ASSESSMENT OF SUPPLY, PROVISION, AND USE OF THE INTRAUTERINE DEVICE IN THE PHILIPPINES

JUNE 7, 2006
This publication was produced for review by the United States Agency for International Development. It was prepared by Chemonics International Inc.
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USAID/Philippines Contract No.: 492-C-00-04-00036-00
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ACKNOWLEDGEMENTS

The IUD Study Team would like to thank PRISM leadership (Don Levy, project director; Lief Doerring, chief of party; and Grace Migallos, deputy chief of party) and key PRISM staff (Lemuel Marasigan, Leila Vicente, Angie Ong, Liza Jane Domingo, Russel Farinas, Reynaldo Fuentes, Therese Benavidez, Concepcion Domag and Odilyn de Guzman) for their efficient and effective assistance on this assessment. We also thank USAID/OPHN-Manila for requesting and supporting this crucial investigation.
## ACRONYMS AND ABBREVIATIONS

<table>
<thead>
<tr>
<th>ACRONYM</th>
<th>FULL FORM</th>
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<tbody>
<tr>
<td>AIDS</td>
<td>Acquired Immune Deficiency Syndrome</td>
</tr>
<tr>
<td>BFAD</td>
<td>Bureau of Food and Drugs</td>
</tr>
<tr>
<td>CDLMIS</td>
<td>Contraceptive Distribution and Logistics Management Information System</td>
</tr>
<tr>
<td>CMW</td>
<td>Currently married women</td>
</tr>
<tr>
<td>CSR</td>
<td>Contraceptive Self-Reliance</td>
</tr>
<tr>
<td>DND</td>
<td>Department of National Defense</td>
</tr>
<tr>
<td>DOH</td>
<td>Department of Health</td>
</tr>
<tr>
<td>DOLE</td>
<td>Department of Labor and Employment</td>
</tr>
<tr>
<td>FM</td>
<td>Family medicine</td>
</tr>
<tr>
<td>FP</td>
<td>Family planning</td>
</tr>
<tr>
<td>FPOP</td>
<td>Family Planning Organization of the Philippines</td>
</tr>
<tr>
<td>FPS</td>
<td>Family Planning Survey</td>
</tr>
<tr>
<td>GATHER</td>
<td>Greet, Ask/Assess, Tell, Help, Explain, and Return/Refer</td>
</tr>
<tr>
<td>GP</td>
<td>General practitioner</td>
</tr>
<tr>
<td>HIV</td>
<td>Human Immunodeficiency Virus</td>
</tr>
<tr>
<td>IUD</td>
<td>Intrauterine device</td>
</tr>
<tr>
<td>KAE</td>
<td>Knowledge, attitudes, and experiences</td>
</tr>
<tr>
<td>MW</td>
<td>Midwives</td>
</tr>
<tr>
<td>NCR</td>
<td>National Capital Region</td>
</tr>
<tr>
<td>NDHS</td>
<td>National Demographic Health Survey</td>
</tr>
<tr>
<td>NGO</td>
<td>Nongovernmental organization</td>
</tr>
<tr>
<td>NSO</td>
<td>National Statistics Office</td>
</tr>
<tr>
<td>OB-GYNE</td>
<td>Obstetrician-gynecologist/obstetrics-gynecology</td>
</tr>
<tr>
<td>Acronym</td>
<td>Description</td>
</tr>
<tr>
<td>---------</td>
<td>-------------</td>
</tr>
<tr>
<td>OPHN</td>
<td>Office of Population, Health, and Nutrition</td>
</tr>
<tr>
<td>PHILHEALTH</td>
<td>Philippine Health Insurance Corporation</td>
</tr>
<tr>
<td>PRISM</td>
<td>Private-Sector Mobilization for Family Planning</td>
</tr>
<tr>
<td>RH</td>
<td>Reproductive health</td>
</tr>
<tr>
<td>RTI</td>
<td>Reproductive tract infection</td>
</tr>
<tr>
<td>SO</td>
<td>Strategic objective</td>
</tr>
<tr>
<td>STI</td>
<td>Sexually transmitted infection</td>
</tr>
<tr>
<td>USAID</td>
<td>United States Agency for International Development</td>
</tr>
<tr>
<td>WRA</td>
<td>Women of reproductive age</td>
</tr>
</tbody>
</table>
The assessment examined the supply, provision, and use of the intrauterine device (IUD) in the Philippines. The data inform PRISM’s goal of mobilizing the private sector for family planning — specifically, for developing a commercial IUD market in the country.

**SUPPLY, PROVISION, AND USE AS PUBLIC PHENOMENA**

- Although some IUD supplies in the Philippines have come from private sources (such as the Family Planning Organization of the Philippines and pharmaceutical companies whose IUD products are registered with the Bureau of Food and Drugs), the bulk has been from the public sector. From 1995 to 2003, the government of the Republic of the Philippines received 776,000 USAID-donated Copper T (CuT380-A) units.

- The donated IUDs have been distributed chiefly through public health facilities across the country, and all have been used by women from the same sources (see Table 2.3).

- The public sector gets IUDs for free and inserts them at virtually no cost. The private sector, such as the Planning Organization of the Philippines (FPOP) — which obtains IUD supplies from the International Planned Parenthood Federation — sells its IUD for 36 pesos each. The cost including insertion is 250 pesos. The two pharmaceutical companies interviewed for this assessment sold IUDs for 1,000 to 8,000 pesos each.

- The evidence strongly emphasizes the centrality of the public-health sector insofar as IUD supply, provision, and use are concerned. For example, most (74.8 percent) of the public and private providers interviewed said that the IUDs they used for their clients came from the public sector. Most current IUD users (80.1 percent) pointed to the public sector as their most recent source of the device.

- The overwhelming use of the public sector is more than just a function of the low cost of the IUDs it provides. Low-income users may also have been
attracted to the free or donation-based (ranging from five to 75 pesos) insertion services provided by the public sector.

- For some high-income IUD users, the public sector is not an option. Evidence indicates that 18 percent of IUD users are private-sector clients who are charged several hundred pesos for IUDs and their insertion. Private-sector IUD users are a small minority, though, compared to public-sector users.

**Use and non-use: Function of knowledge, attitudes, and experiences (KAE)**

- Factors that govern adoption of the device include the need for family planning and small family size (due to economic hard times) and the desire to be free of the burden of successive childbearing and rearing.

- Regardless of the method they use, women are knowledgeable about a range of contraceptive devices.

- Movement toward greater IUD use rests on favorable attitudes toward the advantages, rather than the disadvantages, of the IUD, and KAE of other methods.

- Movement away from IUD use rests on KAE of the disadvantages and negative experiences with the IUD.

- The KAE of current IUD use is influenced by individuals within a woman’s personal network and health system (see Chapter IV).

- The prevailing KAE on IUDs tends toward its disadvantages rather than its advantages. These attitudes sustain the relatively low preference for the IUD. Through the years, the base of currently married IUD users in the Philippines has been low — only three to four percent, or 180,000 to 240,000 of the 6.02 million married users of family planning.

**IUD supply and demand**

- Low IUD use rates, while chiefly attributed to women’s greater KAE of the IUD’s disadvantages, could also be affected by limited supply of IUDs. Year to year, the number of donated IUDs has been limited to 50,000-160,000 units.

- All donated and sold IUDs, however, have been consumed, indicating that there may be more demand for the device.

- The IUD’s positive characteristics are not well-known to most Filipino women, men, or healthcare providers, likely because there has been no marketing or promotion of the IUD in the country. (The absence of marketing and promotion is by no means limited to the IUD: the lack of increase in overall contraceptive prevalence and in method-specific prevalence could be a
result of lack of marketing and promotion of family planning in general. See tables 2.5 and 2.6).

- The decades-long absence of promotion and effective management of IUD side effects has contributed to negative and undesirable KAE of IUDs.

Potential first-time IUD user populations and supply gaps

- The following figures detail the estimated 391,400 potential new IUD users. The figures do not include potential IUD users among the 8.0 million single Filipino women.

320,000 intenders =

- 120,000 (4.9 percent) of currently married women with unmet need for contraceptives, and
- 200,000 (8.1 percent) of currently married women who are non-method users.

71,400 IUD switchers =

- 30,400 (1.6 percent) of the 1.9 million currently married pill users, and
- 8,000 (1.8 percent) of the 440,000 currently married injectable users, and
- 5,700 (2.2 percent) of the 260,000 currently married condom users, and
- 2,400 (5.4 percent) of the 46,000 currently married users of natural family-planning methods (mucus/bbt/stm, standard days, and LAM), and
- 13,400 (1.6 percent) of the 842,000 currently married users of periodic abstinence, and
- 11,500 (1.4 percent) of the 827,000 currently married users of withdrawal.

- The movement toward private-sector involvement in the production, supply, and insertion of the IUD is likely to bring about change in the above scenarios, due to marketing and promotional efforts.

There is no near-term plan to phase out USAID donations of the IUD, so for the foreseeable future, donations of 50,000-160,000 units shall continue to flow into the country.

- An unknown, albeit small portion of the donated units in 2006 will replace those currently used by three to four percent, or 180,000-240,000, currently married women.
Most IUDs, however, will be consumed by first-time IUD users who can be classified as “intenders” or “switchers” (see pp. 21-22).

Given the 2006 USAID donation of 96,000 IUD units and the 3,000-5,000 combined units from the FPOP and the two pharmacies mentioned in Chapter II, approximately only 100,000 of the 391,400 potential new users will be provided with IUD units.

Supply for the remaining 291,000 potential new users will be unmet. Clearly, there is demand for increased IUD supply.

**IUD marketing and promotion**

- Systematic marketing and promotion strategies must be developed and implemented to effect IUD use among potential users. The strategies should inform non-IUD users about the advantages of the IUD, including its low discontinuation rate, and about the disadvantages of the pill and injectables.

  Marketing efforts should also address the non-IUD user’s KAE of the disadvantages of the IUD, especially its side effects. Non-acceptors should be informed that negative effects are not experienced by all users, and that any effects that do occur are short-lived and treatable.

- Marketing and promotion strategies should employ influential individuals within the personal networks and health systems accessed by potential IUD users.

- Current IUD-related knowledge, practices, and skills are inadequate among doctors and midwives. Providers should be given: 1) Re-orientation on the advantages and disadvantages of the IUD; 2) Standard protocols and tools for marketing and promotion strategies, counseling and screening potential users, insertion and removal procedures (to lessen expulsion cases), and post-insertion services; and 3) Skills to enable them to effectively address women’s concerns about side effects and to effectively manage those side effects.

In particular, providers should be oriented to pay special attention to women’s first-year use of the IUD, as this is the period when users are likely to experience side effects.

Providers who advocate or users of family planning — particularly, satisfied long-term IUD users — are very effective at marketing and promotion.

- Tapping influential members of personal networks and health systems will build a critical mass of individuals with positive IUD-related KAE and who will recommend the IUD to other women. These individuals create a supportive familial and social environment not only for those currently using IUDs, but also for those who want to use them. With supportive social structures, the population of new and continuing IUD users will grow, which will only serve to persuade even more women to use the device.
There is no conclusive evidence that IUD users are restricted to particular demographic groups — IUD users are similar to pill users in this respect. Future efforts should focus on market segmentation and profiling of target audiences.

For private-sector involvement in the IUD market, the priority market should be women capable of paying for IUDs and their insertion. These women belong to middle- and high-income groups and are willing to pay up to 800 pesos per IUD.

As USAID donations decrease and eventually cease entirely, the private market should further develop and offer a variety of safe and effective IUDs to respond to the varying economic levels of female clients. Through further research and development, the private sector should find other ways to make the IUD more widely accepted — for instance, upgrading the materials used for the IUD, improving the IUD string, or manufacturing a range of sizes.

Along with product development, product packaging should also be improved — the language used to describe the product and its side effects should be carefully crafted. “Side effects” has a negative connotation that many women have associated with the IUD for decades.

Heightened sensitivity in IUD provision is also needed. IUDs should be easily accessible and female providers should insert them with appropriate instruments. With a more developed product and sensitive marketing, promotion, and provision, prospects for a commercial IUD market are bright.

The IUD market in the Philippines is small, but there is actual and potential demand for it among women and healthcare providers who are aware of the device’s advantages. Effective marketing, promotion, and training strategies are needed to build a critical mass of support among private-sector users and providers. The greater the support network, the greater the chance for the IUD market to grow. As the number of private users increases, the demand for IUDs also increases — a market condition bound to spur response from and directly benefit private manufacturers and suppliers.
I. BACKGROUND

Supply, provision, and use of the intrauterine device (IUD) is primarily a public-sector phenomenon in the Philippines. For more than 30 years, the government of the Republic of the Philippines has received IUDs donated by USAID and provided them to women at low or no cost through its network of health facilities. However, the country is moving toward contraceptive self-reliance as USAID phases out its yearly donation of IUDs and the private sector increases its involvement in family planning. Beside producing and selling the IUD (among other family-planning methods), the private sector will also offer insertion services at market price.

The transition to private-sector involvement is a complex process, though. The production, supply, provision, and use of the IUD deal with more than just financial considerations — there are stakeholders to consider. For example, while IUD users may be willing to shoulder the expense of using the device, they expect quality insertion services and a safe, cost-effective product.

The private sector (including pharmaceutical companies and private health-providers) will produce and insert the IUD only under the expectation that there is a profitable market for their product or service. The move from public- to private-dominated IUD provision poses complex questions: Is there a critical mass of actual or potential IUD users in the Philippines on which to build a private market? What should be done to develop the IUD market so that key players — suppliers, health providers, and users — effectively respond to and benefit from the process?

While studies on the IUD have already been undertaken in the Philippines, their findings have not been analyzed in the context of creating a commercial market for the IUD. In the last quarter of 2005, at the request of USAID/Philippines, PRISM (Private-Sector Mobilization for Family Planning) commissioned an assessment of the country’s IUD supplies, provision, and use. The intent was to form evidence-based perspectives and recommendations that will help guide PRISM on how best to support the commercial sector to better serve women who wish to use IUDs as their contraceptive method of choice. The assessment responds to the USAID/Population and Health’s Strategic Objective 3 (“Desired family size and improved health sustainably achieved”), specifically to the objective’s Intermediate Result 2: “Expanded provision of quality services by private and commercial providers.”
ASSESSMENT OBJECTIVES AND METHODS

The objectives of the assessment are:

1. Gather and review secondary data on IUD supply, provision, and use;
2. Gather and analyze primary data on women’s use or non-use of IUD, men’s knowledge and experience of their female partners’ use of IUD, and providers’ attitudes, practices, and experiences in IUD provision.
3. Form evidence-based perspectives and recommendations for the development of a commercial IUD market in the Philippines.

The assessment’s objectives were accomplished using three research methods (Table 1.1). The first objective was accomplished through literature review. Previous studies were identified, accessed (hard and electronic copies of 30 research reports were obtained), and reviewed. The assessment collected and reviewed statistical records from the OPHN (Office of Population, Health, and Nutrition)/USAID/Philippines; the government of the Republic of the Philippines, specifically from the Department of Health’s CDLMIS (Contraceptive Distribution and Logistics Management Information System) and BFAD (Bureau of Food and Drugs); a nongovernmental organization, FPOP (Family Planning Organization of the Philippines); and two pharmaceutical companies.

**TABLE 1.1. RESEARCH ACTIVITIES AND COVERAGE**

<table>
<thead>
<tr>
<th>LITERATURE REVIEW</th>
<th>FOCUS-GROUP DISCUSSIONS (N=24)</th>
<th>INTERVIEWS</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Husbands/male partners of current users</td>
</tr>
<tr>
<td>30 studies, and statistical records from the USAID/OPHN, government (CDLMIS and BFAD), a nongovernmental organization (FPOP), and two pharmaceutical companies.</td>
<td>Current IUD users (n=6)* Former IUD users (n=6)* Intenders (n=6)** Limiters (n=6)**</td>
<td>15</td>
</tr>
</tbody>
</table>

*Private- and public-sector users

**Low- and middle-to-high-income users

***Mainly public providers

The second objective was fulfilled by conducting a series of focus-group discussions with four groups of women: current IUD users, former IUD users, intenders (women who may or may not be using any method but have an intention to use the device), and limiters (women using the pill, injectables, condoms, and natural family-planning methods). Each group participated in six discussion sessions. Each group’s sessions were equally divided into sessions with two subgroups. Among current or former IUD
users, three sessions were conducted with women who used the public sector and three with women who used the private sector. Among intenders or limiters, three sessions were held with low-income women and three with middle- to high-income women backgrounds. In total, 24 discussions were held, each with 6-8 participants. Prior to the discussions, screening forms and profile questionnaires were administered to all participants.

The second objective was also addressed by conducting personal interviews with 1) the husbands or male partners of 15 current IUD users who participated in the group discussions; and 2) four categories of IUD providers — general practitioners (GP), family medicine (FM), midwives (MW) and obstetricians-gynecologists (OB-GYNE). A total of 87 providers were interviewed. Except for GP, the number of providers was almost evenly divided between the public and private sectors. (There was difficulty in recruiting private-sector GP who inserted the IUD; thus of the seven GP respondents, only one was a private provider). Interviewees were recruited deliberately.

In an effort to capture a range of experiences from around the country, interviews and discussions were conducted in three geographic areas: Luzon (Bulacan, Cavite, Batangas, Cagayan Valley, and the National Capital Region, or NCR), Visayas (Cebu City), and Mindanao (Davao, Tagum, and Panabo). In the NCR, Metro Cebu, and Metro Davao, researchers also consulted five drugstores about the availability of IUDs. Interview and discussion guides were developed and used to gather data, which was then analyzed with the Windows version of the Statistical Package for the Social Sciences. Group-discussion data were processed using thematic analysis.

This report discusses the findings from the assessment’s research. Chapter II covers the results from the literature review and statistical records; Chapter III presents the data gathered from the focus-group discussions with women and interviews with husbands/male partners of current IUD users. Chapter IV discusses the results from the interviews with providers. Using the highlights of all research findings, Chapter V offers a perspective within which IUD supply, provision, and use in the Philippines can be viewed, and recommendations for pursuing a commercial IUD market.
II. PUBLISHED EMPIRICAL EVIDENCE AND STATISTICAL DATA ON IUD SUPPLY, PROVISION, AND USE

A. SUPPLY, DISTRIBUTION, AND CONSUMPTION

Three supply sources of the intrauterine device were identified; from these, data on the number of units donated, distributed, and/or inserted were requested. These sources include the government (USAID and the Philippines’ Department of Health, or DOH), a nongovernmental organization (FPOP), and pharmaceutical companies.

USAID donations, DOH distribution, and consumption data

According to USAID/OPHN, from 1995 to 2003, the DOH was given a total of 776,360 USAID-donated IUD units (all are Copper T IUDs, the CuT380-A) (Table 2.1). No USAID donations were made in 1996, 2004, or 2005. For 2006, USAID has requested 96,000 units for the Philippines; as of this writing, delivery is still pending (personal communication with Vickki C. Dagohoy, administrative program assistant).

TABLE 2.1. USAID-DONATED IUD UNITS TO THE PHILIPPINES (1995-2006)

<table>
<thead>
<tr>
<th></th>
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</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>90,400</td>
<td>0</td>
<td>64,000</td>
<td>160,160</td>
<td>88,000</td>
<td>152,600</td>
<td>67,800</td>
<td>103,400</td>
<td>50,000</td>
<td>0</td>
<td>0</td>
<td>96,000*</td>
</tr>
</tbody>
</table>

Total USAID-donated units for the period 1995-February 2003: 776,360
Total USAID-donated units for the period 1998-February 2003: 621,960

*Yet to be delivered.

Source: USAID/OPHN.
### TABLE 2.2. USAID-DONATED IUD UNITS DELIVERED BY THE DOH AND DISTRIBUTION CHANNELS (1998-2004)

<table>
<thead>
<tr>
<th></th>
<th>1998</th>
<th>1999</th>
<th>2000</th>
<th>2001</th>
<th>2002</th>
<th>2003</th>
<th>2004</th>
</tr>
</thead>
<tbody>
<tr>
<td>DOH</td>
<td>128,700</td>
<td>146,000</td>
<td>104,400</td>
<td>135,400</td>
<td>144,400</td>
<td>129,600</td>
<td>92,700</td>
</tr>
</tbody>
</table>

Total USAID-donated units delivered by the DOH for the period 1998-2004: 881,200

<table>
<thead>
<tr>
<th>CHANNELS</th>
<th>1998</th>
<th>1999</th>
<th>2000</th>
<th>2001</th>
<th>2002</th>
<th>2003</th>
<th>2004</th>
<th>TOTAL</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>PHO/LGU hospitals*</td>
<td>16,513</td>
<td>16,586</td>
<td>18,836</td>
<td>17,561</td>
<td>13,516</td>
<td>13,146</td>
<td>9,912</td>
<td>106,070</td>
<td>15.1</td>
</tr>
<tr>
<td>RHUs</td>
<td>69,622</td>
<td>70,542</td>
<td>73,997</td>
<td>73,671</td>
<td>58,406</td>
<td>63,857</td>
<td>57,875</td>
<td>467,970</td>
<td>66.5</td>
</tr>
<tr>
<td>NGOs</td>
<td>6,870</td>
<td>7,687</td>
<td>6,733</td>
<td>6,558</td>
<td>5,934</td>
<td>4,505</td>
<td>4,119</td>
<td>42,406</td>
<td>6.0</td>
</tr>
<tr>
<td>Others</td>
<td>19,445</td>
<td>14,763</td>
<td>14,271</td>
<td>13,921</td>
<td>11,015</td>
<td>7,378</td>
<td>6,751</td>
<td>87,544</td>
<td>12.4</td>
</tr>
<tr>
<td>TOTAL</td>
<td>112,450</td>
<td>109,578</td>
<td>113,837</td>
<td>111,711</td>
<td>88,871</td>
<td>88,886</td>
<td>78,657</td>
<td>703,990</td>
<td>100</td>
</tr>
</tbody>
</table>

Total USAID-donated units delivered by the DOH for the period 1998-2004 by channels: 703,990

*Provincial health office (PHO)/local government unit (LGU)

Source: DOH/CDLMIS

Records show that while the DOH delivered a total of 881,200 USAID-donated IUD units throughout the country during the period 1998-2004, that figure drops to only 703,990 units if based on the channels through which the deliveries were made (Table 2.2). The discrepancy is due to the fact that the DOH gets IUD supplies from the United Nations Population Fund. For example, in 2002, the fund donated 290,000 IUDs to the Philippines. The public-health sector (population health offices, local government hospitals, and rural health units) has received the bulk of the supplies (81.6 percent), with the private sector (NGOs and private health facilities and providers) receiving the rest.

Data further reveal that consumption of USAID-donated IUD units throughout the country, between 1998 and 2004, amounted to 772,641 units (Table 2.3). Regions with the highest consumption rate are Region 11 at 15.72 percent (Compostela Valley, Davao City, etc.), Region 4 at 13.2 percent (Aurora, Batangas, Cavite, etc.), and Region 10 at 11.3 percent (Bukidnon, Cagayan de Oro City, etc.).
### TABLE 2.3. REGIONAL CONSUMPTION DATA ON USAID-DONATED IUD UNITS (1998-2004)

<table>
<thead>
<tr>
<th>REGION</th>
<th>NUMBER OF UNITS CONSUMED</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>I</td>
<td>19,043</td>
<td>2.5</td>
</tr>
<tr>
<td>II</td>
<td>54,464</td>
<td>7.1</td>
</tr>
<tr>
<td>III</td>
<td>31,316</td>
<td>4.1</td>
</tr>
<tr>
<td>IV</td>
<td>101,811</td>
<td>13.2</td>
</tr>
<tr>
<td>V</td>
<td>11,414</td>
<td>1.5</td>
</tr>
<tr>
<td>VI</td>
<td>38,519</td>
<td>4.9</td>
</tr>
<tr>
<td>VII</td>
<td>72,100</td>
<td>9.3</td>
</tr>
<tr>
<td>VIII</td>
<td>27,769</td>
<td>3.6</td>
</tr>
<tr>
<td>IX</td>
<td>45,163</td>
<td>5.8</td>
</tr>
<tr>
<td>X</td>
<td>86,958</td>
<td>11.3</td>
</tr>
<tr>
<td>XI</td>
<td>121,626</td>
<td>15.7</td>
</tr>
<tr>
<td>XII</td>
<td>48,836</td>
<td>6.3</td>
</tr>
<tr>
<td>NCR</td>
<td>54,911</td>
<td>7.1</td>
</tr>
<tr>
<td>CAR</td>
<td>10,449</td>
<td>1.4</td>
</tr>
<tr>
<td>CARAGA</td>
<td>41,674</td>
<td>5.4</td>
</tr>
<tr>
<td>ARMM</td>
<td>6,588</td>
<td>0.85</td>
</tr>
<tr>
<td>TOTAL</td>
<td>772,641</td>
<td>100.00</td>
</tr>
</tbody>
</table>

Figures computed from raw DOH/CDLMIS data.

### OTHER NON-USAID/DOH SOURCES OF IUD

**Nongovernmental organization: Family Planning Organization of the Philippines (FPOP)**

For the period 2003 through the 3rd quarter of 2005, the FPOP dispensed a total of 7,971 IUD units (2003: 1,652; 2004: 3,774 (93 percent of whom were new acceptors); and 2005: 2,545). The units dispensed in 2003-2004 were taken from those received from the International Planned Parenthood Federation in 2000 and 2001, totaling 4,800. In 2005, the 2,545 dispensed units represented 35.8 percent of the year’s total supply of 7,100 from the federation. The FPOP, which uses only one type of IUD (the CuT380-A) distributes its IUD supplies to its own network of 33 strategically located clinics throughout the country. The unit price of the IUD is 36.02 pesos but can vary by clinic. FPOP clinics charge 250 pesos for an IUD insertion, including the cost of the unit.

**Commercial sources: Pharmaceutical companies**

Two companies (referred to here as Company 1 and Company 2) provided IUD data.
Company 1 did not distribute IUDs in the Philippines from 2000-2005. But from 1994-1998, it marketed, via its own distribution network, the Multiload IUD at a price ranging from 1,200 to 1,500 pesos. The company expressed concern regarding the high cash-out for production and supply; low acceptance among women and providers because of its side effects (even some medical doctors consider it abortifacient); and lack of qualified IUD providers. To re-engage them in the IUD market, Company 1 suggested that providers should be trained on the benefits and potential risks and side effects of IUDs and free IUD supplies should be made available in public-health facilities.

**TABLE 2.4. TOTAL UNITS DISPENSED BY FPOP AND PHARMACEUTICAL COMPANIES**

<table>
<thead>
<tr>
<th>ORGANIZATION</th>
<th>UNITS DISPENSED</th>
<th>PERIOD COVERED</th>
</tr>
</thead>
<tbody>
<tr>
<td>FPOP</td>
<td>7,971</td>
<td>2003 through the 3rd quarter of 2005</td>
</tr>
<tr>
<td>Company 2</td>
<td>338</td>
<td>2000, 2004-2005</td>
</tr>
</tbody>
</table>

*Company 1 did not provide sales figure.*

Company 2 has sold several types of IUD, totaling 338 units, in the Philippines. In particular, it sold 200 units of Nova-TCU at approximately 600 pesos per pack in 2000. From 2004-2005, it sold 138 units of Mirena, an intrauterine system which lasts five years, with a unit price of 8,820 pesos, excluding insertion. Since both are low-volume products and require a well-trained OB-GYNE (the company does not employ midwives for its IUDs) for insertion, the products have been made available only through the company’s own medical representatives and offices and not in drugstores.

IUD production is not an issue to Company 2 because IUDs are one of the products they regularly manufacture in their plants. The company’s concern lies more with distribution: Due to low demand among Filipino women, the company’s headquarters is reluctant to ship IUD supplies to their Philippine operations. Owing to taxes levied on imported IUDs and marketing and promotional costs to overcome its low acceptance, the company also cites the high cash-out that would be incurred. To Company 2, the income derived from IUD units would not cover the costs of promoting wide acceptance of the device.

The drugstores in the NCR, Metro Cebu, and Metro Manila do not stock IUDs.

**Registered IUD brands at the BFAD**

The BFAD has confirmed four registered brands of IUD: Mirena 20mcg levonorgestrel and NovaTCU (both imported by Schering), Pregna-IUCD (imported by Zuellig), and a generically named “intrauterine contraceptive device” (imported by AAA Pharma). The BFAD did not provide sales information on any of the products.
B. PROVISION

Knowledge and attitudes of providers

Family planning providers believe that the services they provide enhance their public image as professionals, and their religious beliefs notwithstanding, they would recommend modern FP methods to users (NFO Trends, 2004).

Midwives and public-health nurses are limited in their knowledge of the biomedical side effects of birth-control methods, including the IUD (Henry, 2001). Moreover, “most providers assess themselves as lacking adequate knowledge and skills to effectively counsel clients” (Lamberte et al, 2004).

Although some providers in the Philippines — in particular, midwives in rural clinics — prefer the IUD because its long term of use means they do not have to keep a large supply of it on-hand, some others, including physicians, do not mention the IUD among the choices available to women (Finger, 1996) or do not recommend it (The Social Acceptance Project — Family Planning, undated). The unwillingness to prescribe IUDs rests on a number of reasons: 1) they are sometimes misplaced; 2) the string makes them uncomfortable, 3) pregnancy can still occur, 4) users can develop complications or infections, and 5) they can induce abortion (The Social Acceptance Project — Family Planning, undated). A census and knowledge/attitudes/practice study among health providers similarly disclosed that 27-47 percent of providers (physicians and non-physicians) regard the IUD as a cause of pelvic infection and sometimes abortion (NFO Trends, 2004).

Practices of providers

Based on the observations derived from a qualitative study in four rural health clinics in the Quirino province, family-planning providers — in particular, midwives — take the following steps when conducting a routine visit with a client (Henry, 2001):

1. Assess the woman’s reason for visiting the clinic.
2. Provide information on methods and follow-up.
3. Counsel on side effects and other method use issues.
4. Depending on the method used, perform appropriate procedures (for example, taking the client’s blood pressure, obtaining her consent, inserting IUD, giving an injection, or providing supplies and referrals).

For first-time family-planning method users, the study further indicated that the providers would ask women about their marital status and would provide services only if they are married; if they are, providers would then ask if they have their husbands’ consent. Counseling on side effects occurs not only prior to contraceptive use but also in follow-up visits. However, it was observed that while providers would listen to women’s reports of the IUD’s side effects and health concerns — such as body malaise, obstructions in the body, abdominal tenderness, ectopic pregnancy, and
hemorrhage, among others (Lamberte et al, 2004) — they do not take these as real but rather as psychological (Henry, 2001). The most that some providers would do in such a particular instance would be to take note of side effects, without any attempt at directly addressing them (Lamberte et al, 2004).

While a great majority have heard of the GATHER approach, only 10 percent of providers consistently use it in counseling sessions, with others selectively utilizing it with first time clients or not using it at all (Lamberte et al, 2004). GATHER, a widely used counseling approach, stands for greet, ask/assess, tell, help, explain, and return/refer. For the majority of providers, counseling focuses more on information-giving than on “affective/emotional FP concerns, active communication as well as verbal exchange and question clarifications,” and, more importantly, the counseling does not adequately address user reports of side effects and health concerns (Lamberte et al, 2004). GATHER, a widely used counseling approach, stands for greet, ask/assess, tell, help, explain, and return/refer. For the majority of providers, counseling focuses more on information-giving than on “affective/emotional FP concerns, active communication as well as verbal exchange and question clarifications,” and, more importantly, the counseling does not adequately address user reports of side effects and health concerns (Lamberte et al, 2004). Broadly, health providers tend to give more information (74-97 percent vs. 41-57 percent) on FP methods than on counseling (NFO Trends, 2004) and spend more counseling time with a potential user than with a current or past user (Raymundo et al, 1990). However, “providers are highly respectful of the patients’ right to know the advantages and disadvantages of using the methods and of their right to decide on what method to use” (NFO Trends, 2004). In general, the quality of family-planning service provision, based on results of an intervention study (Costelo et al, 2001), has much room for improvement.

The general view is that few physicians recommend the IUD as their first choice of method, despite findings that among those whose top choice was IUDs, physicians inserted the method for an average of 13 percent of their acceptors, whereas those physicians who preferred other methods inserted it for only 7 percent (MacCorquodale, 1974). The degree of religiosity of physicians did not determine their propensity to insert or not insert the method (Briton, 1969, in MacCorquodale, 1974).

In the late 1970s, the Bohol IUD program concluded that “for an IUD program to be successful, it is important that local women are comfortable with staff practices. For many Boholano women, who have been brought up to be modest, especially in the presence of men, IUD insertions performed by doctors, the majority of who are males, are unacceptable. The study further noted that getting local acceptance of the IUD is not easy. However, by using trained nurses and midwives who are gentle, familiar to and trusted by women, and willing to do insertions in the home has made the method much more acceptable to Boholano women” (Saniel, 1979).

Although no significant differences were found between physicians and nurses or midwives in IUD discontinuations due to expulsion, removal, or pregnancy, nurses and midwives had significantly fewer losses to follow up; greater total number of referrals; and more follow-up contact with their clients (Eren, Ramos, and Gray, 1983). A past Philippine project indicated that an insufficient supply of anatomical models with which to practice IUD insertion hampered the skills-acquisition stage of IUD training (Finger, 1996).
C. USE

General family-planning knowledge, attitudes, and practices of women

In 2004, the number of Filipino women of reproductive ages was 20.869 million; among these, 12.202 million were currently married women (CMW) (Family Planning Survey, or FPS, 2004). Over a five-year period, there was only slight growth in the numbers of women of reproductive age and CMW (Table 2.5).

The 2003 National Demographic Health Survey (NDHS) results revealed that all women and currently married women preferred ideal family sizes of 3.0 and 3.2 children, respectively. Women’s desired family size was found to have also been preferred by their husbands in two out of three instances. Approval of family planning is nearly universal among Filipinos (Agence France-Presse, 2004). Specific to family-planning methods, a 1993 survey similarly disclosed a markedly favorable attitude: 72 percent of husbands and 77 percent of wives strongly approved of contraception (Casterline et al, 1997).

The NDHS further indicates that there is universal knowledge of family-planning methods among Filipino women and men. Between modern and traditional methods, more women and men are aware of the former than the latter. Knowledge of the IUD is high: 83.6 percent for all women and 91.0 percent for currently married women. Among men, the figures are 64.1 percent and 75.2 percent, respectively.

TABLE 2.5. CONTRACEPTIVE PREVALENCE AMONG WOMEN OF REPRODUCTIVE AGE (WRA) AND MARRIED WOMEN OF REPRODUCTIVE AGE (MWRA) IN 2004 AND EARLIER YEARS

<table>
<thead>
<tr>
<th></th>
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<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Women of reproductive age (in millions)</td>
<td>20.8</td>
<td>20.5</td>
<td>20.0</td>
<td>19.5</td>
<td>19.1</td>
</tr>
<tr>
<td>MWRA (in millions)</td>
<td>12.2</td>
<td>11.6</td>
<td>11.3</td>
<td>11.0</td>
<td>11.1</td>
</tr>
<tr>
<td>Women currently using contraception (in %)</td>
<td>29.6 (WRA)</td>
<td>28.0 (WRA)</td>
<td>28.5 (WRA)</td>
<td>27.1 (WRA)</td>
<td>28.9 (WRA)</td>
</tr>
<tr>
<td></td>
<td>49.3 (MWRA)</td>
<td>48.8 (MWRA)</td>
<td>49.5 (MWRA)</td>
<td>47.0 (MWRA)</td>
<td>49.3 (MWRA)</td>
</tr>
</tbody>
</table>


Based on the 2004 FPS, the current contraceptive prevalence rate is 49.3 percent (6.02 million) of currently married women use a family planning method (Table 2.5). As the table further shows, the 2004 figures are similar to those found in previous years, which means that family-planning method use has not seen considerable increase for some time. Conversely, 51.7 percent, or 6.18 million CMW, are not using any method. Among current users, 35.1 percent (4.0 million) used any modern method,
compared to the 14.2 percent (2.0 million) of traditional-method users. Among non-method users, 39.8 percent (2.46 million) intend to use a method in the future. Total unmet need for family-planning services in the Philippines — referring to the percentage of CMW who either do not want any more children or want to wait before having their next child, but are not using any method — stands at 20.6 percent, or 2.51 million (broken down into 10.8 percent for spacing births and 9.7 percent for limiting births) (FPS, 2004).

Current users and non-users
The percentages of current-user CMW who have used the device for a decade (1995-2004) have ranged only from three to four percent, or 180,000 to 240,000 women (Table 2.6). (Across five years, as Table 2.6 indicates, the prevalence of other methods — the pill, injectables, condoms, calendar/rhythm, and withdrawal — also has not increased). There was a greater proportion of current IUD users among CMW than among all women (married and unmarried). Among all eight types of modern-method users, current IUD users ranked third in terms of their percentage share among all users, outnumbered by current pill (13.2 percent or 800,000) and female sterilization adopters (10.5 percent or 630,000); the percentages of injectables and male condom-users were 3.1 percent (186,000) and 1.9 percent (114,000), respectively.

TABLE 2.6. TRENDS IN IUD USE (1995-2004) AND IN THE USE OF OTHER METHODS: PERCENTAGES OF CURRENTLY MARRIED WOMEN CURRENTLY USING METHODS (%)

<table>
<thead>
<tr>
<th></th>
<th></th>
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<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>4.1*</td>
<td>3.9**</td>
</tr>
<tr>
<td>OTHER METHODS</td>
<td>Pill</td>
<td>13.1</td>
<td>13.7</td>
<td>14.1</td>
<td>13.2</td>
<td>15.6</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Injectables</td>
<td>2.7</td>
<td>2.5</td>
<td>2.8</td>
<td>3.1</td>
<td>3.6</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Condom</td>
<td>1.7</td>
<td>1.3</td>
<td>1.7</td>
<td>1.9</td>
<td>2.1</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Calendar/rhythm</td>
<td>9.6</td>
<td>9.5</td>
<td>10.4</td>
<td>6.7</td>
<td>6.9</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Withdrawal</td>
<td>6.7</td>
<td>4.8</td>
<td>5.6</td>
<td>8.2</td>
<td>6.8</td>
<td></td>
</tr>
</tbody>
</table>

For all women, the figures are 2.6%* and 2.3%**

In private Well-Family Midwife Clinics, however, a majority of clients (51.1 percent) are IUD users (the pill is second); in fact, in four NGO clinics, IUDs are the most popular (Lamberte, 1999). In the 1970s, among the family-planning method acceptors at the Jose Fabella Memorial Hospital, 90 percent were IUD users (1,800 women involving immediate and non-immediate post-abortal and postpartum acceptors, and non-acceptors) (Iglesias, 1977). According to a Population Council study (1998), women accepted the IUD primarily because they wanted to limit or space the
number of their children. The study further points out that IUD is an option for older women with many children because of some health-related problems barring them from using hormonal contraceptives or due to the side effects of the other methods they used.

IUD is not the first-choice method for many women: Two-thirds of privately served IUD users (67.7 percent), for example, are previous users of pills, injectables, or natural family-planning methods (Lamberte, 1999). According to a qualitative study, IUD is not women’s first choice or is not chosen by most women because is thought that IUDs ”would prevent a woman from working in the wet rice paddies,” “it might be expelled during menstruation,” “it may hurt or harm the penis of their husbands during intercourse;” or “it might hurt to have it put in” (Henry, 2001), or it might expose the uterus to the cold (The Social Acceptance Project — Family Planning, undated).

Source of IUDs currently used, quality of service, and informed choice

Current users most recently obtained their IUDs from the public sector (80.1 percent), which includes government hospitals, rural and urban health centers, barangay service point officers, and barangay health stations. To a far lesser extent, the private sector (18 percent) (private hospitals and clinics, pharmacies, private doctors, nurses, and midwives, and industry-based clinics), the church (1.7 percent), and puericulture centers (0.2 percent) represent the other most recent sources of IUDs. Between the public and private sectors, the latter is perceived to be superior in terms of infrastructure, equipment, supplies, and quality of care (Population Council, 2001). In terms of total quality, only slightly more than a third of family-planning clients receive “high quality care” (Javier, undated). There has been an increase in the use of the private sector for family-planning services since 1998 (NSO, DOH, and OCR Macro, 1999). Of current IUD users, 43.6 percent were informed by their initial method source (private or public) about the side effects or problems of the method used, 42.1 percent about what to do if they experienced side effects, and 45 percent about other possible methods.

Profile of currently married IUD users

The 2003 NDHS showed that the high percentages of currently married IUD users are found in Northern Mindanao (8.9 percent), Davao (8.4 percent), SOCCSKSARGEN (8.4 percent), Caraga (7.7 percent) and Cagayan Valley (7.1 percent). Moderate numbers come from Central Visayas (6.2 percent) and Zamboanga Peninsula (6.1 percent). The low percentages are in CALABARZON (3.8 percent), Western Visayas (3.6 percent) and National Capital Region (3.3 percent), among other sites. Similar patterns of geographic distribution are evident in the 2004 FPS.

Characteristics of currently married current IUD users, based on NDHS and FPS data (Table 2.7), include:

- Most are aged 25 and older.
• They come from either urban or rural areas.
• They have one to two or three to four children.
• Most have elementary or secondary education.
• They are engaged in either gainful or non-gainful occupations.
• While their wealth index quintile ranges from lowest to highest, their socioeconomic status was more likely to be non-poor than poor.

TABLE 2.7. DEMOGRAPHICS OF CURRENTLY MARRIED CURRENT IUD AND PILL USERS

<table>
<thead>
<tr>
<th>CHARACTERISTICS OF IUD USERS</th>
<th>2003 NDHS</th>
<th>CHARACTERISTICS OF IUD USERS</th>
<th>2004 FPS</th>
<th>CHARACTERISTICS OF PILL USERS</th>
<th>2004 FPS</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Age group</strong></td>
<td></td>
<td><strong>Age group</strong></td>
<td></td>
<td><strong>Age group</strong></td>
<td></td>
</tr>
<tr>
<td>15-19</td>
<td>2.4</td>
<td>15-19</td>
<td>0.44</td>
<td>15-19</td>
<td>1.5</td>
</tr>
<tr>
<td>20-24</td>
<td>14.2</td>
<td>20-24</td>
<td>11.3</td>
<td>20-24</td>
<td>16.1</td>
</tr>
<tr>
<td>30-34</td>
<td>25.2</td>
<td>30-34</td>
<td>26.2</td>
<td>30-34</td>
<td>26.5</td>
</tr>
<tr>
<td>35-39</td>
<td>18.8</td>
<td>35-39</td>
<td>20.0</td>
<td>35-39</td>
<td>17.8</td>
</tr>
<tr>
<td>40-44</td>
<td>14.7</td>
<td>40-44</td>
<td>15.1</td>
<td>40-44</td>
<td>7.9</td>
</tr>
<tr>
<td>45-49</td>
<td>5.5</td>
<td>45-49</td>
<td>5.2</td>
<td>45-49</td>
<td>1.6</td>
</tr>
<tr>
<td><strong>Residence</strong></td>
<td></td>
<td><strong>Residence</strong></td>
<td></td>
<td><strong>Residence</strong></td>
<td></td>
</tr>
<tr>
<td>Urban</td>
<td>46.3</td>
<td>Urban</td>
<td>44.3</td>
<td>Urban</td>
<td>48</td>
</tr>
<tr>
<td>Rural</td>
<td>53.7</td>
<td>Rural</td>
<td>55.7</td>
<td>Rural</td>
<td>52</td>
</tr>
<tr>
<td><strong>Living children</strong></td>
<td></td>
<td><strong>Number of children ever born</strong></td>
<td></td>
<td><strong>Number of children ever born</strong></td>
<td></td>
</tr>
<tr>
<td>1-2</td>
<td>41.0</td>
<td>1-2</td>
<td>41.3</td>
<td>0</td>
<td>0.1</td>
</tr>
<tr>
<td>3-4</td>
<td>43.3</td>
<td>3-4</td>
<td>36.4</td>
<td>1-2</td>
<td>49.9</td>
</tr>
<tr>
<td>5+</td>
<td>15.7</td>
<td>5+</td>
<td>22.3</td>
<td>3-4</td>
<td>34.9</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>5+</td>
<td>15.1</td>
</tr>
<tr>
<td><strong>Education</strong></td>
<td></td>
<td><strong>Highest grade completed</strong></td>
<td></td>
<td><strong>Highest grade completed</strong></td>
<td></td>
</tr>
<tr>
<td>Elementary</td>
<td>30.7</td>
<td>None</td>
<td>0.44</td>
<td>None</td>
<td>0.7</td>
</tr>
<tr>
<td>High school</td>
<td>47.1</td>
<td>Elementary</td>
<td>27.4</td>
<td>Elementary</td>
<td>24.8</td>
</tr>
<tr>
<td>College or higher</td>
<td>22.2</td>
<td>High school</td>
<td>45.0</td>
<td>High school</td>
<td>48.5</td>
</tr>
<tr>
<td></td>
<td></td>
<td>College or higher</td>
<td>27.2</td>
<td>College or higher</td>
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<td><strong>Occupation</strong></td>
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<td><strong>Occupation</strong></td>
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<tr>
<td>Gainful</td>
<td>NA</td>
<td>Gainful</td>
<td>49.9</td>
<td>Gainful</td>
<td>44.2</td>
</tr>
<tr>
<td>Non-gainful</td>
<td></td>
<td>Non-gainful</td>
<td>50.1</td>
<td>Non-gainful</td>
<td>55.8</td>
</tr>
<tr>
<td><strong>Wealth index</strong></td>
<td></td>
<td><strong>Socioeconomic status</strong></td>
<td></td>
<td><strong>Socioeconomic status</strong></td>
<td></td>
</tr>
<tr>
<td>Lowest</td>
<td>16.9</td>
<td>Poor</td>
<td>34.3</td>
<td>Poor</td>
<td>32.4</td>
</tr>
<tr>
<td>Second</td>
<td>26.1</td>
<td>Non-poor</td>
<td>65.7</td>
<td>Non-poor</td>
<td>67.6</td>
</tr>
<tr>
<td>Middle</td>
<td>23.2</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
It should be noted that the aforementioned characteristics of IUD users also apply to pill users (Table 2.7). While the 2003 NDHS and 2004 FPS data do not clearly point to the predominant characteristics of IUD users, earlier and more detailed analyses of the profiles of IUD acceptors provide some hints. For example, an analysis of the 1998 NDHS (Po, 2001) found:

- IUD acceptors are most often aged 26 to 30,
- Catholic women, particularly those residing in Mindanao, were more likely to use the method than non-Catholics, and
- Women who prefer IUDs are willing to travel one hour to their source of the method.

Another study in the 1970s concluded that the IUD was used primarily by older women with three or more children (Ballweg, 1972).

**Discontinuers and reasons for discontinuation**

The percentage of IUD users who discontinued the method within 12 months since its first adoption is 14 percent, the lowest rate among other modern methods (condom at 58 percent, injectables at 52.7 percent, and pill at 39.2 percent). Of all method users who discontinued within five years of the survey, only 4.3 percent (n=181) were IUD users; 35.8 percent (n=1,494) and 12.6 percent (n=525) were pill and injectable users, respectively. The most frequently reported reason for discontinuing IUD use was side effects (32.0 percent), which, along with health concerns (16.8 percent), may include an increase in menstrual flow, dizziness, and abdominal pain and cramps, according to the findings of a qualitative study (Henry, 2001). Method failure and husband disapproval are not primary reasons for discontinuation, as these represent only 4.5 percent and 3.2 percent, respectively, of all reported reasons. No one mentioned cost or accessibility as a cause of discontinuing IUD use.

**Intenders and switchers and willingness to pay**

There are 320,000 potential IUD intenders from two groups of women. Among CMW with unmet need (2.51 million), 120,000 (or 4.9 percent) intend to use the IUD either for spacing or limiting births (NDHS, 2003). Among CMW who are not using any method but intend to use one in the future, 200,000 (or 8.1 percent) also intend to adopt the device (NDHS, 2003). Among both groups of women, however, the IUD ranked only third or fourth among all modern methods they intend to use. The pill, injectables, and male condoms are the top three methods (in that order) they chose.
There are 71,400 potential IUD switchers from two groups of women. The first group, CMW currently using modern methods with an expressed preference for the IUD as a future method, is comprised of:

- 30,400 (1.6 percent) of the 1.9 million currently married pill users,
- 8,000 (1.8 percent) of the 440,000 currently married injectable users,
- 5,700 (2.2 percent) of the 260,000 currently married condom users, and
- 2,400 (5.4 percent) of the 46,000 currently married users of natural family planning methods (mucus/bbt/stm, standard days, and LAM).

The second group, CMW currently using traditional methods with a preference for the IUD as a future method, is comprised of:

- 13,400 (1.6 percent) of the 842,000 currently married users of periodic abstinence, and
- 11,500 (1.4 percent) of the 827,000 currently married users of withdrawal.

The total of intenders and switchers is 391,400 potential new IUD users.

Among CMW who intend to use the IUD, husband/partner opposition, cost, and access are not issues against the device, as these factors represent only between 0.4 percent and 3.7 percent of all the mentioned reasons. Regarding cost, most (79.5 percent) are willing to pay an average of 216 pesos for an IUD. Non-use of contraception is related generally with the method, particularly with its health concerns and fear of side effects (NDHS, 2003 and FPS, 2004).

D. A COMPARATIVE STUDY OF IUD PROVISION IN HIGH-VERSUS LOW-PREVALENCE SITES (POPULATION COUNCIL, 1998)

In the late 1990s, the Population Council/Manila investigated the factors influencing high and low levels of IUD use by comparing Misamis Oriental (high prevalence at 30.5 percent) and Iloilo (low at 2.8 percent). The study employed modified situation analysis of 77 service-delivery points (51 for Iloilo and 26 for Misamis Oriental), with physicians and non-physicians as respondents.

Findings indicate that the high-prevalence site of Misamis Oriental “has come out to be clearly and consistently better” than Iloilo in terms of physical infrastructure, technical capability of personnel, and availability of services (Table 2.8). Misamis Oriental was also better in that more of its service providers regarded the adherence to pre-insertion protocols as essential (Table 2.9); were more knowledgeable of side effects; and fewer providers would impose their religious convictions on IUD use.

Both sites, however, were similar with reference to their providers’ knowledge of when to insert the IUD (Table 2.10), under what conditions its insertion is not
acceptable (Tables 2.11), and quality of service (Table 2.8). Moreover, they were also identical in that a fairly equal number of providers from both sites agreed that reproductive-tract infection/sexually transmitted infection (RTI/STI) examination is not an important procedure before the device is inserted. They are also placing restrictions on who can use IUD, based on factors such as age and number of children (with at least one child).

Although the two sites differed in some ways, their IUD users were satisfied with the service they received from health providers. Services were not only seen as friendly and accommodating, but also lauded because they were free. However, participants, from both study sites said that the clinical procedures done to them were inadequate. Women also voiced their willingness to give donations or even pay for the cost of family-planning methods if they are for sale.

**TABLE 2.8. COMPARATIVE RESULTS OF HIGH- AND LOW-PREVALENCE SITES ACROSS A NUMBER OF INDICATORS**

<table>
<thead>
<tr>
<th>MAJOR AREAS AND INDICATORS</th>
<th>MISAMIS ORIENTAL</th>
<th>ILOILO</th>
</tr>
</thead>
<tbody>
<tr>
<td>A. Physical infrastructure: adequate and clean water, working toilets, separate examination rooms, and well-supplied with IUD equipment and supplies.</td>
<td>+</td>
<td>–</td>
</tr>
<tr>
<td>B. Technical capability of service providers: more years of family-planning provision experience, higher proportion of trained (in insertion and removal) and practicing certified providers, 100% of all certified providers insert IUDs.</td>
<td>+</td>
<td>–</td>
</tr>
<tr>
<td>C. Availability of services: wider array of FP/RH services, IUD services are one of four services provided every day.</td>
<td>+</td>
<td>–</td>
</tr>
<tr>
<td>D. Quality of service: friendly and accommodating, free service or voluntary donation (10-20 pesos).</td>
<td>+</td>
<td>+</td>
</tr>
<tr>
<td>E. Medical and provider barriers: Adherence to procedures and test before IUD insertion is considered essential. RTI/STI screening is considered an important part of the procedure.</td>
<td>+</td>
<td>–</td>
</tr>
</tbody>
</table>


**TABLE 2.9. PROVIDERS REPORTING THAT PARTICULAR PROCEDURES SHOULD BE FOLLOWED BEFORE IUD INSERTION (%)**

<table>
<thead>
<tr>
<th>PROCEDURES</th>
<th>MISAMIS ORIENTAL</th>
<th>ILOILO</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Medical history</td>
<td>90</td>
<td>69</td>
</tr>
<tr>
<td>2. Blood pressure</td>
<td>80</td>
<td>42</td>
</tr>
<tr>
<td>3. Pelvic examination</td>
<td>84</td>
<td>72</td>
</tr>
<tr>
<td>4. Breast examination</td>
<td>86</td>
<td>54</td>
</tr>
<tr>
<td>5. Urine/blood/pregnancy lab tests</td>
<td>33</td>
<td>18</td>
</tr>
<tr>
<td>6. RTI/STD screening</td>
<td>25</td>
<td>11</td>
</tr>
<tr>
<td>7. Sepsis/anti-sepsis examination</td>
<td>11</td>
<td>25</td>
</tr>
<tr>
<td>8. Pap smear/gram staining</td>
<td>8</td>
<td>28</td>
</tr>
<tr>
<td>9. Uterus exam</td>
<td>6</td>
<td>16</td>
</tr>
</tbody>
</table>
## TABLE 2.10. PROVIDER KNOWLEDGE OF WHEN TO INSERT IUD (%)

<table>
<thead>
<tr>
<th>CONDITIONS</th>
<th>MISAMIS ORIENTAL</th>
<th>ILOILO</th>
</tr>
</thead>
<tbody>
<tr>
<td>An IUD can be inserted:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1. Any time as long as the woman is not pregnant.</td>
<td>74</td>
<td>78</td>
</tr>
<tr>
<td>2. Any time during the menstrual cycle.</td>
<td>82</td>
<td>86</td>
</tr>
<tr>
<td>3. Within 48 hours of delivery.</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>4. 4-6 weeks or 6-8 weeks postpartum.</td>
<td>8</td>
<td>5</td>
</tr>
<tr>
<td>5. If size of uterus is 6.5 cm.</td>
<td>67</td>
<td>10</td>
</tr>
<tr>
<td>6. No abnormalities during physical exam.</td>
<td>4</td>
<td>9</td>
</tr>
</tbody>
</table>


## TABLE 2.11. PROVIDER KNOWLEDGE OF WHEN NOT TO INSERT IUD (%)

<table>
<thead>
<tr>
<th>CONDITIONS</th>
<th>MISAMIS ORIENTAL</th>
<th>ILOILO</th>
</tr>
</thead>
<tbody>
<tr>
<td>An IUD cannot be inserted:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1. When high risks for STIs are present.</td>
<td>87</td>
<td>88</td>
</tr>
<tr>
<td>2. When heavy menstrual bleeding with clinical signs of anemia is present.</td>
<td>91</td>
<td>93</td>
</tr>
<tr>
<td>3. Between 48 hours and 4 weeks postpartum.</td>
<td>91</td>
<td>55</td>
</tr>
<tr>
<td>4. When high risk of HIV or HIV/AIDS infection is present.</td>
<td>90</td>
<td>91</td>
</tr>
<tr>
<td>5. When benign trophoblasa disease is present.</td>
<td>94</td>
<td>93</td>
</tr>
<tr>
<td>6. When pregnancy is present.</td>
<td>99</td>
<td>100</td>
</tr>
<tr>
<td>7. When a woman has active STI or PID within past 3 months.</td>
<td>99</td>
<td>99</td>
</tr>
<tr>
<td>8. When she has sepsis following childbirth or abortion.</td>
<td>98</td>
<td>98</td>
</tr>
<tr>
<td>9. When she has abnormal vaginal bleeding.</td>
<td>99</td>
<td>100</td>
</tr>
<tr>
<td>10. When has severely distorted uterine cavity.</td>
<td>100</td>
<td>99</td>
</tr>
<tr>
<td>11. When she has cervical-endometrial or ovarian cancer.</td>
<td>100</td>
<td>100</td>
</tr>
<tr>
<td>12. When she has pelvic tuberculosis.</td>
<td>100</td>
<td>98</td>
</tr>
</tbody>
</table>

SUMMARY

Supply
- IUD supply in the Philippines has come primarily from USAID donations, which have been distributed through the public sector. All donated supplies have been consumed at no cost to users.

Provision
- IUD-related knowledge, attitudes, and practices among the providers interviewed are far from uniform. There are geographic areas and instances in which IUDs have been provided in high-quality terms.

Use
- Current demand for and use of the IUD has been limited at three to four percent; the lack of dramatic increase in IUD demand and use is a phenomenon which is also true for the pill, injectables, and condoms.
- Despite low IUD prevalence, users seldom stop using the device; those who discontinue do so for reasons of health and side effects.
- IUD users were found to have similar demographic characteristics as those using the pill.
- Among current method and non-method users, there exists a potential demand for and use of the IUD — intenders and switchers are estimated at 391,400.
III. PROVIDER ATTITUDES, PRACTICES, AND EXPERIENCES IN IUD PROVISION: FINDINGS FROM PERSONAL INTERVIEWS

A total of 87 IUD providers (7 GP, 39 MW, 16 FM, and 25 OB-GYNE) from the private and public sectors (except for GPs, who were overwhelmingly public providers) were interviewed. In some analyses, these providers were grouped into two categories (GP/FM/OB-GYNE and MW) and compared. In most instances, because of similarities in their responses, both categories are referred to in the discussion as “providers.” Providers were aged between 29 and 69, and most were female (90 percent) and with private or public hospitals, clinics, and rural health centers. Respondents have been providing IUD services for between one and 35 years.

A. FAMILY-PLANNING AND IUD-RELATED ATTITUDES AND PRACTICES

The providers interviewed all accepted family planning and, without reservation, consider it important because “it helps the country control its population,” “enables the couples to feed and educate their children well,” and “offers couples and individuals, especially women, an opportunity to plan their future to ensure quality of life.”

Regarding their attitudes toward the IUD, almost all providers were accepting of the method, calling it excellent or one of the best methods because it is:

- **Effective** — it prevents pregnancy with 98-99 percent effectiveness.
- **Long-term and permanent** — once it is inserted, it stays inside the sex organ for years.
- **Convenient** — it is inserted only once and does not need to be used before sexual intercourse (like the condom) or taken every day (like the pill) and it does not require compliance, making it suitable for working women.
- **Safe** — side effects are not systemic, so it is suitable for breastfeeding women.
• **Immediately reversible** — a user can easily have the device removed if pregnancy is desired.

• **Inexpensive and cost-effective** — the method is less costly because one insertion lasts years.

Providers with positive attitudes toward the IUD, as well as the few others with negative attitudes (because of their own clients’ experiences with it), also cited the disadvantages of the method, indicating that its use can cause:

• Pronounced body changes (heavy, prolonged, and painful menstruation; cervical irritation; and abdominal pain)

• Pain to the user and her husband/partner during sexual intercourse

• Ectopic pregnancies

Particularly for the few holding negative attitudes toward the IUD, they mentioned the device’s abortifacient properties as a disadvantage. Other providers stated additional disadvantages of the IUD, including that it does not protect women from HIV and AIDS; it consumes a provider’s time during insertion; it gets expelled at times; and it is inconvenient because it requires a series of regular check-ups. When providers were asked to assess and compare the advantages and disadvantages of the IUD, they overwhelmingly indicated that its use has more of the former than the latter. Some underscored that while there are disadvantages, they are manageable and tolerable, indicating, for example, that heavy menstruation is not a regular occurrence and that abdominal pain and menstrual cramps can be treated.

Of the 87 providers, two-thirds (60) — from both the private and public sectors — had ever used effective modern family-planning methods, the most common being the IUD and the pill (Table 3.1). Of the 30 providers who used the IUD, about two-thirds were midwives. Respondents used family-planning methods for a period ranging from one week to 29 years. Between the IUD and the pill, the former had longer usage duration (eight months to 22 years vs. one week to 13 years).

**TABLE 3.1 FAMILY PLANNING METHODS EVER USED BY PROVIDERS**

<table>
<thead>
<tr>
<th>METHODS</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Intrauterine device</td>
<td>30</td>
</tr>
<tr>
<td>Pill</td>
<td>28</td>
</tr>
<tr>
<td>Ligation</td>
<td>13</td>
</tr>
<tr>
<td>Natural family planning (rhythm and cervical mucus)</td>
<td>12</td>
</tr>
<tr>
<td>Condom</td>
<td>10</td>
</tr>
<tr>
<td>Injectable</td>
<td>9</td>
</tr>
</tbody>
</table>

*Multiple responses (n=60)
Generally, providers had positive experiences with the methods they used, saying that they did not encounter any problems or that any problems (for example, nausea and headaches while on the pill) were tolerable and manageable. Specific to IUD use, only eight of the 30 providers had negative experiences with the method. These included body changes (profuse, heavy, and prolonged menstruation; menstrual pain; dysmenorrhea; skin rashes; and infection), effects on husbands/male partners (pain during sexual intercourse), expulsion, and pregnancy. Compared to the number of dissatisfied IUD users among the providers, the number of dissatisfied pill users was greater (8 vs. 14). Half of the 28 pill users had negative experiences while they were using the method, perceiving its use as inconvenient and the cause of pronounced body changes, such as headache, dizziness, or nausea; vomiting; hunger; bloating; weight gain; skin rashes; leg cramps; heavy menstrual bleeding; or dryness. The providers who did not use any family-planning method at all cited reasons such as: “were single or separated,” “already menopausal,” “have difficulty in getting pregnant,” or “pro-life.”

B. IUD-PROVISION TRAINING, GUIDELINES, AND CLIENT-SELECTION CRITERIA

Almost all providers had formal training on the IUD — primarily basic comprehensive training, as well as OB/GYNE residency training and competency-based training. In terms of family-planning counseling, the 87 providers were almost equally divided into those who had and those who had not attended such training. While a handful had taken training activities within the last five years, the majority were trained more than 20 years ago. Respondents attended training programs organized chiefly by the DOH, and to a degree, by NGOs and local government units and during their residencies. A little more than half reported having received updates on the IUD from seminars, lectures, and conferences.

Only a third of the 87 providers had a copy of the DOH’s IUD Policies and Guidelines. Apart from the DOH document, these providers — along with others who had no such document — were guided by other protocols, primarily by the Family Planning Training Manual, and to a degree, by the Family Planning Clinical Standards Manual and the OB/GYNE Book.

Of the 87 providers, more than half (50) would recommend the IUD only to select types of women. Among the 50, there were more medical providers (31) than midwives (19). The remaining third of the 87 providers clarified that it was their practice not to recommend the IUD to particular groups of women; they said that they offer women information on all family-planning methods and let them decide which methods to use. To some of these providers, the IUD is not for a particular set of women, but, in fact, in the words of one provider “any woman can use the IUD.”

Among the providers who recommended the device only to particular groups of women, their criteria were many and varied. Among their reported criteria, the most common related to a woman’s family-planning method use and preference, followed with her socio-economic characteristics and fertility status (Table 3.2). There were
other instances in which providers would not recommend the IUD, such as the user’s physical and medical condition (Table 3.2).

**TABLE 3.2 CRITERIA ON WHICH PROVIDERS BASE THEIR DECISION TO RECOMMEND OR NOT TO RECOMMEND THE IUD TO WOMEN**

<table>
<thead>
<tr>
<th>WOULD RECOMMEND BASED ON:</th>
<th>WOULD NOT RECOMMEND BASED ON:</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>I. Socio-economic characteristics</strong></td>
<td><strong>I. Socio-economic characteristics</strong></td>
</tr>
<tr>
<td>a. Age (35 years and above)</td>
<td>a. Type of work (if engaged in lifting heavy objects)</td>
</tr>
<tr>
<td>b. Education (high education)</td>
<td>b. Is engaged in commercial sex work</td>
</tr>
<tr>
<td>c. Income status (low)</td>
<td></td>
</tr>
<tr>
<td>d. Work status (employed/busy)</td>
<td></td>
</tr>
<tr>
<td><strong>II. Fertility status</strong></td>
<td><strong>II. Fertility status</strong></td>
</tr>
<tr>
<td>a. Proven fertility (has a child already)</td>
<td>a. Number of children (has only one child)</td>
</tr>
<tr>
<td>b. Number of children (has at least two children)</td>
<td></td>
</tr>
<tr>
<td>c. Completed family size</td>
<td></td>
</tr>
<tr>
<td>d. Postpartum status (just delivered a baby)</td>
<td></td>
</tr>
<tr>
<td><strong>III. Medical conditions</strong></td>
<td><strong>III. Medical conditions</strong></td>
</tr>
<tr>
<td>a. Is hypertensive</td>
<td>a. Pallor/anemic</td>
</tr>
<tr>
<td>b. Has varicose veins</td>
<td>b. Has weak body</td>
</tr>
<tr>
<td>c. Has high blood pressure</td>
<td>c. Has history of ectopic pregnancy</td>
</tr>
<tr>
<td>d. Has hormonal problem</td>
<td>d. Has history of cervical infections</td>
</tr>
<tr>
<td>e. Has difficulty in pregnancy</td>
<td>e. Has history of sexually transmitted infections</td>
</tr>
<tr>
<td><strong>IV. Family planning method use and preference</strong></td>
<td><strong>IV. Family planning method use and preference</strong></td>
</tr>
<tr>
<td>a. Has family-planning history</td>
<td>a. Has family-planning history</td>
</tr>
<tr>
<td>b. Wants 2 years’ or longer birth spacing</td>
<td>b. Wants 2 years’ or longer birth spacing</td>
</tr>
<tr>
<td>c. Has difficulty in complying with other methods’ requirements, such as the pill’s daily intake</td>
<td>c. Has difficulty in complying with other methods’ requirements, such as the pill’s daily intake</td>
</tr>
<tr>
<td>d. Has negative knowledge about and experience (such as side effects) with other methods</td>
<td>d. Has negative knowledge about and experience (such as side effects) with other methods</td>
</tr>
<tr>
<td>e. Wants a method that is long-acting and without contraindications</td>
<td>e. Wants a method that is long-acting and without contraindications</td>
</tr>
<tr>
<td><strong>V. Practices and lifestyle</strong></td>
<td><strong>V. Practices and lifestyle</strong></td>
</tr>
<tr>
<td>a. Is sexually active</td>
<td>a. Has multiple sexual partners</td>
</tr>
<tr>
<td>b. Has good hygiene habits</td>
<td>b. Has poor hygiene habits</td>
</tr>
<tr>
<td>c. Is breastfeeding</td>
<td>c. Husband has other sexual partners</td>
</tr>
</tbody>
</table>
C. SOURCES AND PRICING OF IUD PROVISION; PHILHEALTH ACCREDITATION

Providers get their IUD supplies not from any foreign source but from three major local sources: 1) the rural health unit, city health office, or local government unit (51.7 percent); 2) NGOs (such as the FPOP, the Friendly Care, and the Philippine NGO Council on Population and Development) (26.4 percent); and 3) the Department of Health (23.1 percent). Three providers reported having clients who brought their own IUDs for insertion; two of these providers recalled that their clients had IUDs imported from Canada, branded as Graviguard; the third provider could not remember any details of the client’s personally supplied IUD.

Almost all of the 87 providers interviewed did not know of any commercial brand of IUD sold in the market. However, almost all acknowledged that they would prescribe one particular brand of IUD, the CuT380-A. About half of them, especially those in the public sector, get their IUD supplies for free from the above-mentioned sources; others, particularly those in the private sector, acquire the device at a price typically not exceeding 200 pesos each. Public providers do not charge clients for IUD insertion and removal. In contrast, private providers offer the IUD as a package of services (including a professional fee, commodity, counseling, physical exam, Pap smear, gram stain, and follow-up consultation) at a cost generally ranging from 100 to 500 pesos, with exceptions in the 1000-1500 peso range. (Some of these private providers indicated that they would offer their services for free to low-income clients). Concerned providers ranked these costs as lower than those charged by other providers within their area of operation.

About two-thirds of the 87 providers (64.4 percent), most of whom are medical doctors, were accredited by PhilHealth. Approximately the same proportion of the health facilities where these providers are affiliated (63.2 percent) are also accredited by PhilHealth. Of the 87 providers, only 21.8 percent were aware that IUD insertion and removal is covered by PhilHealth. Of those accredited and aware of PhilHealth’s coverage of IUD service, only four providers had applied for reimbursement.

D. IUD SERVICE PROVISION PRACTICES

In the five years prior to their interview, half of the 87 providers reported having fewer than 1,000 family-planning acceptors, while others had a thousand or more. The proportion of IUD users among family-planning clients differed from one provider to another. While 44 percent of the 87 providers estimated the proportion of their IUD users to be between 1-20 percent (for providers with a thousand family planning acceptors, this would be 10-200 IUD users), roughly the same percentage of providers (40 percent) reported the proportion of their IUD users to range from 21-40 percent (for providers with a thousand family planning acceptors, this would be 210-400 IUD users). A handful of respondents indicated even higher proportions.

Providers described their IUD users as in their early 20s to late 30s; with three to six children; having elementary, high school, or college education; A-E income classes;
and most were Roman Catholic (a few were members of a Christian church group, Protestant groups, and Islam). Users were not only walk-in clients: Most providers (82.8 percent) also received referrals from their personal networks (relatives, friends, and neighbors), private and public health systems (medical doctors, midwives, nurses, barangay health workers, IUD users, and traditional healers), and NGOs.

When women would visit the health facility, did they already have the IUD or any other family-planning method in mind? About three-fourths of the 87 providers estimated that only between one and 60 percent of women had already chosen the IUD on their visit to the facility; a far lesser proportion of providers (26.4 percent), however, reported 61-100 percent having already decided. Regarding family-planning methods, on the whole, about two-thirds stated that 41 to 100 percent of their family-planning acceptors would already be clear and definite as to the method they wanted to use; on the other hand, 39.1 percent of providers reported a lower figure (40 percent and below). Some providers explained that considerable numbers of family-planning users (including IUD acceptors) would come to use certain methods not because they had thought about them for a long time, but by chance. According to a provider’s account, when women are in the health facility for non-family planning-related medical consultations, they would come into contact with health providers who would then communicate information on family-planning methods, which would then result in women’s method practice. The provider also noted that during their visit, women were often accompanied by someone — a husband, relative, friend, neighbor, or child.

Pre-insertion and insertion phase

Whether or not women have already decided to use the IUD, many would ask questions about the device while visiting the health facility, according to providers. Their most frequent questions pertained to the IUD’s advantages and disadvantages. Their issues and concerns dealt with about the device’s effectiveness against pregnancy; safety (for instance, does it cause abdominal pain, cancer, myoma, or menstrual bleeding?); contraindications (does it affect breastfeeding women?); duration of use; cost; mechanism in preventing pregnancy; administration and procedure of insertion; pain during insertion and while in use (is it painful for the user and her husband/partner?); expulsion; and post-insertion requirements (how many times does a user have to undergo check-ups?). Some providers pointed out that many of the women’s concerns and questions on the IUD were based on hearsay.

In addressing women’s questions and concerns about the IUD, providers would inform and counsel women of the truth regarding the device. In particular, providers would explain the method’s mechanism, administration, and insertion; and its advantages and disadvantages (such as those mentioned on pp. 27-28). In the process, respondents would also debunk the myths the women previously believed. In explaining the IUD, particularly its disadvantages, providers would stress that:

- Every family-planning method, including the IUD, has a failure rate.
• Pain is a consequence when a foreign object, such as an IUD, is inserted inside the body, but that such pain can be managed and treated.

• There is no pain during insertion because it is done when the woman is menstruating and her cervix is open.

• Body changes, like heavy menstrual bleeding, are only temporary, and user can get used to it. And such changes do not occur to everyone.

• The IUD will not be expelled, but it can be removed anytime.

In emphasizing their points, some providers would use a cue card, chart, book, or other evidence; examples and analogies; or show an actual IUD and allow women to touch and feel it. Others would address women’s concerns point by point and would reassure them of the safety and effectiveness of the IUD and of the provider’s competence in inserting the device properly. Providers would also inform women that satisfaction with IUD use is also strongly contingent on the user’s adherence to the provider’s instructions.

Most providers (82.8 percent) would complete their information-giving and counseling in 30 minutes or less. However, not all providers would conduct counseling to all family-planning users. While most providers (85.1 percent) — both the medical doctors and midwives — would counsel (for the broad purpose of correcting women’s misconceptions regarding family planning), the remaining would not. In the latter’s words, counseling is unnecessary because women “already knew about family planning in general,” “it is not their first time to use a method,” and considered counseling as “too long” in light of the many clients they see in a day. A few of the family-medicine providers would refer women to midwives and nurses for counseling.

Providers reported that counseling has differing outcomes on a woman’s decision. While some women would have already decided to get an IUD after information-giving and counseling, others were not so sure. For the overwhelming majority of respondents, the issues serving as turning points for a woman’s decision on whether to use an IUD related with the method’s advantages and safety. They also said that the person to decide whether to use an IUD should be no one but the user herself. Providers did not think that husbands/male partners should make decisions about IUD acceptance. However, concurrence of husbands/partners was indicated as needed, though a far greater number of providers — including both the medical doctors and the midwives — would not require it as a condition for IUD insertion, compared to those who would require it (61.4 percent vs. 38.6 percent).

According to some of the providers who would require partner concurrence, agreement is important because it affects not only the user but also her husband/partner (“his sex organ will also come into contact with the device and he will complain”); he might get angry; and it might lead to legal action against the provider. Among some providers who would not require partner concurrence, they
stressed that it is not needed because “it is the woman’s choice and right to decide on what is best for her” and “it is her body.” One midwife mentioned that she would not ask for concurrence because the husband would not usually agree, while another said that the husband/partner would not usually come to the health facility.

Once the providers have gone through information-giving and counseling and have not met any problems, they would now ask about the woman’s medical conditions (see Table 3.2 for a list of specific medical conditions considered by providers). If the providers found no medical problems, 43.7 percent would then proceed to IUD insertion. However, for more than half of the 87 providers, the inquiry on the woman’s medical condition is not the end of the pre-insertion phase. They would still require the woman to undergo a medical procedure (such as physical examination, blood pressure examination, x-ray, thyroid panel, complete blood count, urinalysis, pregnancy test, or, most frequently, Pap smear) to rule out abnormalities such as cervical erosion, infection, pelvic inflammatory disease, or pregnancy. Some providers indicated they go through these procedures because they do not want to be blamed or sued, or that these are part of the service package or baseline information on the user. Both groups interviewed (medical doctors and midwives) are represented among the pre-insertion examination and no-examination groups.

Three-fourths of the 87 providers interviewed would insert the IUD in a separate room, contrasting the remaining one-fourth who would perform the procedure in a family planning, examination, pre-natal, or consultation room. Almost all (84 of 87 providers) would use the “old” IUD technique to insert the device, while the few others would use the “no-touch” technique. The difference between these two lies in the insertion of the IUD into the inserter. The “old” technique involves removal of the entire plastic cover of the sterile IUD before it is inserted. The “no-touch” technique entails the partial or half-way removal of the plastic cover, ensuring that the IUD is still inside the pack when it is inserted. Women are generally unaccompanied when undergoing IUD insertion.

Once the procedure is completed, almost all providers would dispense verbal instructions to the woman, stressing one or more of the following items:

- How to check if the IUD is positioned correctly (feel for the IUD string);
- The side effects that she may experience (such as heavy menstrual bleeding);
- Warning signs of serious side effects (such as continuous bleeding);
- What to do if these warning signs are observed (rest and avoid sexual contact, use home medication like pain relievers, and visit a health facility);
- Practices that should be done (such as maintaining personal hygiene) and avoided (abstain from sexual contact for 5-10 days and do not carry heavy objects); and
• Schedule post-insertion consultations (visit the clinic on a schedule — after a week, a month, three months, six months, a year, and then yearly thereafter).

Very few providers (four medical doctors and three midwives) would dispense written instructions to the client after her insertion. Three-fourths of the 87 providers (37 medical doctors and 28 midwives) would suggest home medication to IUD users who experience side effects. Furthermore, the prescribed schedule of post-insertion consultations differed from provider to provider, including the medical doctors and midwives. While some providers used the above schedule, others used a different schedule. To validate if the newly inserted IUD user has clearly understood the instructions, a provider would ask if she had questions or clarifications; if not, she would then be released.

Post-insertion phase

Reports tend to indicate that after insertion, the majority of IUD users return for their scheduled follow-up consultations, though some do not. Reflective of the differing schedules given to them by their providers, IUD users come for follow-up consultations on varied time schedules — for instance, after insertion, some would report after a week and others after a month or several months. In follow-ups, providers would usually interview users to determine the status, experience, and any problems; offer solutions; correct new or persistent misconceptions; and examine them to check that the IUD is in place and also to check for erosion. Providers would also reiterate the same instructions they gave immediately after insertion, including the warning signs of serious side effects and a schedule of follow-up consultations.

Providers’ clients tended to have three common complaints about the IUD: heavy menstrual bleeding (60.9 percent), abdominal pain (50.6 percent), and that her husband/partner feels a pricking pain in his penis during sexual intercourse. In addressing these complaints, a provider would do the following: 1) reassure clients that these are normal IUD side effects (and may disappear in time as the uterus adjusts to the device); 2) conduct examination of the sex organ and check the IUD and overall condition; 3) conduct a Pap smear; 4) offer medications and vitamins; 5) advise her husband/partner that the IUD string would soon be soft and cease to be painful to him; 6) advise that she bring her husband/partner to the facility for counseling; and 7) advise replacement of the IUD with a new one.

Almost all providers said that the steps they usually take to address complaints are taken well and confirm the user’s decision to continue with the IUD. However, for a handful of providers, despite reassurance and support, some of their users pursue their request for removal. Generally, providers report that the decision to have the IUD removed rests primarily on the client (79.3 percent) or on the husband/partner (36.8 percent). About 15 percent of providers mentioned that only they decide when a medical condition warrants removal.

In the past five years, all but eight of the providers had IUD users request removal of their IUDs. The number of removals varied: for about half of the 87 providers (53.2
percent), for example, the figure was between one and 10 users; and for the rest, the number ranged from 11 to 20 (20.3 percent) or higher. Removal was contingent on a range of factors and conditions: biological (menopausal); social/familial (had no husband/male partner anymore because he was abroad or dead or they had separated; or they wanted to have another child); and method-related (had serious side effects like infection, heavy menstrual bleeding, or menstrual cramps; or decided to switch to another method). According to the providers, among their clients who dropped the IUD in favor of another method, the pill was their first choice after the IUD, with injectables as a distant second choice.

E. RECOMMENDATIONS FOR ENCOURAGING MORE WOMEN TO USE THE IUD AND FOR IMPROVING THE IUD

Respondents said that more women would be encouraged to use the IUD if they were informed and educated about the method’s advantages and related misconceptions. In addition, they stated that women should be taught about human anatomy and physiology. In carrying these out, respondents suggested the use of interpersonal communication (such as one-on-one conversations with a medical doctor, midwife, nurse, satisfied IUD user, medical representative, or barangay health worker), groups (such as health classes and professional associations like Philippine Obstetrics and Gynecological Society (POGS), and the mass media. However, they pointed out that the IUD should be made affordable and readily available — for instance, in pharmacies. Respondents indicated that all providers as need regular updates on IUD promotion, counseling, and provision if they were to persuade more women to accept the method.

Of the 87 providers, one-fifth (17, or 19.5 percent) had recommendations to improving the design of the IUD, but most were happy with the Copper T they were currently providing at the time of the interview. Those with a suggestions for improvement mentioned that the IUD should be ‘S’ rather than ‘T’-shaped (“because it is easier to insert”), should be made of inert plastic, and should be treated with progestasert to prevent profuse menstrual bleeding among users.
SUMMARY

- For the most part, the providers interviewed — including the medical doctors and midwives — have favorable attitudes toward family-planning and the IUD.

- The providers have no recent training on IUD provision and are not guided by proper protocols. They have a range of selection criteria as to whom they recommend the IUD.

- The source of IUD supply among the providers (whether public or private) is public-health facilities. Private providers acquire each IUD unit from these sources for 200 pesos or less, and insert it at costs ranging from a low of 100 to 500 pesos to a high of 1,000 to 1,500.

- The providers’ clients do not come from any specific sociodemographic groups. They come to health facilities without the IUD or any specific family-planning method in mind.

- Prior to IUD insertion, providers first counsel clients using varying approaches and messages and then satisfy a range of other requirements (including medical examinations).

- After insertion, providers dispense instructions to clients, including post-insertion consultation schedules. Providers encourage home medication.

- After having had the IUD for a while, providers’ clients have three common complaints, mostly about side effects.

- Almost all providers have had clients request removal of their IUDs.

- Providers recommend that more women be educated about and given access to the IUD.

- Most providers are happy with the Copper T they were providing at the time of the interview.
As mentioned earlier, four categories of women were involved in discussions — current IUD users, former IUD users, intenders, and limiters. Two discussions were held for each of the four groups. Prior to the discussion, all women completed a two-page screening form and profile questionnaire, and the husbands/male partners of 15 of these women were also interviewed. This section presents data from the group discussions with the women, their completed forms, and discussions with the husbands/male partners.

A. PROFILE OF DISCUSSION PARTICIPANTS

In general, women were aged 21-54 (mean 32.7) and most were married, had high-school or college education, and were either housekeepers or workers (vendors, sales clerks, teachers, health workers, nurses, supervisors, managers, etc). Their husbands or male partners were 22 to 57 years old (mean 36.3), most of whom had either secondary or college education and worked as drivers, clerks, construction workers, seamen, businessmen, supervisors, managers, etc. The women had one to three children (mean 2.4), families with either one or two income earners (monthly family income is less than 20,000 pesos), and owned their homes.

B. CURRENT IUD USERS

Women who were using IUDs at the time of the study had been using the method for between two months and 25 years (mean 60 months). Almost all were users of the Copper T (TCu-200B); several were users of the Lippes loop or of both the loop and the Copper T. Except for a handful of women who were users of the IUD exclusively, most were previous, serial users of one to four other family-planning methods, such as the pill, injectables, condoms, or withdrawal. The duration of use of any of these four methods did not, in most instances, exceed 12 months. The IUD was the second, third, or fourth choice after the four other methods. Frequently, IUD use was immediately preceded by the pill or injectables. IUD repeaters — former IUD users who dropped out and returned to it again — were rare.
Reasons for using the IUD

Prior to adopting the IUD, current users learned about the method from individuals within their personal networks (sisters, sisters-in-law, mothers-in-law, relatives, friends, co-workers who were IUD users) and the health system (medical doctors, midwives, nurses, and barangay health workers). The pre-marriage family-planning counseling seminar was also a source of information.

Whether as their first or subsequent family-planning method, women used the IUD for a number of reasons. They were attracted to the IUD because of its advantages:

- **Effective** — it prevents pregnancy.
- **Long-term and permanent** — once inserted, it stays inside the sex organ for years.
- **Convenient** — it is inserted only once and does not need to be used before sexual intercourse (like the condom) or taken every day (like the pill).
- **Safe** — side effects are localized, felt only within the sex organ or lower extremities and do not affect the whole body and are felt only by the user herself (for example, an IUD does not affect a breastfeeding baby).
- **Immediate reversibility** — users can easily have the device removed if pregnancy is desired.
- **Inexpensive** — one IUD lasts for years.

The husbands/male partners of current users were also aware of some of the advantages. (One husband, for instance, reported of “his long-time knowledge of the effectiveness of the IUD against pregnancy,” while another talked about “the relative absence of serious side effects stemming from using the device”).

Women also adopted the IUD also because of the side effects they experienced with other family-planning methods. For example, previous pill users recounted that the nausea, headaches, irritability, reduced or irregular menstrual flow, daily oral intake, weight gain, and spotting that they had on the pill were intolerable; their recourse, therefore, was to shift to the IUD. These former pill users also selected the IUD because, unlike the pill, it poses no risk to babies they were breastfeeding. A participant noted, “I gained weight and I always had headache while on the pill; was afraid that it would continue; I stopped and then shifted to the IUD.”

Finally, women opted for the IUD because individuals in their personal networks (friends and relatives who were IUD users, and husbands) and the health system (medical doctors and nurses) recommended it, convinced them to try it, or supported their decision to use it.
Current users knew about the disadvantages of the IUD, not just its advantages. They knew, for example, that IUD use is inconvenient (it requires users to visit a clinic for insertion and regular check-ups); unsafe (the IUD string wraps around the partner’s penis during intercourse; scrapes the user’s uterus; causes abdominal pain; and the IUD gets rusty); and it has contraindications (it is not suitable for someone with blood pressure problems or who has a job that requires her to lift heavy objects). Despite having heard of the method’s disadvantages, however, the women pursued its use because 1) they had support from their husbands and relatives; 2) they had a great need for family planning; 3) they had more knowledge of the method’s advantages; 4) they were dissatisfied with their previous methods; and 5) they had not yet met anyone who had experienced serious side effects from the IUD.

Providers

Current users got their IUDs from and had them inserted by either public- or private-sector providers. The most frequently accessed providers were midwives, and a few had their devices inserted by medical doctors or nurses. According to the husbands/male partners of the users, they did not accompany their wives/partners to the insertion because they were working. One husband recounted his wife’s IUD insertion: “I knew that she would go to the clinic for the IUD insertion because we agreed on it. I wanted to come with her, but she asked me not to anymore since doing so would mean I had to miss a day’s work.” Device insertion in the public sector was cost-free or entailed a donation of up to 75 pesos, and a client’s purchase of betadine and gloves. The cost of private provision ranged from 100 to 350 pesos.

When asked, women who used the public sector for IUD insertion indicated that a private-sector insertion cost of 350 pesos was affordable to them. However, given the free IUD services in public health centers and given the priority that they place on basic needs like food, they — or other women from low-income groups — may be unwilling to spend such an amount for IUDs. Some participants explained: “Cash inflow tends to be limited. Thus, even if a woman would be interested in having an IUD insertion and ready to pay for it, the need to buy food for her children sometimes prevents her from pursuing her use of the device.” Some of these women recognized, though, that the amount of 350 pesos would be small compared to the difficulty and expenses that they would shoulder if they were to get pregnant and have another baby. The amount of 100 pesos was identified as the most acceptable cost to women who want an IUD.

When asked to evaluate public- and the private-sector services in terms of quality, the women unanimously agreed that the private health providers, while costly, offer quality services by providing them advice on check-ups and providing necessary information. However, their opinion regarding the public sector was divided. On the one hand, there were those who assessed the public sector’s service as of poor quality; on the other hand, some pointed out that some public health centers, while cost-free, are also competent and of high quality, and that they would continue to access the public sector for their IUD-related needs. Additionally, women have a clear preference for female providers.
Generally, IUD insertion was described by the women as an experience either without pain or with some amount of tolerable pain. One participant described her own experience: “I thought it was going to be painful! It was not at all. I was even asked to read a newspaper and then suddenly it was over!” Women compared the pain they felt when the IUD was inserted and in place to being bitten by an insect or pricked by a needle, which some underscored as nothing compared to the pain of childbirth. While pain was not a great concern, many were nervous and frightened, though, particularly when their vaginal canal was being opened by the provider with a clamp. Generally, though, the procedure was described as relatively painless and quick (according to some women, the procedure took about 10-15 minutes to complete). No insertion-related problems or complications were reported by the participants.

Immediately following insertion, the women were given advice by their providers on the need to have regular check-ups and pap smears, and to abstain from sexual intercourse for a few weeks. However, the advice that women received, specifically on the timing of their check-ups, varied from provider to provider. Some recall the schedule as monthly, while others mentioned it as every three or five months.

Experience in using the IUD and reasons for continued use

Not all of the women in the group discussions had appreciable changes in their bodies after receiving the IUD. Only some have had body changes, including weakness; loose bowel movements; weight gain; irregular, prolonged, early, or heavy menstruation; and mild pelvic and lower abdominal pain. In addition to these changes, women and their male partners had also felt poking in the uterus and penis during sexual intercourse. A number of these women with body changes reported that over time, they got used to the IUD, and with medical consultation, their weakness and pelvic and abdominal pain had disappeared and their bowel movements and menstruation level had reverted back to their pre-IUD days. Also, the poking sensations ceased, as evidenced by reports from the men. A husband who was hesitant about his wife’s use of the IUD because of what he heard about its effects on the partner mentioned: “My male friend told me that the IUD inside the uterus would hurt me whenever we would have sexual intercourse. At first, it did, but it was not really that painful.” Women explained that the disappearances of the poking effect indicated that the body had finally adjusted to the presence of the device, or that the device — particularly its string — had softened.

However, among those with body changes, there were others who continue to experience weight gain, erratic menstruation periods and strong menstrual flow, and mild pelvic and lower abdominal pain — even at the time of the discussions. To these women, though, the changes were not of great concern to them. Regarding weight gain, for example, women took it as a good sign that their bodies are hiyang, or compatible, with their IUD use. Heavy menstruation was likewise perceived positively, in that a relatively strong menstrual flow is healthy because it cleanses the body and sex organ, which may prevent dysmenorrhea and myoma. Women who had mild pain in the pelvis or lower abdomen, though they did not take a positive view of it, learned how to manage it from health providers. They lie on their backs and raise
or elevate their lower extremities; for abdominal pain, the user simply exhales to ease it. On the whole, current users — then and now — have not experienced effects that they considered serious or beyond personal control and management. In other words, current users are happy with the IUD and they point to their long history with the IUD as an indicator of their satisfaction.

Women were happy with the IUD not only because of the absence of negative side effects but also because the device has met their expectations as an effective method for preventing pregnancy. As a result, they have peace of mind and carry less fear of pregnancy. (For many women and their husbands/male partners, pregnancy is a burdensome experience; with economic hard times, they see that it is necessary and urgent to prevent it). More importantly, they were happy with the IUD because it has not had any effect on the spontaneity of their sexual relations. Likewise, they are happy with the device because, generally, the devices have not been expelled from their sex organs. (A few experienced IUD expulsion with the Lippes loop, so they shifted to Copper T). Women attributed their relatively risk- and problem-free IUD use, and its effectiveness, to regular and prompt consultations with their health providers and to their personal practices, which involve — among others — routinely checking while in the bath that the IUD is still in the right place, and refraining from lifting heavy objects. One discussant attested: “The rumors that I heard about the side effects of using the IUD were untrue. So long as you have regular medical check up and you take some personal precautions, it is a very good method.”

**Recommendations for encouraging more women to use the IUD and improving the IUD**

Current users pointed out that they, and to an extent, their husbands, have already attempted to and have succeeded in convincing other women (sisters, cousins, and friends) to use the IUD. They specified that for other women to be attracted to the IUD, they should hear about the positive aspects of its use — the convenience, safety, immediate reversibility, and affordability, especially as compared to the pill and injectables. Future users also need to be informed of the importance of regular medical check-ups and Pap smears.

Regarding the design of the IUD, many were happy with the Copper T they used. Some thought that the IUD string should be soft, removed, or shortened depending on the size of the user’s uterus. They also thought that IUDs — such as the Lippes loop — could be improved so they are not easily expelled and that the horizontal portion of the Copper T could be extended to prevent sperm from getting through.
C. FORMER IUD USERS

The former IUD users had used the device once in their lives, for periods ranging from two months to more than 15 years (mean 63.5 months). They primarily used the Copper T; secondarily, the Lippes loop. A few of these women had never used a method other than the IUD, but most had used a variety of methods, including the pill, ligation, withdrawal, and injectables. The IUD was the first choice among many serial method users and was the second or third choice among a few others, which, as indicated, was worn by some women for more than 15 years. In all instances, women’s IUD use was preceded and/or followed by their use of the pill or injectables. Very few were IUD repeaters. At the time of the study, the former users were using either the pill or ligation or had already stopped using any method.

Reasons for using the IUD

Women learned about the IUD from individuals in their personal networks (grandmothers, mothers, mothers-in-law, sisters-in-law, friends, and neighbors); the health system (medical doctors, midwives, nurses, and barangay health workers); pre-marriage family planning seminars and mothers’ classes; school; and the mass media (radio and television).

Several reasons influenced women to choose the IUD as an initial or subsequent family-planning method. One reason was the method’s advantages:

- **Effective** — it prevents pregnancy.
- **Simple** — administration of the device only requires one insertion.
- **Long-term and permanent** — once inserted, it stays inside for years.
- **Convenient** — it is inserted only once and does not need to be used before sexual intercourse (like the condom) or taken every day (like the pill).
- **Safe** — side effects are localized, felt only within the sex organ or lower extremities and do not involve the whole body, and are felt only by the user herself (for example, an IUD does not affect the baby she breastfeeds).
- **Immediate reversibility** — a user can easily have the device removed if pregnancy is desired.
- **Inexpensive** — one IUD lasts for years.

The second reason why women chose the IUD was because of their previous use or knowledge of other family-planning methods, wherein they experienced or heard about pregnancy or serious side effects while on the pill. For example, some women pointed out that they got pregnant or had nausea, headaches, high blood pressure, water retention, weight gain or loss, or reduced breast milk quantity when they had an IUD.
A third reason women adopted the IUD was because it was recommended by individuals in their personal networks (husbands and grandmothers) and the health system (medical doctors). Health providers told some women, post-childbirth, about the IUD’s health benefits and its painless insertion. One participant indicated: “Some time after I delivered my third child, the attending doctor informed me about the IUD, and I was convinced right away and had it inserted immediately.”

Beside knowing about the advantages of the IUD, women also knew of its disadvantages — for example, that the device causes discomfort the first time it is worn; urinary tract infections; irregularity in menstruation; cancer; foul vaginal discharge; it is not suitable for anemic women; and it prohibits a user from lifting heavy objects or engaging in strenuous activities. Between the advantages and disadvantages, however, women tended to possess greater knowledge of, favorable attitudes toward, and greater focus on the IUD’s advantages at the time of method adoption.

Providers

Women obtained IUDs from and had them inserted or removed by public- or private-sector providers. These providers were frequently midwives, and to some extent, medical doctors. Public-sector insertion services were free or asked for small donations (50 pesos at most) and that the user purchase betadine and gloves; in the private sector, the cost was 150 to 750 pesos. Some women had free IUD removal from public and private providers; others paid between five and 200 pesos in the public sector and 50 to 500 pesos in the private sector.

A private-sector cost of 300-350 pesos for IUD insertion was regarded by women as affordable (price beyond the quoted range was deemed costly) and acceptable, assessing it as small relative to the expense they would incur for unwanted pregnancy and child delivery. However, they said that low-income women should receive free insertion, as explained by a participant: “I do not care about those women who could afford. However, I pity poor women who have to shell out this expense just so she could use the IUD.”

Between private- and public-sector providers, there was a marked preference for the former. In describing private providers, women in the discussion groups used the terms “better” and “organized.” With private providers, for instance, waiting time is short and there is high-quality service, such as unhurried and careful insertion of the IUD, courtesy, sensitivity to the client’s needs, provision of complete information in one visit, and clean and safe facilities and instruments. Some women mentioned, though, that despite their preference for the private sector, they would still go to public health centers because their family-planning services are free. Women prefer male providers only if there were not any female providers; according to many of the women, “it is embarrassing for a woman to open her legs with a man in front.” They also prefer a courteous provider.
Although the women gave a predominantly positive evaluation of IUD insertion and removal (saying that it was a comfortable, relatively pain-free, and brief experience, lasting only five minutes), some had opposing accounts. Some women mentioned feeling pain (as if their internal sex organ was being pressed, pricked, or pinched) and a burning sensation during insertion or removal, especially when it was done when they were not menstruating. For one woman in particular, she had to request anesthesia to tolerate the insertion. After insertion, women were usually told to have monthly check-ups.

**Experience in using the IUD and reasons for discontinuing**

Except for a few, the women had one or more negative experiences when they used the method. First, they had body changes they considered undesirable, which persist a long time in either the early or later period of their usage. Changes included getting tired easily; body weakness; pain in the abdomen, pelvis, or uterus; weight gain or loss; low blood pressure; anemia; abnormal menstrual cycles and bleeding; difficult and painful urination; foul odor in menstrual discharge; and growth of cysts or lumps in the uterus. Some thought these changes were due to an incompatibility of the IUD with their bodies (*hindi hiyang*) or from a lack of regular check-ups and Pap smears. One woman reported her experience with side effects: “Ay! I had so many bad experiences when I used the IUD. My back was aching, my menstruation was irregular, and I had pain in my uterus!”

Second, women’s husbands/partners felt pain when they had sexual intercourse because the device would poke the penis. Women indicated that their husbands/partners could not penetrate well during intercourse. Along with the pain, men and women feared that the IUD wire or string would wrap around the penis while having sexual intercourse. These concerns, according to some women, had reduced the frequency of intercourse and the quality of sexual relations. It was noted, though, that some of the husbands/male partners felt no more pain after 5-10 occasions of sexual intercourse.

Third, women experienced one or two IUD expulsions, and fourth, they got pregnant while using the IUD. On her experience of expulsion, one woman recalled: “While I was walking, I felt like the IUD was already going out of my sex organ. I had to run to the house and there I saw it was already on my underwear!”

The reasons former IUD users gave up the device, then, include prolonged body changes and their attendant physical and psychological effects; effects of IUD use on sexual relations and on husbands/male partners who — based on women’s accounts — requested its discontinuation; expulsion; and ineffectiveness of the IUD in preventing pregnancy. In addition, women discontinued IUD use because their neighbors and friends told them negative, fear-inducing stories about to IUD — for instance, that it is ineffective or gets embedded within the flesh of the uterus. The few women who had positive experiences and were satisfied with the IUD dropped the practice not because of its side effects but because they intended to have more
children. Their previous satisfaction with the IUD, though, led them to say they would return to IUD use in the future.

**Recommendations for encouraging more women to use the IUD and improving the IUD**

As former IUD users’ experiences were primarily negative, very few of these women are willing to recommend the method to others. The women who would recommend were those discontinued the method not because of their dissatisfaction but because they wanted more children. They indicated that they had already promoted their positive experiences with the IUD (and would continue to promote the device) and were able to recruit new users.

The discussants indicated that local governments (such as that of the city of Manila) should sell, rather than prohibit, family planning to people because “life is difficult now.” They added that the IUD’s benefits — it has various designs and types and is effective, permanent but immediately reversible, convenient, affordable, and relatively painless when inserted and removed — should be disseminated through the mass media and interpersonal communications. Women also said that the IUD can be promoted as a method with fewer restrictions; for example, unlike the pill, the IUD can be used by breastfeeding women. Regarding the heavy menstrual flow that may stem from IUD use, women did not appear worried about it because to them it is seen in a positive light in that “it is a way of cleansing the uterus.” The women noted that more women are likely to use the device if, like the pill, it is readily available in most drugstores and from many healthcare providers. They also felt that the IUD should be explained as “women’s partner in life.”

Finally, the women pointed out that the IUD string should be shortened or removed and should be made of soft material.

**D. INTENDERS**

Intenders are women were not using family-planning methods at the time of the study but expressed a preference to use the IUD in the future. Many had previously used other methods — such as the pill, injectables, condoms, withdrawal, and rhythm — for a range of time periods. The pill, for example, was used for periods ranging from two months to seven years.

**Knowledge of IUD**

Intenders heard about the IUD from individuals within their personal networks (mothers, sisters-in-law, cousins, and friends who were IUD users); in the health system (medical doctors and midwives); in schools; and in the media (print and television). Some said they had heard about the IUD more from friends than from health providers. A participant noted: “I seldom go to the health center. Thus, I always hear many things about the IUD from my neighbors and they have been saying lots of things about it.”
When asked what they know about the IUD, women said that it is a method of family planning that is inserted inside the sex organ and that it has ‘S’ and ‘T’ types. They knew its advantages and disadvantages (although women tended to know more of the former than the latter) and thought that the disadvantages were contingent on individual users and could be reduced by getting regular medical check-ups. Regarding advantages, women knew that the IUD is:

- **Effective** — it prevents pregnancy.
- **Simple** — administration of the device only requires one insertion.
- **Long-term and permanent** — once inserted, it stays inside the sex organ for years.
- **Convenient** — it is inserted only once and does not need to be used before sexual intercourse (like the condom) or taken every day (like the pill).
- **Safe** — side effects are localized, felt only within the sex organ or lower extremities, do not involve the whole body, and are felt only by the user herself (for example, the IUD does not affect the baby she breastfeeds).
- **Immediately reversible** — a user can easily have the device removed if pregnancy is desired.
- **Inexpensive** — one IUD lasts for years.

Women knew the disadvantages of the IUD from talking to others (including health providers), including its design (the hard string and its metallic appearance evoke fear); side effects (menstruation becomes heavy; it might embed in the baby’s flesh or within the uterus and cannot be removed; it causes irritation to the sex organ; it leads to weight loss; husbands feel pain during sexual intercourse; blood clotting inside the uterus; and the string might wrap the husband’s penis); restrictions (the user cannot lift heavy objects); and inconvenience (monthly check-ups are necessary). When asked, women pointed out that many of the disadvantages were hearsay, yet they are what is commonly known.

It was not just the disadvantages of the IUD that women knew about: because some of the intenders had used other methods of family planning, they were aware of the disadvantages of the pill (it has to be taken every day; it has side effects like nausea, headache, varicose veins, and weight gain; and has slow reversibility because the hormones remain in the body); injectables (they are ineffective and cause sleeplessness); condom (they are inconvenient because they must be purchased and worn before intercourse; messy; reduce sexual pleasure; and require skill to maintain sexual momentum); and withdrawal (ineffective). One woman pointed out: “We already know a lot about family-planning methods — not just about the IUD but also about the pill and injectables. We know their advantages and disadvantages.”
Reasons for intending to use the IUD

Women expressed wanting to practice family planning because “life is too hard.” They added that having many children would be “too expensive” and “difficult for them to maintain.” They said that their husbands/male partners felt the same way. These women wanted to use the IUD as a first or subsequent method for three reasons.

One, they liked the IUD’s advantages, including being effective, safe, convenient, and inexpensive. Two, they intended to adopt it because they were dissatisfied with their previous family-planning methods (ineffectiveness and side effects being the main reasons for dissatisfaction) or discouraged by what they heard about other methods (for example, some women and their husbands/male partners rejected ligation for fear that it would make them sexually promiscuous). Third, they intended to use the IUD because it was recommended by individuals within their personal networks and the health system — especially by midwives. Reflecting on her own experience, one woman mentioned: “My mother has been telling me to use the IUD because she has been a satisfied user. I have not followed her yet because my husband has heard about its effects on the partner.”

It should be underscored that while some discussants had already decided to use the IUD and were simply waiting for menstruation to have the IUD inserted, others were ambivalent about the method. The latter group said they were likely to pursue IUD use if they got more information about it and were served by competent providers with good track records in IUD insertion. One woman emphasized: “I am not sure of the competence of the providers. I have been hearing from my friends that the one who inserted the IUD to them is not yet a medical doctor but an intern! I do not trust such person.” Furthermore, they mentioned their husbands’ approval as critical.

Providers

Women were aware of the public and private health centers where they can go for IUD insertion, with the quoted cost ranging from 200 to 300 pesos. Whether they were from high- or low-income groups, the discussants believed private providers are far better than their public-sector counterparts. Many regard private-sector providers as “people who serve their clients with tender loving care.” For instance, they provide good service (short waiting times) and clean, safe facilities, and they are friendly (they do not shout at the clients), accommodating, and courteous. Public providers were seen as biased toward clients they know, to the detriment of those who are not within the providers’ personal networks. Generally, there was willingness to pay 200-300 pesos for IUD insertion, with the cost range extending to 600 pesos for high-income discussants. The fee was seen as small compared to the expenses they would incur for pregnancy and child care and the risks associated with delivery. One woman pointed out: “If you just compare the cost of branded milk for your baby over the years with the few hundreds of pesos for the IUD insertion, there is a marked difference.” Female providers were greatly preferred for IUD insertion and removal, though a few woman said a provider’s gender does not matter so long as he/she is competent.
Recommendations for encouraging more women to use the IUD and improving the IUD

Discussants felt that to increase the number of IUD users, women must be given accurate and adequate information on the effectiveness and safety of the device, and they must also be offered lower service costs. To improve the device, the women suggested varied sizes of the IUD to accommodate different women. The IUD string — a source of pain, especially for husbands/male partners during sexual intercourse — was also cited as an area requiring improvement.

E. LIMITERS

Limiters are women who were using the pill, injectables, or condoms at the time of the study. Their use of these methods ranged from periods of two months to 15 years (mean 37.7 months). Although some were first-time method users, most were former users of up to three other methods. For instance, current pill users were past users of injectables, withdrawal, or condoms. Among first-time and subsequent method users, the pill tended to be the first choice.

Knowledge of IUD

Limiters heard about the IUD from individuals within their personal networks (mothers, sisters, cousins, and friends, some of who are IUD users); the health system (medical doctors, midwives, and nurses); and from government-required premarital family-planning seminars. They know that the IUD is for spacing and limiting births and that it is inserted into the uterus during menstruation. They also know about its advantages and disadvantages. One woman explained: “The IUD is very popular among us, and even among our other friends. We have been talking about it. We know the good and the bad side of it.” On the advantages of the IUD, Women reported knowing the following advantages of the IUD:

- **Convenient** — it is inserted only once and does need to be used before sexual intercourse (like the condom) or taken every day (like the pill).

- **Safe** — side effects are localized, felt only within the sex organ or lower extremities, and do not involve the whole body, or are felt only by the user herself (not by the baby she breastfeeds, for instance).

- **Immediately reversible** — a user can easily have the device removed if pregnancy is desired.

- **Inexpensive** — one IUD lasts for years.

According to some women, the IUD was the method first recommended to them by medical doctors when they visited hospitals and clinics. However one discussant was cautious: “Whatever the doctors say about the IUD, I know deep inside that I am still unsure of using it because I have heard so many things about its side effects.”
The women cited disadvantages of the IUD, including its administration (having it inside the uterus gives the user a feeling of having a foreign body inside her); ineffectiveness (there is no guarantee that she will not get pregnant); safety and side effects (menstruation becomes heavy; it might embed in the baby’s flesh or within the uterus and cannot be removed; it causes irritation, lacerations, lumps, infections, abdominal pain, and cancer of the sex organ; weight loss; husbands feel pain during sexual intercourse; and the string might wrap the husband’s penis); restrictions (the user cannot lift heavy objects during menstruation); expulsion; and inconvenience (have to wait for menstruation to have it inserted; waiting time in health center for insertion; insertion is painful; and monthly check-ups). In addition, women felt that IUD providers are not well-trained or competent and that insertion and removal are painful. Between the advantages and disadvantages, women knew more about the latter than the former. One woman said: “I have a female friend who told me of her friend who was an IUD user before. Then this user got pregnant and when she delivered the baby, it had the IUD on its face.”

**Reasons for using methods other than the IUD**

When asked to elaborate why they were not using the IUD, women cited four reasons. First, they cited its disadvantages, calling it unsafe and having a range of side effects. They indicated that kept hearing about the disadvantages from friends and neighbors. Some discussants said that they are frequently “lifting heavy objects,” which to them is incompatible with IUD use because it can lead to expulsion. One woman stated: “I could not avoid working and carrying heavy objects and chores at home because I do not have a house helper.” Second, along with concerns on safety and side effects, women were discouraged by perceived lack of training and incompetence of providers. One participant testified: “In the clinic we visited, the provider appeared to be careless and unmindful of the condition of the client during IUD insertion. She was not asked any question and the insertion was very quickly done.”

Third, women cited satisfaction with their current methods. Some pill users reported that they had not had any illnesses since starting the pill, and that it was inexpensive (35 pesos for a one-month supply). Condom users said that their method was inexpensive, readily available in drugstores, convenient to use, and has no side effects. Injectable users similarly underscored the affordability of their method (250 pesos per month). Others, though, cited some physical discomforts from their current methods (for example, nausea and headache from the pill), but said these are manageable. Finally, women avoided the IUD because their husbands told them to; their husbands instead decided to use condoms.

**Providers**

Limiters knew where to have IUDs inserted, citing easily access to private- and public-sector providers. These women had a clear preference for private providers, calling their services are generally good — courteous and accommodating with short waiting times and updated, safe facilities and equipment. Also, they reported that in private clinics, medical doctors perform insertions, compared with public health centers where interns administer the service. Despite the disparity between the public
and private sectors, discussants (particularly those from low-income groups) still prefer public-sector providers because of the free or low cost. One woman noted: “Even there is inconvenience in the public health center and the waiting time is long, it suits me well because the service is free.” Relative to the costs of pregnancy, delivery, and child care, limiters thought that a one-time cost of 500-800 pesos for IUD insertion (for high-income women) or 200-300 pesos (for low-income women) is affordable. These women had no gender preference for IUD insertion.

**Recommendations for encouraging more women to use the IUD and improving the IUD**

Women emphasized that family planning is important because of economic hard times (“life is difficult”) — a view shared by their husbands/male partners. While there is a fundamental push for family planning, these women — when prompted — offered suggestions on how women like them can be persuaded to use family-planning methods, particularly the IUD.

Discussants said that women should be given, first and foremost, accurate and adequate information on the effectiveness, safety, convenience, and affordability of the IUD. Family-planning decisions, according to discussants, should be made in the context of having complete information on all methods. The information should be given by gynecologists and other experts with several years of clinical practice, and with quality, adequate, and scientific counseling skills. These standards could eliminate fear and apprehension. The women pointed out that interns — especially in public health centers — should never be allowed to administer IUDs, and added that IUD users and their positive stories and experiences are critical to encouraging other women.

In addition to method information, women should have easy access to health services for regular check-ups and Pap smears after IUD insertion. Free insertion was also seen as a likely strategy for attracting more adopters.

As to the design of the IUD, discussants indicated that they would adopt the device if its string were removed.

**SUMMARY**

**Current IUD users**

1. Current IUD users have been using the method for periods ranging from two months to 25 years (mean 60 months). Almost all were users of the Copper T. Most were previous, serial users of up to four other family-planning methods, such as the pill, injectables, condoms, or withdrawal.

2. Current users knew about the advantages and disadvantages of the IUD and of other family-planning methods.
3. Current users adopted and continued to use the IUD because of its advantages and their positive experiences with it (with minimal or tolerable body changes), and also because of their negative knowledge of or experiences with other methods. Adoption and continued use of the IUD were reinforced by individuals in women’s personal networks and the health system.

4. Current users got their IUDs from and had them inserted by public- or private-sector providers at costs ranging from 100 to 350 pesos, which they considered acceptable and affordable. They saw private providers as better.

5. IUD insertion was described by as painless or tolerably painful and quick.

6. Many current users were happy with the Copper T they were using. Some thought that the IUD string should be soft, removed, or shortened; or that the IUD could be made more effective against pregnancy by extending the horizontal portion of the Copper T to prevent sperm from passing.

**Former IUD users**

1. Former IUD users had used the method once for periods ranging from 2 months to 15.2 years (mean 63.5 months). Prior to the IUD, these women had used a variety of methods — the pill, ligation, withdrawal, and injectables.

2. Former users knew about the advantages and disadvantages of the IUD and of other family-planning methods.

3. Former users adopted the IUD because they had more knowledge of its advantages than of its disadvantages and because of their knowledge of or negative experiences with other methods. They dropped the IUD because of negative experiences (mainly about its side effects). Their decisions were reinforced by individuals within their personal networks and the health system.

4. Former users obtained their IUDs from and had them inserted or removed by public- or private-sector providers (frequently midwives) at a cost of between 150 and 750 pesos. A cost of 300-350 pesos for private-sector insertion was seen as affordable. There was marked preference for private providers.

5. Former users had both positive and negative experiences during IUD insertion and removal.

6. Former users wanted the IUD string shortened, removed, or made of soft material.

**Intenders**

1. Intenders were not users of family-planning methods at the time of the study, but had expressed a preference to use the IUD in the future. Many had previously used the pill, injectables, condoms, withdrawal, or rhythm.
2. Intenders knew about the advantages and disadvantages of the IUD and of other family-planning methods.

3. Intenders intended to use the IUD because of its advantages (of which they had more knowledge than its disadvantages) and dissatisfaction with other family-planning methods (due to side effects). Intenders were influenced by individuals within their personal networks and the health system.

4. Intenders were aware of public and private health centers where they could go for IUD insertion, with costs ranging from 200 to 300 pesos. They had a clear preference for private providers. They were willing to pay 200-300 pesos for insertion, with the cost for higher-income intenders extending to 600 pesos.

5. To improve the device, intenders suggested varied sizes of the IUD to take into account the varied sizes of women’s sex organs. The IUD string — a source of pain, especially for husbands/male partners during sexual intercourse — was also noted as an area requiring improvement.

Limiters

1. Limiters were using the pill, injectables, and condoms at the time of the study, for periods ranging from two months to 15 years (mean 37.7 months). Although some were first-time method users, most were former users of injectables, withdrawal, or condoms.

2. Limiters knew about the advantages and disadvantages of the IUD and of other family-planning methods.

3. Limiters do not like the IUD because of their greater knowledge of its disadvantages as opposed to its advantages, and because of satisfaction with their current methods. Their choice not to use the IUD was reinforced by individuals within these their personal networks.

4. Limiters knew where to have IUDs inserted, citing easy access to private- and public-sector providers. They had a clear preference for private providers and considered affordable costs of 500-800 pesos for high-income women and 200-300 pesos for low-income women.

5. Limiters indicated that they would adopt the device if its string were removed.
V. SUMMARY, CONCLUSIONS, AND RECOMMENDATIONS: TOWARD A COMMERCIAL IUD MARKET IN THE PHILIPPINES

The assessment examined the supply, provision, and use of the intrauterine device in the Philippines. The data inform PRISM’s goal of mobilizing the private sector for family planning — specifically, for developing a commercial IUD market in the country.

Supply, provision and use as public phenomena

Although some IUD supplies in the Philippines have come from private sources (such as the Family Planning Organization of the Philippines and pharmaceutical companies whose IUD products are registered with Bureau of Food and Drugs), the bulk has been from the public sector. From 1995 to 2003, the government of the Republic of the Philippines has received 776,000 USAID-donated Copper T (CuT380-A) units. These have been distributed chiefly through public health facilities across the country, and all have been used or consumed through the same sources (Table 2.3, page 13). The evidence from literature review, focus-group discussions, and personal interviews strongly emphasizes the centrality of the public-health sector insofar as IUD supply, provision, and use are concerned. For example, most (74.8 percent) of the public and private providers interviewed said that the IUDs they used for their clients were from the public sector. Based on the NDHS, most current IUD users (80.1 percent) pointed to the public sector as their most recent source of the device.

The overwhelming use of the public sector is more than just a function of the low cost of the IUDs it provides. Low-income users may also have been attracted to the free or donation-based (ranging from five to 75 pesos) insertion services provided by the public sector. However, for some high-income IUD users, the public sector is not an option. Evidence indicates that 18 percent of IUD users are private-sector clients who are charged several hundred pesos for IUDs and their insertion. Private-sector IUD users are a small minority, though, compared to public-sector users.
Use and non-use: Function of knowledge, attitudes and experiences (KAE)

The overwhelming factor governing adoption of the IUD is the need for family planning and small family size (due to economic hard times) and desire to be free of the burden of successive childbearing and rearing. The second major factor is the family-planning method itself — specifically, knowledge of and attitudes toward the advantages of the IUD and KAE of the advantages and disadvantages of other methods.

IUD users are knowledgeable about the IUD’s advantages as well as its disadvantages, but they hold more favorable attitudes toward the former than the latter. In the same vein, IUD users have more KAE of the disadvantages — rather than the advantages — of other methods. In fact, Filipino women (whether current or former IUD users, intenders, limiters, or non-users) almost universally hold KAE about the advantages and disadvantages of a wide range of family-planning methods.

IUD use, non-use, and the reasons therein, are a matter of balance between KAE of the IUD and of other family-planning methods (particularly the pill, injectables, and condoms). Thus, IUD users and intenders have more positive KAE toward the advantages of the IUD and fewer positive KAE toward the advantages of other methods. On the other hand, discontinuers, non-IUD users, and limiters have more positive KAE about the disadvantages of the IUD and higher positive KAE of the advantages of other methods. Women’s KAE about the IUD and other methods is influenced by individuals in their personal networks (mothers- and sisters-in-law, mothers, sisters, friends, neighbors, and other IUD users and non-users). Within the health system, medical doctors, midwives, and nurses exert a similar influence. Women are strongly influenced by interaction with individuals who have KAE about the IUD, whether in favor of or against adoption of the method.

Prevailing KAE on the IUD focuses more on its disadvantages than its advantages. The disadvantages sustain the relatively low preference for and acceptance of the IUD. The evidence is firm: Broadly speaking, the IUD is not women’s clear first choice, (in many instances where it is given as an option, it ranks third or fourth), nor it is women’s most popular choice (the pill and female sterilization are the two top choices). Through the years, the proportion of currently married IUD users in the Philippines has been reliably low — only three to four percent (180,000 to 240,000) of the 6.02 million currently married family-planning method users. These figures are considerably lower than the 800,000 pill users, comparable to the 186,000 injectable users, and higher than the 114,000 condom users.

IUD supply and demand

Although low IUD prevalence could be attributed to women’s greater KAE of its disadvantages, it could have be due to limited IUD supplies. Over the years, the number of donated IUD units — the major source of supply — has been limited to 50,000-160,000 units. The fact that the entire donated supply — and other units sold by the FPOP and pharmaceutical companies — was consumed indicates that there is
demand limited only by supply. Given this constraint, it is hardly surprising that the pill, with unlimited supplies coming from many private companies, has overshadowed the IUD. However, despite supply constraints and lack of marketing and promotional efforts, the IUD has attracted more currently married women than have been attracted by other birth-spacing methods, like condoms and injectables.

That the IUD has edged out some other birth-spacing methods is not hard to understand. The device has several positive characteristics — it is effective, long-term and permanent, convenient, safe, with localized side effects, immediately reversible, and relatively inexpensive. It also has a lower discontinuation rate than the pill and injectables — 14 percent during the first year of use, and 4.3 percent over five years. These positive aspects are not well known among Filipinos because there has been no systematic, vigorous marketing or promotion of the IUD’s advantages. (The absence of marketing and promotion is by no means applicable only to the IUD: The lack of increase in overall contraceptive prevalence could be a result of lack of marketing and promotion of family planning in general). The decades-long absence of promotion and effective management of IUD side effects has contributed to negative and undesirable KAE of IUDs.

**Potential first-time IUD user populations and supply gaps**

The following figures detail the estimated 391,400 potential new IUD users. The figures do not include potential IUD users among the 8.0 million single Filipino women.

320,000 intenders =

- 120,000 (4.9 percent) of currently married women with unmet need for contraceptives, and
- 200,000 (8.1 percent) of currently married women who are non-method users.

71,400 IUD switchers =

- 30,400 (1.6 percent) of the 1.9 million currently married pill users, and
- 8,000 (1.8 percent) of the 440,000 currently married injectable users, and
- 5,700 (2.2 percent) of the 260,000 currently married condom users, and
- 2,400 (5.4 percent) of the 46,000 currently married users of natural family-planning methods (mucus/bbt/STM, standard days, and LAM), and
- 13,400 (1.6 percent) of the 842,000 currently married users of periodic abstinence, and
- 11,500 (1.4 percent) of the 827,000 currently married users of withdrawal.
The movement toward private-sector involvement in the production, supply, and insertion of the IUD is likely to bring about change in the above scenarios, due to marketing and promotional efforts.

There is no near-term plan to phase out USAID donations of the IUD, so for the foreseeable future, donations of 50,000-160,000 units shall continue to flow into the country.

An unknown, albeit small portion of the donated units in 2006 will replace those currently used by three to four percent, or 180,000-240,000, currently married women. Most IUDs, however, will be consumed by first-time IUD users who can be classified as “intenders” or “switchers” (see p. 21-22).

Given the 2006 USAID donation of 96,000 IUD units and the 3,000-5,000 combined units from the FPOP and the two pharmacies mentioned in Chapter II, approximately only 100,000 of the 391,400 potential new users will be provided with IUD units.

Supply for the remaining 291,000 potential new users will be unmet. Each potential new acceptor is expected to use at least two IUDs in her lifetime (Personal communication, Sheelah Villacorta, PRISM, August 2005). Clearly, there is demand for increased IUD supply.

**IUD marketing and promotion**

Systematic marketing and promotion strategies must be developed and implemented to effect IUD use among potential users. The strategies should inform non-IUD users about the advantages of the IUD, including its low discontinuation rate, and about the disadvantages of the pill and injectables.

Marketing efforts should also address the non-IUD user’s KAE of the disadvantages of the IUD, especially its side effects. Non-acceptors should be informed that negative effects are not experienced by all users, and that any effects that do occur are short-lived and treatable.

Marketing and promotion strategies should employ influential individuals within the personal networks and health systems accessed by potential IUD users. For example, husbands, mothers- and sisters in law, mothers, sisters, friends, neighbors, and more importantly, long-term satisfied IUD users and dissatisfied users of other methods can all be channels through which the advantages and benefits of the IUD can be communicated. Health workers — medical doctors, midwives, and nurses, particularly female providers — should also market and promote the IUD and its advantages.

Current IUD-related knowledge, practices, and skills are inadequate among doctors and midwives. Some providers do not directly address users’ concerns about side effects. Providers’ knowledge, practices, and skills are far from uniform — for instance, some require Pap smears and blood counts before first insertion. Some even hold inaccurate views — such as those who believe the IUD is abortifacient.
Providers should be given: 1) Re-orientation on the advantages and disadvantages of the IUD; 2) Standard protocols and tools for marketing and promotion strategies, counseling and screening potential users, insertion and removal procedures (to lessen expulsion cases), and post-insertion services; and 3) Skills to enable them to effectively address women’s concerns about side effects and to effectively manage those side effects.

In particular, providers should be oriented to pay special attention to women’s first-year use of the IUD, as this is the period when users are likely to experience side effects. An effective management of side effects strongly predicts method continuation.

Providers who are advocates or users of family planning — particularly, satisfied long-term IUD users — are very effective at marketing and promotion. By encouraging women to choose the IUD, providers can benefit from the increase in clients.

Tapping influential members of personal networks and health systems will build a critical mass of individuals with positive IUD-related KAE and who will recommend the IUD to other women. These individuals create a supportive familial and social environment not only for those currently using IUDs, but also for those who want to use them. With supportive social structures, the population of new and continuing IUD users will grow, which will only serve to persuade even more women to use the device.

Aside from the restriction that IUD marketing and promotion should be directed only at women aged 25 or older who have one or more children, the fact is that IUD users are of no particular sociodemographic background. Thus, the IUD has no particular niche in the market — its users are found in urban and rural areas and across a range of incomes. In fact, IUD users are similar to pill users in terms of sociodemographic profile — or lack thereof. The lack of distinguishing characteristics of the IUD user is an expected consequence of the absence of audience-based marketing and promotion of the IUD and of family-planning methods in general. Future effort should focus on market segmentation and profiling of target audiences.

For private-sector involvement in the IUD market, the priority market should be women capable of paying for IUDs and their insertion. These women belong to middle- and high-income groups and are willing to pay up to 800 pesos per IUD. Low-income women are definitely not the primary clients of a private IUD market. Although some lower-income women recognize that the cost of an IUD is an incredible bargain given the method’s benefits, their limited cash flow and emphasis on basic needs restrict their ability and willingness to pay. Low-income women who would an IUD should instead use USAID-donated units and have insertion done at public health centers at no or low cost. (This proposal would work even better if an effective evaluation and monitoring scheme were instituted to ensure that donated IUDs are indeed being used by poor women).
As USAID donations phase out, the private market should further develop and offer a variety of safe and effective IUDs to respond to the varying economic means of female clients. Through further research and development, the private sector should also find ways to make the IUD more widely accepted — for instance, improving the materials used for the IUD, improving the IUD string, or making a range of sizes to fit women better.

Along with product development, product packaging should also be improved — the language used to describe the product and its side effects should be carefully crafted. “Side effects” has a negative connotation that many women have associated with the IUD for decades. To make the IUD more attractive, that term should not be used anymore. Alternative terms — such as “body changes,” which some women have used to describe the IUD’s effects — may be employed. Heightened sensitivity in IUD provision is also needed. IUDs should be easily accessible and insertion should be performed largely by female providers with appropriate instruments, such as correctly sized speculums.

With a more developed product and with sensitive marketing, promotion, and provision, prospects for a private IUD market in the Philippines are bright.

In conclusion, the IUD market in the Philippines is still small, but there is actual and potential demand for it among many women and health providers because of its marked advantages in meeting family-planning goals. Effective marketing, promotion, and training strategies are needed to build a critical mass of private-sector users and providers. The greater the support network for the IUD, the greater the chance for the IUD market to grow. As the number of private users increases, the demand for IUDs also increases — a market condition bound to spur response from and directly benefit private manufacturers and suppliers.
REFERENCES


Bailen, Jerome B. and Donald E. Morisky. Traditional Birth Attendants (Hilots) and Modern Family Planning in Marinduque. Quezon City: University of the Philippines-Department of Anthropology, 1974.


Reference:


ATTACHMENT A

IN-DEPTH PERSONAL INTERVIEW GUIDE

Introduction: Introduce yourself and open the conversation with the following:

“Good morning! We are here to conduct an interview regarding your experience in providing IUD services to clients in an effort to understand how to involve the private sector in the supply and provision of the IUD.

Information gathered will help PRISM determine the potential for developing the market for commercial IUDs by analyzing the current market situation.

Before we start, I would like to gather some personal information about you and your current practice.”

I. Profile

<table>
<thead>
<tr>
<th>Name:</th>
<th>Age:</th>
<th>Sex: [ ] M [ ] F</th>
<th>Religion:</th>
</tr>
</thead>
</table>

Profession: [ ] MD [ ] MW  
Specialty: [ ] GP [ ] FM [ ] MW [ ] OB-GYNE

Place of Practice: [ ] NCR [ ] Luzon Province/City: _________  
[ ] Cebu [ ] Davao

Facility: [ ] Hospital [ ] Clinic [ ] Others (specify)  
[ ] Home [ ] Lying-In Clinic

Have you or your partner ever used a method on FP? How long? What was your or your partner’s experience while using the method?

II. IUD TRAINING/POLICIES/GUIDELINES

1. How long have you been providing IUD to clients?

2. Where did you get your training on IUD insertion? When?

3. How do you access trainings/updates on IUD?
4. Do you have a written copy of DOH policies and guidelines for IUD insertion? What standards or protocols do you use in the provision (insertion/removal) of IUD?

III. ATTITUDES TOWARD THE IUD

1. What is your stand on family planning in general? Do you have some reservation on FP? IF YES…What are these?

2. Specifically, how do you view IUD as a FP method? What are its advantages or disadvantages? Do the advantages far outweigh the disadvantages — in what ways do they outweigh or not? What are its benefits, if any?

IV. IUD CLIENT PROFILE

1. Do you recommend IUD to a particular type of client? If yes, in what specific instances do you recommend it? To whom do you recommend it? (Do you consider the socioeconomic status, age, parity, and educational background of the client before recommending IUD?) Why/why not? In what specific instances do you not recommend it and what are your reasons for not recommending?

2. Approximately how many FP acceptors do you have for the past 5 years? How many of these acceptors use IUD? (Approximately what percent are IUD acceptors?) How many of your IUD acceptors came in already with IUD in mind? How many FP clients do you have who came in that do not have any method in mind?

3. Are there differences in the characteristics of the clients? What are these in terms of the following:
   a.) Age
   b.) Number of children
   c.) Educational background
   d.) Socioeconomic class
   e.) Religion

4. For those clients who came in with IUD already in mind, what information do they already know about the IUD? Where did they get the initial information? Do they believe this initial information as truth? For those who came in without a method in mind, what initial information do they know about IUD? Where did they get the information? Do they believe this information to be true?
V. IUD SERVICE PROVISION

1. Do you get IUD referrals? Where do these referrals come from?

   Other midwives ( ) Other MDs ( )
   RHUs ( ) NGOs ( )
   BHWs ( ) Others, specify ______________

2. Who decides on the FP method that your client will use? Does the client’s partner agree with the client’s decision? Do you ask for the partner’s concurrence? Why or why not?

3. What are the most common questions that your clients (those with IUD in mind and those with no method in mind) ask about IUD? What else? How do you address these questions? How do your clients respond to your answers?

4. What is/are the most common medical contraindication/s that you encounter in the use of IUD? What else?

5. How do you help your client make a decision to use IUD? What information about the IUD do you provide the client to help them decide on whether to use or not to use the IUD?

6. What information/s received from you helped your client decide to use IUD? How this/these information/s used in the decision process?

7. Have you received any formal training on FP counseling? If yes, when and who conducted the training? Do you conduct FP counseling to all your FP/IUD clients? Why/why not? How long does your counseling last? Do you think all FP clients should be counseled? Why or why not?

8. What information do you provide your clients during counseling? What questions do your clients commonly ask about IUD during counseling?

9. After conducting the counseling, how many of those clients who came in with IUD in mind and those without a method in mind finally decided to use IUD? How many decided not to use IUD after counseling? What were the reasons for not finally deciding to use IUD among those with a method in mind and those without a method in mind?

10. What medical factors or conditions do you consider when prescribing IUD? What else? What is the importance of these factors?

11. Do you request additional examinations/procedures before prescribing/inserting IUD? If yes, what are these examinations/procedures? What is/are the rationale/s for requesting these procedures?
12. Do you have a separate room for inserting IUD? IF NONE: Where do you do it? Who usually accompanies the client in your clinic? Who accompanies the client while the IUD is being inserted?

13. Please describe the steps in inserting the IUD.

14. After inserting the IUD, what information or instructions do you give your client? Are these verbal or written? How do you validate if the client understood the information or instructions you gave?

15. Do you prescribe home medications? Why/why not? IF YES: What are these medications?

16. How often does the client come for follow-up visits after IUD insertion? What happens during follow-up visits or return visits? What information do you ask the client during follow-up? What information do you give the client during follow-up?

VI. CLIENT SATISFACTION

1. How many of your IUD acceptors had their IUD removed in the past 5 years?

2. What are the common reasons your client gives for having the IUD removed? For reasons other than wanting to get pregnant, how do you respond to the reasons that your client gave? How did these (your responses) affect the client’s initial decision to have the IUD removed?

3. What do you do to ensure that the client is really making the right decision in having the IUD removed? Who decided whether the IUD should be removed, i.e., acceptor/husband/doctor etc.? How much involvement does the male partner have in IUD removal?

4. What are the common complaints of your clients while using the IUD? How do you address these complaints? How does the client respond after you have addressed the complaints?

5. What method do your clients shift to after having the IUD removed? Why this method?

VII. IUD SOURCING AND PRICING

1. Where do you get your IUDs? What brand/s of IUD do you prescribe? Why this brand/s? Do you know of any commercial brand of IUD in the market?

2. Do you have IUD supplies coming from abroad or clients bringing their own IUDs from abroad?

3. What is the acquisition cost of each brand?
4. Do you get “special offers” from the manufacturers/distributors of these IUDs? If yes, what are these “special offers”?

5. Does the IUD come as a package of services? What services are included in the package? What is the package price?

6. How does your price compared against other providers (MD or MW)?

7. Are you or your clinic Philhealth-accredited? Are you aware that IUD insertion is covered by Philhealth? If yes, do you get reimbursement from Philhealth for IUD insertions?

VIII. RECOMMENDATIONS

We are seeking information on which to explore ways of broadening the level of use of IUDs in the Philippines. We are interested in your ideas and opinion on this matter. Please take note that there is no right or wrong answer here.

Based on your experience in inserting and removing IUD and on the reports your clients have communicated to you, are there ways in which the design of the IUD may be improved? What are the ways to increase the number of IUD acceptors in the Philippines? How can the IUD be effectively marketed in the country?

Closing statement:

“Thank you for sharing with us your valuable time, knowing how busy you are. We appreciate the information you have just shared and it will be very helpful in our attempt to help ensure continuity of IUD commodities and services.

As a token of our appreciation we would like to give you this. Thank you very much.”

Note: The entire interview should be continuous. There is no need to provide an introduction for each section as the last question of each section serves as the transition question for the next session (except for the last section). The questions are divided into sections merely to facilitate the analysis phase of the study.

These questions serve as a guide on how to proceed with the interview. Probing and follow-up questions will depend on how or what the respondent answered.
ATTACHMENT B

SCREENING FORM/PROFILE QUESTIONNAIRE FOR FOCUS-GROUP DISCUSSION PARTICIPANTS

I. ABOUT THE RESPONDENT

NAME (optional): _______________________________________

NICKNAME: _____________ GENDER: ______ AGE: ______

ADDRESS: _______________________________________________________

TEL. NO.: _______________

HIGHEST EDUCATIONAL ATTAINMENT:
__________________________________________________________________

SCHOOL GRADUATED FROM:
__________________________________________________________________

OCCUPATION: ________________________________

EMPLOYER: _______________________________________

II. ABOUT THE HUSBAND/MALE PARTNER

AGE: _____ EDUCATIONAL ATTAINMENT: _____________________________

OCCUPATION: ________________________ EMPLOYER: ___________________
### III. FACILITIES OWNED

(Please encircle number if you own it)

<table>
<thead>
<tr>
<th>Item</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>RADIO</td>
<td>1</td>
</tr>
<tr>
<td>CASSETTE RECORDER</td>
<td>2</td>
</tr>
<tr>
<td>COLOR TV</td>
<td>3</td>
</tr>
<tr>
<td>VHS</td>
<td>4</td>
</tr>
<tr>
<td>VCD/DVD</td>
<td>5</td>
</tr>
<tr>
<td>LASER DISC</td>
<td>6</td>
</tr>
<tr>
<td>STEREO COMPONENT</td>
<td>7</td>
</tr>
<tr>
<td>CD PLAYER</td>
<td>8</td>
</tr>
<tr>
<td>AIR CONDITIONER</td>
<td>9</td>
</tr>
<tr>
<td>REFRIGERATOR</td>
<td>10</td>
</tr>
<tr>
<td>FREEZER</td>
<td>11</td>
</tr>
<tr>
<td>STOVE</td>
<td>12</td>
</tr>
<tr>
<td>3-BURNER RANGE WITH OVEN</td>
<td>13</td>
</tr>
<tr>
<td>MICROWAVE OVEN</td>
<td>14</td>
</tr>
<tr>
<td>TELEPHONE</td>
<td>15</td>
</tr>
<tr>
<td>WASHING MACHINE</td>
<td>16</td>
</tr>
<tr>
<td>VACUUM CLEANER</td>
<td>17</td>
</tr>
<tr>
<td>FLOOR POLISHER</td>
<td>18</td>
</tr>
<tr>
<td>PIANO</td>
<td>19</td>
</tr>
<tr>
<td>COMPUTER</td>
<td>21</td>
</tr>
<tr>
<td>LAPTOP</td>
<td>22</td>
</tr>
<tr>
<td>PALM PILOT</td>
<td>23</td>
</tr>
<tr>
<td>CREDIT CARD</td>
<td>24</td>
</tr>
<tr>
<td>CELLPHONE</td>
<td>25</td>
</tr>
<tr>
<td>IPAD</td>
<td>26</td>
</tr>
<tr>
<td>How many?</td>
<td></td>
</tr>
<tr>
<td>AUTOMOBILE/CAR</td>
<td>27</td>
</tr>
<tr>
<td>How many?</td>
<td></td>
</tr>
</tbody>
</table>

### IV. SIZE OF HOUSEHOLD

NUMBER OF LIVING CHILDREN AGED 0-17 yrs: ______________

ADULTS AGED 18 YEARS AND ABOVE: ________________

TOTAL: ____________________

NO. OF SERVANTS/MAIDS: ____________________
V. STATUS
SINGLE 1
MARRIED 2
SEPARATED 3
WIDOWED 4

VI. TOTAL FAMILY MONTHLY INCOME
BELOW - P20,000 1
P20,000 - P29,999 2
P30,000 - P39,999 3
P40,000 - P49,999 4
P50,000 - P59,999 5
P60,000 - P69,999 6
P70,000 - P79,999 7
P80,000 - P99,999 8
P100,00 - P249,999 9
P250,000 AND ABOVE 10

VII. NUMBER OF INCOME EARNERS IN FAMILY:

____________________________________________________________________

VIII. HOME OWNERSHIP
Own house/condo/apartment 1
Rent house/condo/apartment 2

IX. IUD USE/NON-USE
1. Are you currently using any contraceptive? _______ Yes _______ No

1.1 If yes, what contraceptive/s are you currently using and how long have you been using it/them?

Method currently used and length of use (years/months):
1.1.1 Before you used the above-mentioned method, what did you use before and for how long? Start from method first used, then method next used, and so on.

Method/s used before the current one and length of use (years/months):
_____________________________________________________________________
_____________________________________________________________________
_____________________________________________________________________ 

1.2 If not currently using the method, are you planning to use one in the future?
_____ Yes _____ No

1.2.1 If yes, which of the following contraceptive/s you plan to use? (check as many as appropriate):
_____ IUD
_____ Pill
_____ Condom
_____ Injectable (DMPA)
_____ NFP (Natural family planning)
_____ Hormonal patch
_____ Other(s), please specify _______________

**Former and Current Users of IUD**

1. What type/s of IUD have you used/are you using? (Please check the appropriate picture below)
2. Source/s of IUD (please check appropriate answer):

_____ Hospital

_____ Pharmacy

_____ Private provider

_____ Public provider

3. Who performed the insertion and/or removal? Please check and indicate the corresponding costs.

<table>
<thead>
<tr>
<th>PROVIDER</th>
<th>INSERTION</th>
<th>REMOVAL</th>
</tr>
</thead>
<tbody>
<tr>
<td>Private</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nurse</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Doctor</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Midwife</td>
<td></td>
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<tr>
<td>Public</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Doctor</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Midwife</td>
<td></td>
<td></td>
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</tbody>
</table>

COST
FOCUS-GROUP DISCUSSION GUIDE: FORMER IUD USERS (A)

Introduction — names, study purpose, active participation, tape recording, and confidentiality.

Begin by saying: “We are going to discuss your views and experiences regarding your previous use of the IUD.”

1. From whom/where did you learn about IUD?

2. Many women use a particular family-planning method because the method has certain characteristics. (Only say this if participants require it: for example, that it is easy and convenient to use, and reliable.) What attracted you to use the IUD — in other words, what specific characteristics of the IUD motivated you to use the method? (Ask participants to explain what they mean by each characteristic). Which of these characteristics do you like most?

3. (Ask if some participants are former users of other methods): How similar or different is the IUD from previous and other methods that you have used? What are the similarities and/or differences? (Make sure to discuss the answers to this question by method.)

4. You mentioned that you used the IUD for (cite the number of months/years based on questionnaire responses gathered earlier). Were there problems during insertion? Did you experience expulsion? Were there problems during removal?

5. What were your reasons for stopping using the IUD? In what ways did it fail or meet your expectations? Who helped you decide to stop using the method? Did your providers (private/public) advise you to stop or not to stop? Why or why not?

6. What factors do you consider when choosing other FP methods? In your current methods being used now, are these factors present or not? Why or why not?
7. Would you recommend that other women use the IUD? Why or why not? If you were to market the IUD to other women, how would you convince them to use the method?

8. If you were to recommend changes in the design of the IUD, what would be your suggestions?
FOCUS-GROUP DISCUSSION GUIDE: CURRENT IUD USERS (B)

Introduction — names, study purpose, active participation, tape recording, and confidentiality.

Begin by saying: “We are going to discuss your views and experiences regarding your current use of the IUD.”

1. From who/where did you learn about the IUD?

2. Many women use a particular family-planning method because the method has certain characteristics. (Only say this if participants require it: for example, that it is easy and convenient to use, and reliable.) What attracted you to use the IUD — in other words, what specific characteristics of the IUD motivated you to use the method? (Ask participants to explain what they mean by each characteristic.) Which of these characteristics do you like most?

3. (Ask if some participants are former users of other methods): How similar or different is the IUD from the previous methods you used? What are the similarities and/or differences? (Make sure to discuss the answers to this question by method.)

4. Based on your experience, has IUD met your expectations — that IUD is what you thought it was as (cite the characteristics participants mentioned earlier)? In what ways it has met or has not met your expectations? Has your use of IUD also changed the ways you viewed the method before you actually used it? What specific views have been changed or have not been changed?

5. You mentioned that you have used the IUD for (cite the number of months/years based on questionnaire responses gathered earlier). Were there problems during insertion? Have you experienced expulsion? What bodily changes have you experienced in the first three months of using an IUD, and what did you experience after a year or more? What did you do to address these bodily changes? (If participants mention having visited medical professionals, ask if these are public or private providers, and in general ask them the extent in which they are assisted regarding bodily changes.)

6. Would you recommend that other women use the IUD? Why or why not? If you were to recommend the IUD to other women, how would you convince them to use the method?

7. If you were to introduce changes in the design of the IUD, what would be your suggestions?
FOCUS-GROUP DISCUSSION GUIDE: IUD INTENDERS (C)

Introduction — names, study purpose, active participation, tape recording, and confidentiality.

Begin by saying: “We are going to discuss your views regarding your intention to use the IUD.”

1. From whom/where did you learn about IUD?

2. What are your reasons for not using the IUD? What specific characteristics of the IUD did you not like? (Ask participants to explain each of these characteristics.) Which of these characteristics do you like least? What other information or details have you heard about IUD that kept you from using it?

3. What are your reasons for wanting to use the IUD now? (Ask among participants with family-planning method experience if not mentioned.) Does your experience using other FP methods constitute a reason for intending to use the IUD? In what ways has it constituted or has not constituted a reason? How similar or different are the characteristics of the IUD from the previous and other methods that you have used? What are the similarities and/or differences? (Make sure to discuss the answers to this question by method.)

4. What factors do you consider when choosing other FP methods? Previously, what methods did you use, and did you use these factors in the methods you used? Why or why not?

5. How can your intention to use IUD be translated into your actual use of the method?
FOCUS-GROUP DISCUSSION GUIDE: LIMITERS (D)

Introduction — names, study purpose, active participation, tape recording, and confidentiality.

Begin by saying: “We are going to discuss your views regarding how users of pills, injectables, or condoms can be encouraged to use the IUD.”

1. From whom/where did you learn about IUD?

2. What are your reasons for not using the IUD? What specific characteristics of the IUD do you not like? (Ask participants to explain each of these characteristics.) Which of these characteristics do you like least? What other information or details have you heard about IUD that kept you from using it?

3. Has your experience in using other FP methods constituted a reason for not using the IUD? In what ways has it constituted or not constituted a reason? How similar or different are the characteristics of the IUD from the methods you are now using? What are the similarities and/or differences? (Make sure to discuss the answers to this question by method.)

4. What factors do you consider when choosing other FP methods? In your current methods being used now, are these factors present or not? Why or why not?

5. How can women currently using pills, injectables, or condoms — such as yourselves — be encouraged to use the IUD?
INTERVIEW GUIDE FOR MALE PARTNERS OF IUD USERS

“We are conducting a study on the experiences of women regarding their use of the IUD for USAID/PRISM. Part of our respondents includes men whose wives or female partners are currently using the IUD. Please respond to the following questions as frankly as possible. The information you will provide will only be used for the purpose of the study.”

I. Profile
Let me ask some general questions about yourself.

1. How old are you? ___________
2. How are old is your wife/female partner? ________________
3. How many living children do you have? ________________
4. What is the highest education have you completed?
   ___Elementary
   ___High school
   ___College
5. What is your occupation? ________________________________
6. In every month, what is your income? ______________________
7. What is the occupation of your wife/female partner? __________________
8. In every month, what is the income of your wife/female partner? ______

II. Knowledge, Attitudes, and Experiences
At this point, let me ask about your knowledge, attitudes, and experiences concerning the IUD use of your wife/partner.

1. When your wife/female partner began using the IUD, were you asked what you thought about it? What did you say — were you approving or disapproving of its use? Why or why not? What were your reasons for approving or disapproving?
2. How long (in months/years) has your wife/female partner been using the IUD? How many has she used? When she had the IUD inserted, did you accompany her? Why or why not?
3. Has your wife/female partner had any problems while using the IUD? What are these and how did you help her solve the problem?
4. Have you had any problems while your wife/female partner was using the IUD — for instance, when you have sexual intercourse with her, do you get hurt or do you feel pain in your penis? Please describe this experience further.

5. Would you recommend that other men recommend that their respective wives/female partners use the IUD? Why or why not? What would you say to convince other men?
SCOPE OF WORK

Private-Sector Mobilization for Family Planning (PRISM) Project
Short-term consultancy
IUD MARKET ANALYSIS

I. Background
The phase out of USAID-donated intrauterine devices to the Department of Health is anticipated as a logical consequence of the Agency’s decision to increase private-sector support of the country’s family-planning program. As shown by the oral and injectable hormonal-contraceptive markets, USAID’s decision is likely to increase demand for IUDs in the commercial sector. The commercial sector must prepare for this consequence by making available an adequate supply of IUDs. However, little is currently known about the commercial market for IUDs in the Philippines. More information is needed to inform PRISM decisions about how best to support the commercial sector to better serve women who wish to use the IUD as their contraceptive method of choice.

II. Objective
To determine the potential to develop the commercial market for IUDs through an analysis of the current market situation.

III. General tasks
Two consultants will be hired for this project. The lead consultant will be responsible for assessing the demand (user) side of the market, including profiling user groups, describing their device and provider choices, and prices they pay. The second consultant will assess the supply (service provider) side of the market. Three research assistants will gather statistics and secondary data and help arrange interviews and focus groups. The market analysis should:

A. Describe the demand side of the market by delineating profiles of IUD users in the private and public sectors and by major regions, i.e., NCR, Luzon, Visayas, and Mindanao.
B. Describe the supply side of the market for IUDs, differentiating between devices and services, including products sold and clinical services offered by providers.

C. Estimate the commercial market potential of IUDs, taking into account users’ and providers’ attitudes, public policies, supply trends, sources, and availability of IUDs by regional locations, among others.

D. Recommend near- and medium-term action plans to sufficiently prepare for the impending USAID phase out of IUDs.

IV. Specific tasks and activities
The lead market analyst/consultant, assisted by research assistants, will be responsible for the following:

A. Obtain and analyze secondary data (such as the 2003 DHS and the 2004 FPS) to describe the present IUD market, with particular attention to private sources of IUDs acquired by clients and the clinical services associated with IUD usage. Identify different service providers by type, e.g., GP, IM, OB-GYNE, MW, etc., and estimate their respective shares of total services rendered.

i. Identify IUD brands available in the domestic retail market, including those purchased overseas by individual clients and those provided by or leaked from the public sector.

ii. Compare sales activity for IUDs (including Mirena) registered at BFAD for the past five years.

iii. For each type of provider source, describe services provided to private-sector IUD users and provide assessment of quality of care, including counseling and medical protocol, e.g., screening exams prior to IUD insertion, follow-up care, and removal.

iv. Analyze pricing for IUD devices, insertion services, pre- and post-insertion care, removal, and other charges for services obtained in the private sector vis-à-vis demographic profile of users.

v. Using estimates derived from DHS analysis on private IUD insertions, provide the number of private insertions using devices obtained from sources other than the domestic commercial market.

B. Run focus-group discussions, each consisting of six to eight participants, to gain insight on factors surrounding the women of reproductive age’s (WRA’s) IUD usage, non-usage, discontinuation of use, and future intentions to use the IUD. For each area, there will be two focus-group discussions for each type of respondent (defined below), totaling 24 groups:

i. Previous IUD users who no longer use an IUD.
ii. Current IUD users.

iii. “Intenders,” defined as women who are not currently using an IUD and have never used an IUD, but intend to become a user.

iv. “Limiters,” defined as women who want no more children but are currently using a short-term method (pills, injectable contraceptives, or condoms) rather than a more appropriate long-term method (IUD or voluntary female or male sterilization).

These discussions will obtain information on participants’ experiences with IUDs (group B), attitudes and reasons for IUD use (groups A and B) or non-use (groups C and D), reasons for discontinuation (group A), factors considered in choosing other FP methods (groups A and D), and reasons behind intent to use IUD (group C). Particularly, the focus-group discussions will also:

1. Profile IUD clients in terms of socioeconomic status, demographic and geographic characteristics, duration of IUD use (groups A and B), and reasons for discontinuation/removal (group A).

2. Compare and contrast profiles of IUD users who obtained their device and services from private providers against those who obtained them from public providers (groups A and B).

3. Determine if limiters who use short-term FP methods are potential IUD users (group D).

C. Compare public-sector service-delivery statistics (community-based FP management information system) with public-sector consumption data (Contraceptive Distribution Logistics management information system) to estimate the number of devices leaked from the public sector.

D. Estimate the potential for a private IUD market in light of the donation phase out, private-provider incentives to increase provision of IUD services, the effect of the donor phase out on the mix of methods chosen by modern-method FP users, consumer and provider attitudes (from results of the second consultant’s investigation) toward IUD as a family-planning method, and DOH and the Philippine National Drug Formulary policies regarding inclusion of IUDs, among other factors.

E. Estimate total IUD market through 2010, differentiating between projected private- and public-sector supply sources.

F. Integrate findings on the current IUD market situation (including recommendations on the best market opportunities to develop) culled from primary — both consumers’ and service providers’ perspectives — and secondary data analyses.
The second market analyst/consultant will concentrate on the following tasks:

A. Conduct 80 in-depth interviews among private doctors and midwives who provide IUD services to different socioeconomic WRAs specifically as follows:
   i. General practitioners: Five each from NCR, Luzon, Cebu, and Davao.
   ii. Family medicine: Five each from NCR, Luzon, Cebu, and Davao.
   iii. Obstetrician/gynecologists: Five each from NCR, Luzon, Cebu, and Davao.
   iv. Midwives: Five each from NCR, Luzon, Cebu, and Davao.

The interviews will provide insight on attitudes toward the IUD, factors considered when prescribing IUDs and related services, IUD patient profiles, sources of IUDs and purchase costs, professional fees, FP counseling conducted, and the referral system for IUDs tapped.

B. For each type of provider, describe services provided to IUD users and assess the quality of care, including counseling and medical protocol, e.g., screening exams prior to IUD insertion, follow-up care, and removal.

C. Content-analyze interviews and assist the lead consultant in creating a comprehensive report that integrates the results with the rest of the research data.

The research assistant for each of the study areas will recruit focus-group participants, organize the discussions, and:

   i. Screen and recruit WRAs for each of the specific focus-group discussions as described in Section IV (B) above.
   ii. Prepare venues and meals for the discussions.
   iii. Document and transcribe the discussions.
   iv. Collect secondary data from relevant agencies and individuals.
   v. Contact and set appointments with key resource persons who can provide additional information on the IUD market in their assigned areas.

For the above tasks, each research assistant is given 20 person-days for each of the study areas, except for the NCR-area research assistant, who is given an additional 10 person-days for gathering secondary data. Most IUD-related information is expected to be found in institutions within the NCR.

V. Deliverables/report requirements and due dates
This consultancy is expected to run approximately 52 person-days, commencing on or about October 15, 2005, and ending no later than January 30, 2006.

<table>
<thead>
<tr>
<th>DELIVERABLES/REPORT REQUIREMENTS</th>
<th>DUE DATES</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Work plan design and timetable addressing the tasks in Section IV.</td>
<td>No later than 2 days after signed acceptance</td>
</tr>
<tr>
<td>2. Preliminary report on secondary-data analysis from lead consultant.</td>
<td>2 weeks after approval of design and timetable</td>
</tr>
<tr>
<td>3. Presentation of discussion guides for focus-group discussions and in-depths, review, and acceptance.</td>
<td>1 week after preliminary report on secondary data accepted</td>
</tr>
<tr>
<td>4. Conduct focus-group discussions and in-depths in all 4 areas.</td>
<td>2 months after acceptance of discussion guides</td>
</tr>
<tr>
<td>5. Final integrated report from lead consultant: “Situational Analysis of the Current IUD Market.”</td>
<td>2 weeks after conduct of all interviews/discussions</td>
</tr>
</tbody>
</table>

**TOTAL** 13 weeks

VI. **Supervision**

The consultants will report directly to the market development director.

VII. **Personnel**

Below are the qualifications for the position of market analyst/consultant:

i. Post-graduate, preferably in social sciences.

ii. Appreciation of the Contraceptive Self-Reliance (CSR) program with working knowledge of FP methods.

iii. Exposure to NGO FP programs is an advantage.

iv. At least five years’ professional experience in qualitative and quantitative market research, preferably on pharmaceuticals or consumer products.

v. Data-analysis skills.

vi. Demonstrated ability to quickly develop good working relationships.

vii. Work experience requiring leadership skills and strategic thinking ability is an advantage.
## VIII. Level of effort (LOE)

<table>
<thead>
<tr>
<th>ACTIVITIES</th>
<th>ESTIMATED LOE</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Lead consultant:</strong></td>
<td></td>
</tr>
<tr>
<td>Work plan design and timetable</td>
<td>2 person-days</td>
</tr>
<tr>
<td>Organize and analyze secondary data</td>
<td>10 person-days</td>
</tr>
<tr>
<td>Run focus-group discussions</td>
<td>20 person-days</td>
</tr>
<tr>
<td>Collation, integration, and analysis</td>
<td>10 person-days</td>
</tr>
<tr>
<td>Final report writing: integration of secondary data, key informant interviews, focus-group discussions and in-depths</td>
<td>10 person-days</td>
</tr>
<tr>
<td><strong>TOTAL person-days</strong></td>
<td>52 person-days</td>
</tr>
<tr>
<td><strong>Assistant consultant:</strong></td>
<td></td>
</tr>
<tr>
<td>Run in-depth interviews in NCR, Luzon, Cebu, and Davao</td>
<td>30 person-days</td>
</tr>
<tr>
<td>Content analyze interviews and assist lead consultant in their integration into the final report</td>
<td>5 person-days</td>
</tr>
<tr>
<td><strong>TOTAL person-days</strong></td>
<td>35 person-days</td>
</tr>
</tbody>
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