
<b>3. Place of Delivery</b> (N=3,446)		
RHU	179	5.2
Hospital	929	27.0
Home	2202	63.9
Private Clinic	136	3.9
<b>4. Attendant at Delivery</b> (N=3380)		
MD	1027	30.4
Nurse	54	1.6
Midwife	1217	36.0
TBA	1082	32.0
<b>5. Average Number of Live births</b> <b>When Accepted FP</b> (N=3442)		
1 - 2	1744	50.8
3 - 4	1111	32.4
5 - 6	414	12.0
7 +	164	4.8
Mean Number of Live Births - 3.2		
<b>6. Provider for First Postpartum</b> <b>Method</b> (N=3412)		
MD	426	12.5
Nurse	419	12.3
Midwife	2424	71.0
CBD/BHW	143	4.2
<b>4. Source of FP Services</b> (N=3452)		
Public	2717	78.7
Private/NGO	735	21.3

**Table 16: Characteristics of Family Planning Acceptance Among Postpartum Clients**

Selected Characteristics	Number	Percentage
<b>1. Months Postpartum When Family Planning Was Adopted</b>		
1	1451	42.0
2	596	17.3
3	443	12.8
4	384	11.1
5	342	9.9
6	235	6.8
Mean Number of Months= 2.4		
<b>2. First Method Accepted by Mother Following Delivery</b>		
Pills	842	24.4
IUD	1217	35.3
DMPA	1054	30.6
Condom	82	2.4
NFP	24	.7
LAM	229	6.6
<b>Reasons for FP Acceptance</b>		
Limiting Spacing		43.5
		56.5

**Table 17: Percentage of Postpartum Clients Accepting Temporary and Long-Term Family Planning Methods at Different Periods Following Delivery: All Mothers**

Method	Within One Month (N=1451)	Two-Three Months (N=1037)	Four-Five Months (N=726)	Six Months (N=235)
Pills	12.0	29.6	36.1	42.1
IUD	47.7	26.5	28.6	18.3
DMPA	24.1	37.9	32.0	34.0
Condom	2.1	2.5	2.1	4.3
NFP	0.3	1.1	0.8	0.9
LAM	13.8	2.4	0.4	0.4
<b>Total</b>	<b>100.0</b>	<b>100.0</b>	<b>100.0</b>	<b>100.0</b>

**Table 17a: Percentage of Postpartum Clients Accepting Temporary and Long-Term Family Planning Methods at Different Periods Following Delivery: Breastfeeding Mothers**

Method	Within One Month (N=1280)	Two-Three Months (N=875)	Four-Five Months (N=641)	Six Months (N=215)
Pills	8.0	25.7	33.9	40.0
IUD	49.9	27.8	30.1	19.5
DMPA	24.5	40.0	32.8	34.9
Condom	1.6	2.5	1.9	4.2
NFP	0.4	1.1	0.9	0.9
LAM	15.6	2.9	0.5	0.5
<b>Total</b>	100.0	100.0	100.0	100.0

**Table 17b: Percentage of Postpartum Clients Accepting Temporary and Long-Term Family Planning Methods at Different Periods Following Delivery: Mothers Never-Breastfeeding**

Method	Within One Month (N=169)	Two-Three Months (N=160)	Four-Five Months (N=82)	Six Months (N=20)
Pills	42.0	50.6	54.9	65.0
IUD	31.4	20.0	17.1	5.0
DMPA	20.7	26.3	24.4	25.0
Condom	5.9	2.5	3.7	5.0
NFP	-	0.6	-	-
LAM	-	-	-	-
<b>Total</b>	100.0	100.0	100.0	100.0

Table 17c: Patterns of Postpartum Family Planning Acceptance for Main Temporary and Long-Term Methods by Age, Region and Source of Supply

Method		Within One Month	Two-Three Months	Four-Five Months	Six Months	Number
Pills	Luzon	16.8	32.5	36.0	14.7	375
	Visayas	23.6	43.7	24.7	8.0	263
	Mindanao	24.0	34.3	30.4	11.3	204
IUD	Luzon	56.0	24.2	16.9	3.0	504
	Visayas	63.4	16.7	16.1	3.8	372
	Mindanao	51.0	26.7	18.2	4.1	341
DMPA	Luzon	31.6	37.5	23.4	7.5	576
	Visayas	39.0	35.0	19.1	6.9	277
	Mindanao	29.4	39.8	21.9	9.0	201
LAM	Luzon	90.4	**	**	**	52
	Visayas	73.3	22.2	**	**	90
	Mindanao	100.0	**	**	**	87
Pills	15-24	20.4	41.2	28.2	10.2	245
	25-34	20.7	34.8	31.9	12.6	445
	35-49	21.3	36.0	34.8	7.9	89
IUD	15-24	56.3	25.8	14.9	3.0	302
	25-34	58.3	20.5	17.8	3.3	628
	35-49	55.6	27.5	13.5	3.5	171
DMPA	15-24	33.4	38.6	21.1	6.8	308
	25-34	34.2	36.4	23.5	5.9	541
	35-49	31.1	37.1	18.6	13.2	167
LAM	15-24	86.4	11.9	**	**	59
	25-34	83.2	15.8	**	**	101
	35-49	90.3	**	**	**	31
Pills	Public	18.0	35.2	34.2	12.5	622
	Private	28.2	40.0	22.3	9.5	220
IUD	Public	57.0	22.7	16.8	3.5	956
	Private	56.3	22.2	17.6	3.8	261
DMPA	Public	32.3	37.5	22.4	7.8	905
	Private	38.3	36.2	19.5	6.0	149
LAM	Public	89.9	8.7	**	**	149
	Private	82.5	15.0	**	**	80

\*\* - Fewer than 10 Cases

**Table 18: Percentage Distribution of Postpartum Women by Information Related to Breastfeeding, Amenorrhea and Resumption of Sexual Activity (N=3,452)**

Breastfeeding, Menses, and Sexual Activity		Percentage				
1. Duration of Lactation						
Did Not Breast feed		12.7				
1 - 3 Months		28.1				
4 - 6 Months		26.5				
7 - 9 Months		15.7				
10 - 12 Months		7.2				
>12 Months		9.8				
Mean = 6.2; Median = 5.0 Mean Full = 4.2; Median Full = 4.0 Mean Partial = 2.0; Median Partial = 1.5						
2. Interval between Delivery and Resumption of Menses						
1 - 3 Months		61.6				
4 - 6 Months		20.9				
7 - 9 Months		6.5				
10 - 12 Months		5.4				
>12 Months		5.6				
Mean = 4.4 Months; Median = 4.0 Months						
3. Interval Between Delivery and Sexual Relations						
1 - 3 Months		81.0				
4 - 6 Months		14.3				
7 - 9 Months		1.3				
>10 Months		.7				
Mean = 2.4 Months; Median = 2.0 Months						
<b>Average Duration of Amenorrhea by Duration of Breastfeeding and Method Used</b>						
Lactation Duration	Pills	IUD	DMPA	Condoms	NFP	LAM
Did Not Breast feed	2.0	2.2	2.5	1.6	1.0	-
≤ 1 month	1.8	2.3	2.2	3.8	2.0	1.0
2 - 3 mos.	2.8	2.7	3.0	3.3	-	3.7
4 - 5 mos.	3.7	4.1	3.6	1.5	3.3	5.9
6+ mos.	3.9	4.1	4.0	3.8	3.9	8.3

**Table 19: Mean Duration of Breastfeeding, Interval between Delivery and Menses, and Interval between Delivery and Resumption of Sexual Activity by Time of First Postpartum Use for Main Temporary and Long-term Methods**

Time of FP Adoption Postpartum	Mean Duration of Breastfeeding	Mean Interval Between Delivery and Menses	Mean Interval between Delivery and Resumption of Sexual Activity
All Methods	6.3	3.5	2.4
<= 1 Month	6.7	3.8	2.2
2-3 Months	5.5	3.0	2.5
4-5 Months	6.1	3.7	2.6
6 Months	7.4	4.3	2.6
Pills	4.7	2.9	2.4
<= 1 Month	3.5	1.7	1.9
2-3 Months	3.9	2.4	2.3
4-5 Months	5.5	3.7	2.7
6 Months	5.8	4.0	2.5
IUD	6.9	3.7	2.4
<= 1 Month	6.9	3.9	2.3
2-3 Months	6.4	3.0	2.7
4-5 Months	7.0	3.6	2.4
6 Months	9.1	4.0	2.5
DMPA	6.3	3.4	2.4
<= 1 Month	6.2	3.0	2.2
2-3 Months	6.0	3.2	2.5
4-5 Months	6.0	3.6	2.5
6 Months	8.7	4.6	2.7
LAM	8.5	7.6	2.5
<= 1 Month	8.6	7.9	2.4
2-3 Months	6.8	5.2	3.0
4-5 Months	**	**	**
6 Months	**	**	**

\*\* - Fewer than 10 Cases

**Table 20: Percentage Distribution of Postpartum Clients by Initial Choice of Method and Characteristics of Method Switching**

Client Characteristics		Percentage	
1. Percentage Currently Using a Method		88.7	
2. Percentage Still Using Method Previously Accepted		70.6	
3. Percentage Distribution of Initial and Current Method for Switchers		Initial Postpartum Method	Current Method For Clients Who Discontinue Initial Method
Pills		24.4	44.7
IUD		35.3	10.6
Injectable		30.5	13.3
Condom		2.4	6.4
NFP		0.8	8.5
LAM		6.6	0.2
Female Sterilization		-	1.1
Withdrawal		-	15.2
4. Provider of Current Method Used		Initial Method	Current Method
MD		8.9	12.4
Nurse		6.1	12.4
Midwife		67.6	70.5
CBD/BHWs		17.4	4.8
5. Reason for Use Discontinuation of Initial Used Method			
Side Effects		61.4	
Feeling Method Was Not Effective		14.5	
Inconvenience		9.5	
6. Percent Mentioning Side Effects As Reason For Discontinuation of First Method			
Pills		66.1	
IUD		68.3	
DMPA		82.3	
Condoms		8.1	
LAM		1.5	
<b>Main Side Effects Reported by Method</b>			
<b>Pills</b>	<b>IUD</b>	<b>DMPA</b>	<b>LAM</b>
Headache Nausea Weight Change	Abdominal Cramps Bleeding Backache	Amenorrhea Spotting Headache Weight Change	Nausea/dizziness Amenorrhea Spotting

**Table 21: Percentage Distribution of Acceptors by Family Planning Use Status at the Time of Interview**

Use Status		Contraceptive Use-Status		
Initial Method	Continuing Users	Switchers	Dropouts*	Total
Pills	72.4	14.8	12.8	100.0
IUD	85.0	9.7	5.3	100.0
DMPA	61.5	25.4	13.1	100.0
Condom	53.6	23.2	23.2	100.0
NFP	89.2	12.5	8.3	100.0
LAM	39.7	35.4	24.9	100.0

\* Non-user at the Time of the Survey

**Table 22: Patterns of Method Switching Among Initial Postpartum Family Planning Acceptors<sup>1</sup>**

Initial Method	Current Method						Total	Initial Acceptors Switching Methods
	Pills	IUD	DMPA	Condoms	NFP	Withdrawal		
Pills	8.0**	18.4	28.0	13.6	15.2	16.8	100.0	125
IUD	47.4	-	26.7	8.6	6.9	10.3	100.0	116
DMPA	61.5	8.3	-	2.6	7.2	20.4	100.0	265
Condom	50.0	20.0	-	-	20.0	5.00	100.0	20
NFP	66.7	-	-	33.3	-	-	100.0	3
LAM	46.9	18.5	17.3	4.9	3.7	8.6	100.0	81
<b>Current Users who Switched Methods</b>	278	64	80	40	53	95		610

1. Only 7 mothers switched to sterilization and 1 mother switched to LAM. Owing to the small number of cases, estimates for these methods are not shown in Table 24.

\*\* - Other Pill Brands

**Table 23: Characteristics of Provider Support for Postpartum Family Planning Services According to Clients (N=3,452)**

Clients	Percentage
<b>1. Methods Most Commonly Mentioned by Providers According to Clients</b>  Pills IUD DMPA Condom NFP LAM Female Sterilization Male Sterilization	  56.6 49.5 48.8 30.2 10.4 .7 8.3 .7
<b>2. Percentage of Providers who Mentioned Other Methods</b>	54.7
<b>3.. Percentage Who Mentioned Client Can Switch Methods</b>	59.4
<b>4. Methods Recommended for Switching</b>  Pills IUD DMPA Condom NFP LAM Female Sterilization	  41.3 35.2 35.2 12.6 4.4 .1 3.5
<b>5. Percentage Emphasizing One Method</b>  Method Emphasized:  Pills IUD Injectable Condom NFP LAM Female Sterilization Male Sterilization	  64.5  23.0 36.6 29.7 3.7 2.2 2.3 2.5 .1

**Table 24: Percentage Distribution of Postpartum Clients by Circumstances in which Family Planning was Adopted (N=3,452)**

Circumstances	Percentage
1. Percentage Who Waited Before Receiving Attention	33.0
2. Average Number of Minutes Waited	30.0
3. Modal Mode of Transportation	
Tricycle	47.4
Walking	34.9
Average Travel Time = 10-14 Minutes	
4. Percentage Receiving Health Talk	83.1
5. Person Who Gave Health Talk	
Midwife	70.3
Nurse	14.6
6. Percentage Given Advice on FP as part of Postpartum Service	76.8
7. Main Item Discussed During Health Talk	
Side Effects of Contraceptives/Effectiveness	63.3
8. Percentage Informed When During the Menstrual Cycle Client is at Risk of Getting Pregnant	34.1
9. Percentage With Knowledge of Pregnancy Risk During the Menstrual Cycle	43.9
10. Percentage Mentioning Benefits of Child Spacing	75.6
11. When Additional Child is Wanted	
After 4 years	61.8

**Table 25: Percentage Distribution of Clients by Methods Mentioned and Discussed by Provider**

<b>Methods Mentioned/ Discussed</b>	<b>Pills</b>	<b>IUD</b>	<b>DMPA</b>	<b>Sterilization</b>	<b>Condom</b>	<b>NFP</b>	<b>LAM</b>
Method Mentioned	59.6	61.6	55.5	4.9	19.8	7.7	4.9
Advantages and Disadvantages of Method	30.1	35.1	31.4	1.5	6.5	2.1	3.4
Proper Compliance in Method Used	31.9	26.6	29.9	.7	5.4	2.6	2.5
Contraindications	22.1	20.7	15.7	.6	1.6	.4	.7
Common Side Effects	31.8	34.0	32.8	.4	2.6	.5	.6
Treatment of Side Effects	19.5	22.6	19.2	.3	2.0	.3	.5
Where to Get Help for Problems	29.0	32.5	29.5	.4	3.1	.7	1.1
Source of Supply	20.9	13.7	16.2	.5	-	.2	.4

**Table 26: Characteristics of LAM Adoption and Knowledge among LAM Users**

Characteristics	Percentage
LAM Users	
1. Reason for Choice of LAM	
Convenience	17.4
Maternal Health	3.3
No Side Effects	8.3
Good for Infant Health	36.4
Cost	31.0
Others	3.7
2. Person Recommending LAM	
None	26.8
MD	10.4
Nurse	4.9
Midwife	32.2
TBA	4.4
BHW	9.3
CBD	12.0
3. Percentage Believing That LAM Can Be Used if Woman is not Fully Breastfeeding	29.0
4. Percentage Believing That LAM Can be Used When She is Breastfeeding at Night and Providing Supplementation	52.5
5. Percentage Believing That LAM Can be Used When Child is More Than 6 Months Old	58.5
6. Percentage Believing That LAM Can Be Used When Woman's Menses Have Resumed	47.9
7. Percentage Believing that HIV/AIDS can be Transmitted Through Breast Milk	83.0
8. Percentage of LAM Users Who Believe Pregnancy Protection Provided for Six Months or Longer	82.4
9. Percentage of LAM Users with Return Menses in Less than Six Months Following Delivery	35.6
9. Percentage of LAM Users with Return Menses in Less than Six Months Who Believe Pregnancy Protection Provided for Six Months or Longer	26.4

**Table 27: Percentage of Respondents Who Encountered Provider Restrictions in Accepting a Family Planning Method**

Method	Age	No. of Children	Marital Status	Consent of Spouse
<b>1. Restrictions by Method</b>				
Pills	3.4	.7	1.1	2.5
Combined Pill	1.0	.5	1.3	1.6
POP	.3	.4	.1	.2
IUD	.7	.8	3.7	7.5
DMPA	.8	.7	2.2	4.4
NFP	.3	.4	.1	.2
Diaphragm	.3	.4	.3	.1
LAM	.3	.4	.3	.2
Female Sterilization	.3	.6	.5	.5
Male Sterilization	.3	.5	.3	.2
Others	.3	.5	.6	1.2
<b>2. Percentage Informed of Restrictions Regarding FP Use = 34.7</b>				

**Table 28: Percentage Distribution of Respondents Who Underwent Medical Procedures Before Being Provided Family Planning Methods**

Medical Procedures	Procedure Undergone	Procedure Explained	Results Explained	Used in the Method Selection
Medical History	68.0	36.9	33.8	23.3
Blood Pressure	88.8	48.4	65.3	23.3
Weight Check	82.2	43.9	58.1	20.5
Physical Examination	58.1	31.0	32.5	16.2
Pelvic Examination	29.8	15.2	15.0	13.0
Blood Test	2.9	.3	1.0	.3
STD Lab Screening	.3	.1	.2	.1
Others	1.0	.8	.9	.6
<b>Percentage Informed That Some FP Methods Can Protect From STD</b>		<b>9.7</b>		
<b>Percentage Informed That Specific Methods Can Protect From STD</b>				
Pills		1.6		
IUD		2.2		
DMPA		1.6		
Condom		33.3		
NFP		.8		
Diaphragm		1.0		
LAM		1.0		
Female Sterilization		1.0		
Male Sterilization		1.0		

**Table 29: Percentage Distribution of Clients by Whether Services Provided at Service Delivery Point**

Constellation of Services	Percentage
1. Child Health	
1. Immunization	72.2
2. Growth Monitoring	65.4
3. Instruction on Breastfeeding	60.3
4. ORT	55.3
5. ARI Treatment	52.8
6. Child Nutrition Counseling	57.9
7. Vitamin A Supplementation	62.7
2. Maternal Health	
1. Delivery follow-up	56.7
2. TT Immunization	68.2
3. Maternal Nutrition Counseling	56.1
4. Iron Deficiency Supplementation	66.3
3. Reproductive Health	
1. Diagnosis of RTI/STD	8.1
2. Treatment of RTI/STD	6.3
3. Screening for FP Contraindications	60.3
4. Treatment of FP Side Effects	43.3

**Table 30: Percentage Distribution of Respondents by Considerable Emphasis on Quality**

Emphasis on Quality	Percentage
Providing Choice of Contraceptive Methods	34.8
Informing About Side Effects of Methods	27.3
Help in Selecting Methods	30.1
Informing About Possibility of Switching	27.2
Informing of Effectiveness of Methods	23.4
Informing About Mode of Action	19.3
Referral Appropriate Sources for Unavailable Methods	20.3
Cleanliness at Clinic	43.2
Reduction of Waiting Time	41.1
Treatment with Respect	54.1
Privacy in Provision of Service	42.7

## Summary of Main Findings from the Provider and Client Surveys

### The Provider Survey

Main findings from the Provider Survey are summarized below:

1. Most providers (70.3 percent) maintained that their training on postpartum service delivery was adequate. Less than half of all providers had training on LAM and NFP. The average duration of training was 1 to 2 weeks.
2. Many providers recommend that mothers begin using contraception following the cessation of breastfeeding (45.8 percent). The conclusion of full breastfeeding is seen as the point at which family planning use should begin by 22.7 percent of providers, while the ending of partial breastfeeding is cited by 6.2 percent of providers. Methods commonly provided during the postpartum period are IUD, DMPA, LAM and pills. For termination of pregnancy, female sterilization was often recommended.
3. The high level of pill use within three months and between 4-6 months postpartum is somewhat disconcerting in that the vast majority of pills being used by Philippine women are combination (estrogen-progesterone) pills that are generally not recommended for breastfeeding mothers until six months postpartum. Many providers (20.7 percent) believe that combination pills are safe for breastfeeding women within five months following delivery.
4. Many providers are supplying IUDs within the first week, the first six weeks, and within three months of delivery. It is unclear from the results of this study whether guidelines recommending IUD insertion within 48 hours or after six weeks are being followed.
5. A significant number of providers (21.3 percent) began DMPA within six weeks following delivery. This method should not generally be started until after six weeks postpartum.
6. Many providers believe that progesterone-based hormonal contraceptives (progestin-only pills and DMPA) are not safe for breastfeeding women between three and six months postpartum. These methods are generally recommended for breastfeeding women from as early as six weeks postpartum.
7. A small but not insignificant number of providers (10.7 percent) think that a woman can use LAM even if she is partially breastfeeding. More than a fifth (20.1 percent) reported that LAM can still be used even if the child is older than 6 months and 21.0 percent indicated that a woman can still use LAM once her menses resumes. Clearly, many service providers are still unclear about proper compliance and the mode of action for LAM as a method of pregnancy limitation.
8. Inadequate knowledge of certain reproductive health issues is reflected by the fact that only slightly more than half of all providers (53.0 percent) know that AIDS infected mothers can pass the HIV virus to infants through breast milk and just 27.2 percent believe that pregnancy risk is reduced with full breastfeeding. Slightly less than one-third of all providers (30.8 percent) think that LAM can be prescribed to mothers with AIDS and 42.3 percent indicated that LAM can be used by women with tuberculosis.

9. Only 55.9 percent mentioned that women can engage in sexual activity without the risk of becoming pregnant from the fourth day of temperature increase to the end of the cycle. Just 22.8 percent mentioned that mucus is sticky and pasty if a woman is fertile. Nearly half (46.2 percent) of the respondents reported a difference in mucus observation and menstrual cycle between contraceptive and non-contraceptive users. Only 22.5 percent recommend that NFP users track their menstrual cycles and a mere 3.0 percent suggest the use of back-up methods.
10. For pills, IUDs, and DMPA, providers commonly record medical histories, take blood pressure and weight check measurements, and conduct physical examinations. However, very few LAM and NFP users undergo these screening procedures.
11. Despite the removal of restrictions on contraceptive distribution at the national level, provider biases are still in evidence, especially the requirement for spousal consent before IUD insertion, DMPA injection, and female sterilization. A gender bias is noted in that condom use and vasectomy do not require the wife's consent. It is curious to note that clients tend not to report such high levels of provider restriction when obtaining services. This may be largely due to the fact that they are unaware of the judgements made by providers, supposedly on their behalf.
12. Child health services tend to be given most attention by providers. Maternal and reproductive health services are generally less well represented in the constellation of services offered by providers to postpartum family planning clients.

### **The Client Survey**

Notable findings from the Client Survey are summarized below:

13. According to the 1993 Philippine Safe Motherhood Survey, only one-third (32.2 percent) of all mothers in the Philippines obtain any postpartum care<sup>11</sup>. Results from this study indicate that the percentage of mothers accepting family planning during the six month period following delivery is quite low (only 6.7 percent between January, 1996 and July, 1997 in the clinics covered in this study).
14. The average postpartum acceptor was 28 years of age and has had 3 children. A small majority of clients would rather space than limit their childbearing. Clients usually delivered at home attended by a traditional birth attendant or a government midwife. Clients usually accepted a family planning method about 2 to 3 months after delivery, with the midwife being the main source of supply.
15. The main postpartum methods accepted by clients were IUDs (35.3 percent), DMPA (30.5 percent), and oral pills (24.4 percent). At the time of the survey, 11.3 percent of postpartum mothers had discontinued the use of their initial method and had not switched to another form of contraception. Roughly one-quarter of all LAM users discontinued the use of contraception rather than switching to other methods (the highest dropout rate for any method).

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<sup>11</sup> *Philippines National Safe Motherhood Survey: 1993*. (Manila: NSO and Calverton, Maryland, Macro International, October, 1994).

16. Nearly three-quarters of all postpartum family planning acceptors (70.6 percent) were still using their first method. Method switching was generally from IUDs and DMPA to pills, condoms, NFP, and withdrawal. This transition to less effective contraception among postpartum family planning clients should receive priority attention from FP program managers and service providers.
17. Results suggest that pills (principally combination estrogen-progesterone brands) and DMPA may sometimes be initiated too soon following delivery and DMPA (a progesterone-only hormonal contraceptive) may be somewhat underutilized by mothers after six weeks postpartum.
18. Mothers who breast feed are less likely to use pills than mothers who never breast feed, but the percentage of breastfeeding mothers adopting pills at 2-5 months postpartum is still substantial. Among all postpartum pill users who breast feed their children, 86.4 percent began using pills less than six months following delivery.
19. With many mothers resuming sexual relations around 2.5 months following delivery, and with the mean interval of menses resumption at 4.4 months, many postpartum women will be at risk of unwanted pregnancies if some form of contraception is not practiced within 2-3 months following delivery (and even sooner for mothers who do not breast feed).
20. In general, most postpartum acceptors had good understanding of proper compliance in the use of modern methods (pills, IUDs, and DMPA). However, knowledge of LAM was considerably less impressive. Client misconceptions regarding LAM are borne out by the fact that 29.0 percent of LAM users believe that the method can be used if not fully breastfeeding; 58.5 percent believe that LAM can be used when their infant is beyond 6 months of age; and 47.9 percent maintain that LAM can be used when menses has resumed. Slightly more than one-quarter of LAM users (26.4 percent) have experienced return menses at less than six months and maintain that LAM offers effective contraceptive protection for six months or longer. Clearly, there would appear to be considerable potential for unwanted pregnancies to occur given the current level of LAM knowledge among mothers.
21. The knowledge level of pregnancy risks in relation to the use of specific methods was limited. In addition, very few mothers mentioned that some family planning methods can protect from STD infection (only 9.7 percent). In addition, only 33.3 percent of all clients reported that they had been told about the protective abilities of condoms in preventing STD infections. Enhanced provider counseling skills would appear to be needed in these areas.
22. While provider restrictions as reported by clients were few, medical procedures were not usually followed or explained to clients. Likewise, the results were not clearly reported nor used in selection of a method. Information given to clients was rather minimal, particularly in terms of mode of use. While the primary health care system is supposed to provide a constellation of services, knowledge of their availability is limited. The lack of congruence between provider and client responses on the provision of most service components was noteworthy.

## **Discussion: Reiteration of Project Objectives**

The original topical goals for the 1998 Postpartum Family Planning Survey are listed below. Brief accounts of general findings that address these objectives are also presented.

1. *Current provider policies and practices regarding postpartum FP services and the current provider knowledge regarding the provision of postpartum FP services.*

Despite the avowed policies regarding information on the provision of postpartum family planning services, a wide variability of responses was generated in terms of when contraception should be given (after full breastfeeding, resumption of menses, one month, etc.) and what methods should be provided. This may indicate a lack of clear-cut policy guidelines on the period of acceptance, appropriate methods, and concern for lactation and safety of mothers.

Likewise, there was insufficient knowledge on proper compliance for different methods such as NFP and LAM. Many providers reported method restrictions, particularly spousal consent for IUD, DMPA, and female sterilization. However, these restrictions appear not to have been reported to clients. According to providers, a wide range of information on advantages and disadvantages of specific methods, compliance of use, contraindications, and side effects management are commonly supplied. However, clients tend not to report the same level of service provision. The same pattern was also observed for medical procedures, checklists and emphasis on quality, all of which were reported at higher rates among providers than clients.

2. *Documentation of FP Counseling and Information Provided to Mothers*

Mothers are usually recruited to postpartum family planning programs by midwives, barangay health workers, and community based distributors. Based upon the patterns of client response, it seems clear that not much screening was done in terms of breastfeeding and preexisting health conditions. Clients also reported that procedures and examination results were often not explained and did not serve as the basis for method selection. In addition, different methods were often not described adequately in terms of relative effectiveness, side effects management, mode of use, and sources of supply.

3. *Patterns of Method Use Among Mothers*

Except for LAM, which was usually initiated within a month after delivery, all other methods had an average interval of acceptance of 2 to 3 months. In many instances, no clear-cut guidelines appear to have been followed in recommending the timing of use for specific methods. The presence of side effects was commonly given as the reason for terminating or switching methods. According to clients, not much information was given by providers on the probability and nature of side effects.

4. *Initiation of Contraceptive Use Postpartum*

Definitive criteria were generally not reported by providers regarding acceptance for specific methods. This can partly be attributed to an inability to implement existing policies and the lack of knowledge regarding the advantages and disadvantages of methods. Lactational amenorrhea status was often not underscored.

5. *Follow-Up Care of Mothers*

Most providers mentioned the availability of checklists for follow-up visits, including the dates when the clients will return and the sending of reminder notices. The majority of clients were informed when to return to the clinic for follow-up care. However, less than half of all clients reported that they were sent reminders about when to return for follow-up.

6. *Assessment of Overall Quality of Services*

About 33.0 percent of the women reported waiting for services. The average waiting time was 30 minutes. According to clients, the information given to women was inadequate particularly in terms of use modality, advantages and disadvantages of methods, side effects management, and sources of supply. Likewise, medical procedures and results were often not explained adequately. Client satisfaction was reportedly high, although it is not known whether this is in part a politeness response.

7. *Recent Experience With LAM and NFP*

Both LAM and NFP are perceived as adequate postpartum methods since they do not interfere with normal lactation or cause side effects. However, the inadequate transmission of information due to lack of knowledge and training among providers can be seen in the inability of many clients to determine the onset of the fertile period and the correct use of both methods.

Unwanted pregnancies may not simply be the result of contraceptive failure or lack of access to supplies, but can reflect the failure of programs to respond to the specific needs of clients. The present analysis has revealed a number of shortcomings in the postpartum family planning program in the country.

- ▶ Many FP services are not yet organized around the postpartum situation (lactation, amenorrhea, pre-existing conditions) of women and the services and information they need;
- ▶ Access to a range of contraceptive methods and counseling on risks and benefits is still limited in many areas and follow-up is often weak;
- ▶ Many women are using contraceptive methods that are not appropriate for their lactational amenorrhea status. Misuse of contraception is often due to poor information, inadequate discussion of methods, and limited choices;
- ▶ Decisions on which methods to use are too often made by service providers instead of clients;
- ▶ Procedures such as pelvic examinations, STD/RTI diagnosis and treatment, as well as other screening methods are not always done, which may increase problems clients experience with the methods they adopt.

Efforts to advance postpartum family planning programs must ensure that providers have the supplies, technical competence, information, and interpersonal communication skills necessary for offering high quality of care. Written protocols that clearly define steps for routine service

provision and management of side effects are invaluable as a basis for training and supervision. Therefore, there is a need to review and possibly update the postpartum training program of current FP providers as well as the manuals that are currently being used.

### Recommendations

Results for the 1998 Philippine Survey of Postpartum Family Planning Care indicate that efforts should be made to (1) more actively promote postpartum services as essential elements of maternal and child health care in the Philippines; (2) clarify and effectively disseminate guidelines for the provision of postpartum family planning services to providers and clients; and (3) enhance the quality of training in postpartum care (including instruction in family planning counseling and service provision). Specific recommendations that relate to these three broad goals are presented below:

1. *Actively Promote Postpartum Services as Essential Elements of Maternal and Child Health Care in the Philippines*

A. At the present time, only around one-third of all Philippine mothers receive any postpartum care<sup>12</sup>. Estimates from this study suggest that among mothers who obtain postpartum care, only 6.7 percent actually accept a family planning method within six months of delivery. This is despite the fact that an average Philippine mother experiences menses resumption at 4.4 months and becomes sexually active at around 2.4 months. Without effective postpartum family planning care, many mothers in the Philippines may be unnecessarily exposed to the risk of an unwanted pregnancy soon after the birth of their previous child.

B. There is a need to encourage greater promotion of family planning and reproductive health counseling and service provision as part of the constellation of postpartum services offered in the Philippines. At the present time, postpartum services tend to be oriented more toward child health concerns than maternal care. There is also a need to strengthen referral mechanisms for mothers interested in limiting their fertility through the use of permanent clinical methods of contraception not provided through Rural Health Units.

2. *Clarify and Disseminate Guidelines for the Provision of Postpartum Family Planning Services to Providers and Clients*

A. Consideration should be given to revising the postpartum care section of the DOH Family Planning Clinical Standards Manual (*Kung Sila'y Mahaln'yo Magplano*) to more clearly reflect current contraceptive guidelines and policies recommended for postpartum mothers<sup>13</sup>. Many recommendations on postpartum care are currently given in the DOH Family Planning Clinical Standards Manual, but specific recommendations on postpartum

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<sup>12</sup> *Philippine Safe Motherhood Survey, 1993*. Manila: National Statistics Office and Calverton, Md: Demographic and Health Surveys, Macro International, Inc., 1995.

<sup>13</sup> Department of Health (DOH), Family Planning Clinical Standards Manual (*Kung Sila'y Mahaln'yo Magplano*). Manila: Philippine Family Planning Program, The Family Planning Service, 1998.

family planning acceptance are not listed in the postpartum section of the manual. These guidelines are either not presented, or are scattered through different sections of the manual.

B. Steps need to be taken to ensure that mothers are using appropriate methods of contraception in the postpartum period. Combination oral contraceptives (pills with estrogen and progesterone) should generally not be used by breastfeeding mothers up to six months postpartum. IUDs are best inserted within 48 hours and after six weeks following delivery. In addition, DMPA should not generally be started until six weeks following delivery (and certainly not before breastfeeding is well established). Breastfeeding and amenorrhea are two important postpartum considerations and the choice of appropriate postpartum methods should ensure that these elements are not jeopardized

C. Since LAM and NFP are being actively promoted as postpartum methods, information on the proper use of these methods should be made more widely available. Results from this study show inadequate provider and client knowledge of both methods.

D. DOH policies and programs should be made explicit and transmitted directly to women in order to reduce restrictions and biases commonly imposed by providers.

### 3. *Enhance Training in Postpartum Family Planning Care*

A. Efforts should be made to strengthen the postpartum training program, giving particular emphasis to clarifying curriculum content and increasing the duration and frequency of training;

B. A strong information and education campaign directed to mothers concerning different contraceptive methods and their use, including relative effectiveness, can ensure better use compliance. This material should be presented in simple and precise language. Audio-visual materials should be readily available and printed information should be easily comprehended by mothers.

C. Trust and respect through improved interpersonal relations should be nurtured as well as privacy in counseling and consultation. Women should be encouraged to express their fears and concerns so that misconceptions regarding specific methods are eliminated.

D. Adequate supervision to back up health providers, particularly midwives, is important to ensure that providers are technically competent to undertake the numerous tasks of screening and service provision.

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Appendix 1

Distribution of Providers and Clients in the 1998 Philippine Postpartum Care Survey

<i>Site</i>	<i>Provider</i>		<i>Client</i>	
	<i>Frequency</i>	<i>Valid Percent</i>	<i>Frequency</i>	<i>Valid Percent</i>
Cagayan	33	11	142	4.1
Quirino	24	7.1	364	10.5
Nueva Vizcaya	22	6.5	199	5.8
Nueva Ecija	24	7.1	279	8.1
Palawan	10	3.0	15	.4
Kalinga	4	1.2	37	1.1
Ifugao	15	4.4	79	2.3
Bulacan	1	.3	50	1.4
Pangasinan	36	10.7	307	8.9
Camarines Sur	3	.9	40	1.2
Antique	15	4.4	92	2.7
Leyte	4	1.2	273	7.9
Cebu	8	2.4	185	5.4
Iloilo	17	5.0	161	4.7
Negros Occidental	6	1.8	124	3.6
Negros Oriental	2	.6	64	1.9
Capiz	47	13.9	115	3.3
Agusan del Sur	14	4.1	126	3.7
Surigao del Norte	3	.9	59	1.7
Davao del Sur	4	1.2	54	1.6
North Cotabato	5	1.5	70	2.0
Zamboanga del Sur	18	5.3	171	5.0
Aklan	9	2.7	45	1.3
Camiguin	8	2.4	105	3.0
Misamis Oriental	5	1.5	75	2.2
Bukidnon	9	2.7	114	3.3
Lanao del Norte	8	2.4	44	1.3
Zamboanga del Norte	6	1.8	63	1.8
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	338	100.0	3452	100.0

Appendix 2

Distribution of Providers and Clients by Clinic Site, 1998 Philippine Postpartum Care Survey

<i>Clinic Site</i>	<i>Provider</i>		<i>Client</i>	
	<i>Frequency</i>	<i>Valid Percent</i>	<i>Frequency</i>	<i>Valid Percent</i>
Enrile MHO	3	.9	49	1.4
Solana MHO	7	2.1	20	.6
Cagayan Valley Regional Hospital	1	.3	73	2.1
Aglipay HC	3	.9	70	2.0
Cabarroguis HC	3	.9	71	2.1
Madella MHO	4	1.2	104	3.0
Saguday HC	7	2.1	45	1.3
Bagabag MHO	3	.9	15	.4
Dupax del Norte MHO	4	1.2	46	1.3
Sto. Domingo FP/MCH	2	.6	24	.7
Talavera HC	5	1.5	9	.3
St. Patrick Clinic	2	.6	168	4.9
Roxas HC	10	3.0	15	.4
Anini-y HC	7	2.1	83	2.4
Roxas Memorial Provincial Hospital	2	.6	26	.8
Iloilo FPOP	2	.6	34	1.0
San Joaquin HC	2	.6	32	.9
Riverside Rep HC	1	.3	32	.9
V. Sotto Memorial Medical Center	1	.3	7	.2
Mandaue CHO	6	1.8	119	3.4
Silliman University Medical Center	2	.6	64	1.9
Tabuk PHO	4	1.2	37	1.1
Janaeris Medical	1	.3	23	.7
Lamut HC	4	1.2	22	.6
Marilao FP/MCH	1	.3	50	1.4
Bicol Medical Center	3	.9	40	1.2
St. Anthony MCH	1	.3	59	1.7
West Visayas Medical Center	4	1.2	29	.8
Ormoc CHO	2	.6	223	6.5
Bayugan MHO	7	2.1	54	1.6
Davao Medical Center	3	.9	24	.7
Zamboanga City Medical Center	3	.9	19	.6
Family Care Clinic	1	.3	30	.9
Cotabato PRRM	2	.6	10	.3
Cotabato FPOP	3	.9	60	1.7
Bunawan HC	7	2.1	72	2.1
Tubajon HC	2	.6	41	1.2
Bugallon I HC	7	2.1	93	2.7
Bugallon II HC	4	1.2	53	1.5
Lingayen I HC	4	1.2	5	.1
Mangaldan I HC	5	1.5	42	1.2
Mangaldan II HC	5	1.5	64	1.9
Bayombong HC	5	1.5	36	1.0
Solano HC	2	.6	34	1.0
Bambang HC	6	1.8	45	1.3

<i>Clinic Site</i>	<i>Providers</i>		<i>Clients</i>	
	<i>Frequency</i>	<i>Valid Percent</i>	<i>Frequency</i>	<i>Valid Percent</i>
Alaminos I HC	6	1.8	11	.3
Alaminos II HC	2	.6	12	.3
Alaminos FP/MCH	1	.3	9	.3
Alaminos FPOP	2	.6	16	.5
San Jacinto FP/MCH	2	.6	2	.1
Bambang FP/MCH	3	.9	23	.7
San Leonardo FP/MCH	13	3.8	16	.5
Roxas CHO	9	2.7	30	.5
Panay HC	6	1.6	10	.9
Pontevedra HC	7	2.1	11	.5
Ivisan HC	10	3.0	12	.3
Panitan HC	4	1.2	60	.3
Zarraga HC	5	1.5	6	1.7
Leganes HC	2	.6	18	.2
Numancia HC	7	2.1	27	.5
Bangga HC	4	1.2	78	.8
Family Health Care Center	2	.6	50	2.3
Development Concept	1	.3	14	1.4
Bacolod FPOP	2	.6	31	.4
Canelar HC	1	.3	21	.9
Gov. Alvarez HC	1	.3	9	.6
Sta. Cruz HC	3	.9	40	.3
Sta. Maria HC	3	.9	11	1.2
Tetuan HC	1	.3	4	.3
Guiwan HC	2	.6	17	.5
Talon-Talon HC	2	.6	19	.6
San Jose Gusu HC	5	1.5	69	2.0
Mambajao HC	3	.9	36	1.0
Mahinog HC	3	.9	45	1.3
Kauswagan HC	2	.6	30	.9
NHA HC	9	2.7	114	3.3
Malaybalay MHO	8	2.4	44	1.3
Iligan CHO	6	1.8	63	1.8
Dipolog CHO-POPCOM	8	2.4	9	.3
Dao/Tobias Fornier HC	1	.3	25	.7
Nagtipunan HC	6	1.8	49	1.4
Diffun HC	8	2.4	31	.9
Kiangan HC	2	.6	3	.1
Lagawe HC	12	3.6	62	1.8
Cuyapo HC	1	.3	18	.5
Loreto HC				
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	338	100.0	3452	100.0

### Appendix 3

#### **Postpartum Sterilization Acceptance: The Case of the Philippine General Hospital (PGH) in Manila City**

The 1998 Philippine Postpartum Family Planning Survey sampled providers and clients obtaining services in many clinics and health centers (government and NGO facilities) that do not provide sterilization services. Therefore, a decision was made not to obtain information on postpartum sterilization use from these facilities. However, in major provincial and regional hospitals, sterilization is typically provided as a postpartum method. One such facility is the Philippine General Hospital (PGH), one of the largest maternity hospitals in the Metro Manila area.

Based upon client records compiled at PGH hospital, there were 13,439 deliveries during 1996 and 1997. As is shown in Table 3a, 10,657 women accepted family planning at PGH Hospital. Over the period 1996-97, 45.2 percent of mothers accepted the IUD, followed by pills at 22.3 percent. However, a substantial number of clients also accepted sterilization (8.6 percent). In addition, DMPA acceptance, while lower than sterilization, showed substantial gains between 1996 and 1997. The percentage of women counseled about LAM also increased by nearly 400 percent over this two year period. However, it is not possible to know whether women counseled about LAM became confirmed LAM acceptors or whether they adopted LAM within six months of having a child.

Table 3b shows that the percentage of mothers who accepted a method of contraception within six months of giving birth (the postpartum period specified for this study) was only 7.5 percent (1014/13,439). Sterilization was the main postpartum method accepted by mothers at PGH Hospital (70.0 percent over the period 1996-97), followed by IUDs (14.9 percent). The records also showed that very few mothers are confirmed LAM acceptors within six months of delivery (only 2 confirmed postpartum LAM acceptors appear in PGH records over the 1996-97 period).

Characteristics of sterilization acceptors among mothers at PGH Hospital (clients accepting within six months and at later periods following delivery) are shown in Table 3c. The vast majority of sterilization acceptors were 30-49 years of age (64.9 percent), with the median age of acceptance being 31.4 years of age. Mothers accepting sterilization also tend to be high parity mothers. As can be seen in Table 3c, 75.0 percent of sterilization acceptors had four or more children. During 1996-97, most sterilization acceptors at PGH (66.4 percent) underwent their procedure within 2 months of delivery, while only 22.0 percent waited six months or more prior to acceptance.

These findings suggest that sterilization is an attractive option for some mothers soon after delivery. In order to improve the accessibility, use and quality of postpartum services in the Philippines, greater efforts need to be made to enhance sterilization service provision and strengthen referral mechanisms from facilities not able to provide sterilization (which includes the vast majority of service outlets sampled in the 1998 Philippine Survey of Postpartum Family Planning Care).

**Table 3a: Total Number of Family Planning Acceptors (and Women Counseled about LAM) by Year and Method, PGH Hospital, Quezon City**

Total Family Planning Acceptors						
Methods	1996		1997		Total	
	n	%	n	%	n	%
Pills	1096	22.3	1282	22.3	2378	22.3
IUD	2319	47.3	2494	43.4	4813	45.2
DMPA	287	5.8	435	7.6	722	6.8
Female Sterilization	465	9.5	447	7.8	912	8.6
LAM <sup>1</sup>	37	0.8	221	3.8	258	2.4
NFP	8	0.2	0	0.0	8	0.1
Others	694	14.1	872	15.2	1566	14.7
<b>Total</b>	<b>4906</b>	<b>100.0</b>	<b>5751</b>	<b>100.0</b>	<b>10657</b>	<b>100.0</b>

<sup>1</sup> Number of women counseled about LAM rather than confirmed acceptors.

**Table 3b: Total Number of Postpartum Family Planning Acceptors by Year and Method, PGH Hospital, Quezon City**

Total Postpartum Family Planning Acceptors						
Methods	1996		1997		Total	
	n	%	n	%	n	%
Pills	36	7.1	36	7.1	72	7.1
IUD	75	14.9	76	14.9	151	14.9
DMPA	39	7.7	36	7.1	75	7.4
Female Sterilization	354	70.1	356	69.9	710	70.0
LAM	0	0.0	2	0.4	2	0.2
NFP	0	0.0	0	0.0	0	0.0
Others	1	0.2	3	0.6	4	0.4
<b>Total</b>	<b>505</b>	<b>100.0</b>	<b>509</b>	<b>100.0</b>	<b>1014</b>	<b>100.0</b>

Table 3c: Characteristics of Postpartum Family Planning Acceptors, PGH Hospital, Quezon City

Age of Sterilization Acceptors						
Age	1996		1997		Total	
	n	%	n	%	n	%
<= 24 Years	8	1.7	13	2.9	21	2.3
25-29 Years	148	31.9	149	33.7	297	32.8
30-34 Years	192	41.4	174	39.4	366	40.4
35-39 Years	100	21.6	93	21.0	193	21.3
>= 40 Years	16	3.4	13	2.9	29	3.2
<b>Total</b>	<b>464</b>	<b>100.0</b>	<b>442</b>	<b>100.0</b>	<b>906</b>	<b>100.0</b>
<b>Mean</b>	<b>31.6</b>	<b>-</b>	<b>31.3</b>	<b>-</b>	<b>31.4</b>	<b>-</b>
<b>Median</b>	<b>32.0</b>	<b>-</b>	<b>31.0</b>	<b>-</b>	<b>31.0</b>	<b>-</b>
Number of Months Following Delivery when Mothers Adopted Sterilization, by Year						
Interval	n	%	n	%	n	%
< 1 Month	219	47.2	179	40.1	398	43.7
1-2 Months	88	19.0	119	26.7	207	22.7
3-4 Months	32	6.9	34	7.6	66	7.3
5-6 Months	15	3.2	24	5.4	39	4.3
> 6 Months	110	23.7	90	20.2	200	22.0
<b>Total</b>	<b>464</b>	<b>100.0</b>	<b>446</b>	<b>100.0</b>	<b>910</b>	<b>100.0</b>
<b>Mean</b>	<b>7.2</b>	<b>-</b>	<b>6.4</b>	<b>-</b>	<b>6.8</b>	<b>-</b>
<b>Median</b>	<b>1.0</b>	<b>-</b>	<b>1.5</b>	<b>-</b>	<b>1.0</b>	<b>-</b>
Number of Children among Mothers who Adopted Sterilization						
Interval	n	%	n	%	n	%
<= 2 Children	2	10.6	8	2.2	10	1.4
3 Children	74	20.9	93	26.1	167	23.5
4 Children	136	38.4	122	34.3	258	36.3
>= 5 Children	142	40.1	133	37.4	275	38.7
<b>Total</b>	<b>354</b>	<b>100.0</b>	<b>356</b>	<b>100.0</b>	<b>710</b>	<b>100.0</b>
<b>Mean</b>	<b>4.2</b>	<b>-</b>	<b>4.1</b>	<b>-</b>	<b>4.1</b>	<b>-</b>
<b>Median</b>	<b>4.0</b>	<b>-</b>	<b>4.0</b>	<b>-</b>	<b>4.0</b>	<b>-</b>

## 1998 Philippine Postpartum Family Planning Services

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