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The DMPA service provider: Profile, problems and prospects, August 1995

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THE DMPA SERVICE PROVIDER: PROFILE, PROBLEMS AND PROSPECTS

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INTRODUCTION

This report presents the results of interviews conducted with sixty trained DMPA service providers from seven of the ten local government units (LGUs) covered by Phase I of the Philippine Department of Health's DMPA (Injectable Contraceptive) Reintroduction Program. The interviews were undertaken as part of the DMPA Monitoring and Follow-up Studies sponsored by the Population Council under the Asia and Near East Operations Research and Technical Assistance (ANE OR/TA) Project. While the monitoring study and the follow-up survey focused on DMPA users and drop-outs, this study centered on the service provider.

The DMPA Reintroduction Program: Background Information

The DMPA Reintroduction Program was launched by the DOH in April 1994, following the approval of the use of depot-medroxyprogesterone acetate (DMPA), commonly known as Depo-Provera, by the Philippine Bureau of Food and Drugs (BFAD) in November 1993. The program aims to reintroduce DMPA into the Philippine Family Planning Program (PFPP) through the training of local-level doctors, nurses and midwives as service providers, and the provision of free DMPA services in selected public health facilities. The program is being implemented in three phases.

Phase I concentrates on ten local government units (LGUs) consisting of four chartered cities (Baguio City, Quezon City, Iloilo City and Davao City) and six provinces (Pangasinan, Laguna, Cebu, Davao del Sur, South Cotabato and Surigao del Sur) spread out in seven administrative regions nationwide (See Figure 1). Phase II calls for the expansion of DMPA services in early 1995 to the rest of the cities and provinces within the seven regions where the ten pilot LGUs are located. By the third phase, it is

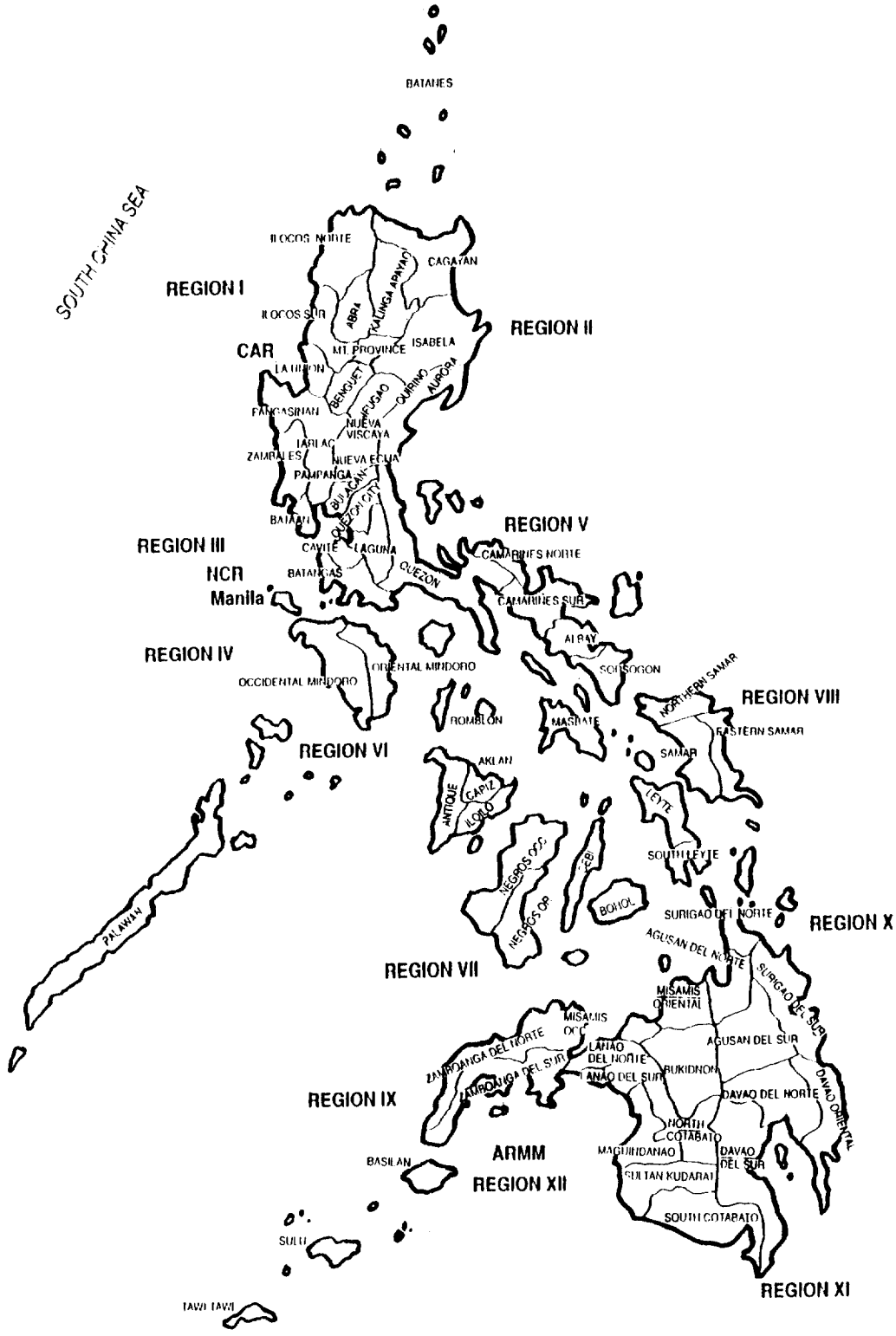
envisioned that DMPA services will be available in all of the 15 regions of the Philippines (Population Council, 1994a:3).

Training of Service Providers on the Provision of DMPA as a Contraceptive Method

Based on reports from the DOH and the family planning program coordinators of the ten LGUs, a total of 86 training courses were conducted between April and July, 1994 as were attended by a total of 1,748 midwives, nurses and doctors from 1,422 health facilities and offices (Population Council, 1994b: see Form 3, Report 4).

Training courses were conducted by local-level "trainors" under the coordination of the DOH Family Planning Service Training Division and the local government health and/or population offices. Each training course is composed of five modules namely: 1) DMPA as a Method, 2) Management of Side Effects and Complications, 3) Counselling DMPA Clients, 4) Provision of DMPA and 5) Return Visit and Follow up of Defaulters (Department of Health, n.d.).

As trained DMPA service providers, these health personnel are expected to offer a host of services to potential and actual DMPA acceptors. Their major tasks include counselling on DMPA, conducting screening and client assessment procedures, administering DMPA injections, providing "post-injection" instructions to clients, managing and treating reported side effects and following up clients to ensure that they return for a reinjection. The service providers are also expected to submit a monthly report on the number of DMPA acceptors and continuing users in their facility.



Map of the Philippines

Figure 1. LGUS Involved in Phase I of the DMPA Reintroduction Program

OBJECTIVES AND METHODOLOGY

This study was designed to obtain a socio-demographic profile of DMPA service providers and to gain an understanding of the problems they face in providing injectable services as well as the strategies they employ to solve such problems. The respondents were also asked to evaluate themselves and the training course given by the DOH in cooperation with the local government units. This information will serve as an input for the future training of service providers.

A total of sixty trained DMPA service providers were interviewed for this study: one from each of the randomly selected health facilities[1] located in Quezon City, Laguna, Cebu, Davao del Sur, Davao City, South Cotabato and Surigao del Sur. The interviews in Luzon were carried out by researchers from De La Salle University's Social Development Research Center (SDRC); those in Visayas by Xavier University's Research Institute for Mindanao Culture (RIMCU); and those in Mindanao by the Ateneo de Davao University's Social Research Office (SRO), using a standard questionnaire (see Appendix A). Data were collected in February and March, 1995.

RESULTS OF THE STUDY

A. PROFILE OF DMPA SERVICE PROVIDERS

A total of 57 female and 3 male service providers were interviewed for this study. The respondents were mostly midwives (comprising 78% of the sample), with some nurses (17%) and a few doctors (3%).

[1] These facilities were among the 100 sampled facilities from which the respondents for the follow-up survey of DMPA acceptors were chosen.

Two out of three respondents were assigned to a barangay health station (BHS) while 32 percent were working in rural health units (RHUs) or municipal health centers (MHCs).

As Table 1 shows, a majority (58%) of the respondents came from the provinces of Davao del Sur, South Cotabato and Surigao del Sur all on the island of Mindanao. Three out of ten respondents were from the province of Cebu in Visayas, while the remaining 12 percent were from Quezon City and Laguna in Luzon.

Table 1. Distribution of Respondents by Study Sites

STUDY SITES	% of Respondents
LUZON	
Quezon City	3.3
Laguna	8.3
VISAYAS	
Cebu	30.0
MINDANAO	
Davao del Sur	28.3
South Cotabato	21.7
Davao City	6.7
Surigao del Sur	1.7

Table 2 provides profile data on the social and demographic characteristics of the respondents. Most (80%) of the sampled service providers were married. The rest were either single (15%) or widowed (5%).

The youngest respondent was 23 years old while the oldest was 62. Average age was 41 years. A considerable number (43%) of the respondents were already in their 30s. About three out of ten (28%) were in their forties while roughly one in five (19%) were already in their 50s.

Most (83%) of the respondents have children. Family size ranged from one to eleven children. A majority (55%), however, had three or fewer children. Among the married women in the sample, the average number of children per respondent was 3.18, which is lower than the national total fertility rate (TFR) of 4.06 (National Statistics Office and

Macro International, 1994:25).[2] The ages of the eldest children ranged from two to 34 years, while those of the youngest children ranged from less than one year old to 31 years of age. Average ages for the two groups were, respectively, 14 years and 7 years.

Table 2. Profile of Respondents: DMPA Service Providers

VARIABLE	% of Respondents
Gender	
Female	95.0
Male	5.0
Civil Status	
Married	80.0
Single	15.0
Widowed	5.0
Age (years)	
23-29	8.5
30-39	43.5
40-49	28.4
50-59	18.5
60-62	1.7
Mean age (years)	(41.12)
Number of Children	
0	16.7
1-3	55.0
4-6	25.0
7-11	3.4
Mean number of living children among married respondents (n=48)	(3.18)
Occupation	
Midwife	78.3
Nurse	16.7
Doctor	3.3
No data	1.7

More than half (55%) of the service providers surveyed were themselves current

[2] Total fertility rate can be interpreted as the "average number of births a hypothetical group of women would have at the end of their reproductive lives if they were subject to the currently prevailing age-specific rates from age 15 to 49" (National Statistics Office, 1994:25).

users of family planning methods. Of these, a third were using intra-uterine devices (IUDs). About one in four had already been ligated, while 15 percent were using DMPA. The rest were practicing natural family planning (9%), using condoms (9%) or taking pills (6%).

Eighty percent of the respondents attended the training course for DMPA providers between April and July 1994. The rest were trained on DMPA service delivery only in late 1994 or early 1995.

To summarize, the typical DMPA service provider is a 41-year old female midwife stationed at a barangay health center. She is married and has three children; the eldest aged 14 years and the youngest aged 7. She is likely to be a family planning user herself: using an IUD if not having already been ligated. She was trained on effective DMPA service delivery in mid-1994.

B. PERCEIVED ROLES AND RESPONSIBILITIES AS DMPA SERVICE PROVIDERS

Respondents were asked to enumerate what they thought were the roles and responsibilities of a DMPA service provider. "Counselling clients" and providing them with information on the advantages and disadvantages of DMPA as a contraceptive method was the most commonly cited. Eight out of ten (83%) respondents gave this answer (see Table 3).

The second most frequently mentioned task has to do with "managing the side effects of DMPA". Half of the service providers said that part of their job is to help women deal with the side effects of DMPA. This includes giving women medicines (i.e. analgesics, vitamins, iron tablets) to relieve them of pain or discomfort, referring them

to doctors for appropriate medical treatment or simply giving them the needed reassurrance that such side effects are to be expected, and that the risks are minimal.

Half of the respondents also said that "following up DMPA clients" to ensure that they continue their use of the injectable, is another important task of a DMPA service provider. In most cases, this means reminding the clients of their scheduled reinjections with the help of the DMPA reminder card (see Appendix B). Where necessary, a few service providers said that they may even pay their clients a visit to remind them that they are due for a reinjection.

Table 3. Perceived Roles and Responsibilities of DMPA Service Providers

ROLES/RESPONSIBILITIES	Percent of Respondents Mentioning Item[a]
Client counselling	83.3
Management of side effects	50.0
Follow-up of clients	50.0
Motivation of clients	35.0
Administration of DMPA injections	28.3
Screening/client assessment	18.3
Management of logistics	3.3

[a] Total exceeds 100% due to multiple responses.

"Motivating women" to accept DMPA as a family planning method was mentioned as a DMPA service provider's task by a third (35%) of the respondents; while "administering DMPA injections" was cited by only 28 percent of the sample.

Interestingly, only 18 percent of the respondents mentioned "proper client screening and assessment" as a responsibility of a DMPA provider. Even though this is one of the tasks expected of a trained DMPA provider, only one out of five respondents remembered to mention it during the interview.

C. SELF-EVALUATION AS A DMPA SERVICE PROVIDER

When asked to evaluate themselves vis-a-vis their perceived roles and responsibilities as a DMPA service provider, the words "capable", "competent" and "committed" were used by those who were interviewed.

Almost half (45%) of the respondents saw themselves as capable DMPA service providers who are "able to perform the tasks expected of them". Fifteen percent considered themselves "competent" while ten percent described themselves as having "sufficient knowledge for the job". Seven percent "believed in what they were doing" and considered themselves "committed" to the task of providing quality DMPA services to women in the communities.

1. Perceived Strengths as a DMPA Service Provider

When asked to enumerate their "strengths" as a DMPA service provider, almost half (45%) of the respondents cited counselling, education and the provision of information about DMPA to women as one of their strong points (see Table 4).

Thirty-seven percent felt that they were good in motivating women to accept and use DMPA as a family planning method. One out of five providers also considered themselves effective in following up their clients and making sure that they come back for their scheduled reinjection. The same proportion of women (20%) also considered themselves competent in helping women deal with the side effects of DMPA use.

Only 12 percent of the providers considered their acquired skill in administering DMPA injections as one of their strengths as a DMPA service provider. Even fewer (3%) considered themselves "strong" in the area of client assessment and screening.

Table 4. Perceived Strengths and Weaknesses as a DMPA Service Provider

AREAS	Percent of Respondents Mentioning Item as a:	
	STRENGTH[a]	WEAKNESS
Client counselling	45.0	3.3
Motivation of clients	36.7	13.3
Follow-up of clients	20.0	23.3
Management of side effects	20.0	15.0
Administration of injection	12.0	0.0
Screening/patient assessment	3.3	0.0
Management of logistics	3.3	0.0

[a] Total exceeds 100% due to multiple responses.

2. Perceived Weaknesses as a DMPA Service Provider

Only a few respondents mentioned any weaknesses with regard to their role as a DMPA service provider. Those who did, cited limitations in the following areas: following up clients to ensure continued use of DMPA (23%), handling complaints about side effects (15%), motivating women to use DMPA (13%) and counselling (3%).

3. Coping Strategies

How did they deal with their identified weaknessses? For 12 percent of the providers, this meant reading materials on DMPA and referring back to their DMPA kits for information to help them counteract rumors about DMPA.

One out of ten said that they simply "tried their best" to answer their clients' queries about the injectable. The same proportion of providers consulted their supervisors.

Other coping strategies employed by the DMPA service providers included delegating some of their tasks to the barangay health worker (11%) and adjusting their work schedules to meet the demands of their job as a service provider (8%).

D. ASSESSMENT OF THE TRAINING COURSE FOR DMPA SERVICE PROVIDERS

When asked to evaluate the content and methodology of the training course they attended, the respondents' assessment was generally positive (see Table 5).

Roughly a third of the providers said that the topics covered by the training were "clearly explained". In particular, this evaluation referred to such topics as: 1) DMPA's mechanism of action, 2) proper administration of DMPA injections, 3) safety, risks and contraindications of DMPA, and 4) effective counselling on DMPA. Between 22 to 25 percent of the providers also said that "adequate information was provided" on each of these four topics.

The methodology used to conduct the training was described as "effective" by 18 percent of the service providers surveyed. In particular, they considered effective such techniques as role-playing, return-demonstrations (especially in learning how to correctly administer injections), use of audio-visual aids and the distribution of reading materials on DMPA (i.e., the DMPA information kit) during the training.

No negative remarks were made with regard to three of the topics covered by the training: DMPA's mechanism of action, the administration of DMPA injections and quality of care. A few respondents though, did express some doubts about the adequacy of the training given with regard to the health risks of DMPA (13%) and their role as a DMPA counsellor (8%).

Table 5. Assessment of DMPA Providers' Training

RESPONDENTS' COMMENTS	CONTENT					METHODOLOGY
	DMPA's Mechanism of Action	Administration of DMPA Injection	Safety/Health Risks of DMPA	Counselling	Quality of Care	
POSITIVE REMARKS						
Very satisfactory	18.3	20.0	13.3	16.7	15.0	-
Good	8.4	10.0	5.0	-	15.0	-
"Okay"	6.7	11.7	5.0	13.3	11.7	6.7
Fair	6.7	-	6.7	5.0	6.7	5.0
Explanation was clear	31.7	36.7	41.6	33.4	25.0	21.7
Information was adequate	23.4	23.3	25.4	21.7	21.6	15.4
Effective	5.0	5.0	6.7	5.0	1.7	18.4
Role-playing was effective	-	-	-	-	-	5.0
Return demonstration was effective	-	3.4	1.7	-	-	-
Use of audio-visual aids/distribution of IEC materials was helpful	-	-	-	-	-	1.7
NEGATIVE REMARKS						
Not clearly explained	-	-	3.4	3.4	-	-
Explanation not comprehensive	-	-	6.7	3.4	-	1.7
Time for discussion too short	-	-	1.7	1.7	-	1.7

1. Perceived Need for Additional Training

Four out of ten service providers feel that they need more training on how to effectively manage and treat the side effects of DMPA (see Table 6). Twenty eight percent also said that additional emphasis should be given to "safety concerns and health risks of DMPA" as a contraceptive.

Other topics or areas mentioned were: DMPA's mechanism of action (15%) and its contraindications (12%), effective counselling on DMPA (13%), how to counteract rumors about DMPA (7%) and how to effectively follow up clients to ensure continued use of DMPA (5%).

Table 6. Areas for which Additional Training is Needed

TOPIC/AREA	Percent of Respondents Mentioning Item [a]
Management of side effects	40.0
Safety/health risks of DMPA	28.3
DMPA's mechanism of action	15.0
Counselling	13.3
Contraindications of DMPA use	11.7
Counteracting rumors about DMPA	6.7
Follow-up of clients	5.0
Screening/assessment of clients	1.7
Advantages of DMPA	1.7

[a] Total exceeds 100% due to multiple responses.

PROGRAM IMPLICATIONS

When asked what topics or areas they feel should be emphasized in future training courses for DMPA providers, the respondents gave basically the same answers mentioned above (see Table 7).

"How to handle and manage complaints of side effects" of DMPA was the most frequently mentioned topic to be emphasized in future trainings. This was cited by 43 percent of the providers who were interviewed.

Seventeen percent felt that future training courses should focus as well on the contraindications and health risks of DMPA use. Other areas that need to be emphasized are: how to counteract rumors about DMPA (13%), how DMPA works/what its mechanism of action is (12%) and how to effectively follow up DMPA clients (8%).

Table 7. Topics/Areas that Need to be Emphasized in Future Trainings

TOPIC/AREA	Percent of Respondents Mentioning Item [a]
Management of side effects	43.3
Contraindications of DMPA use	16.7
Safety/health risks of DMPA	16.7
Counteracting rumors about DMPA	13.3
DMPA's mechanism of action	11.7
Follow-up of clients	8.3
Administration of DMPA injections	5.0
Screening/assessment of clients	3.3

[a] Total exceeds 100% due to multiple responses.

E. SERVICE PROVIDERS' ATTITUDES TOWARDS DMPA USE

Most service providers (93%) approve of DMPA as a family planning method. A

significant number (88%) also say that, as DMPA service providers, they have had no personal conflicts with their religious beliefs. In fact, one-fifth of the sample have already tried using DMPA at one time or another. The rest of the respondents were not using DMPA because they were either using an IUD or have already been ligated (30%), were still single or already widowed (17%), or had "no need" for a contraceptive (13%) at the time of the survey (i.e., husband is abroad, respondent is "too old" or has had menopause already).

The service providers' appreciation of the injectable stems from their perception that it is convenient/easy to use (42%), effective (37%) and safe (20%). A few said that it is readily available (8%) and non-intrusive (3%).

F. PROBLEMS ENCOUNTERED IN SERVICE DELIVERY

When asked what problems they have encountered in providing DMPA services to women, most of the providers did not mention any with regard to accomplishing reports (93%), following up drop-outs (83%) or managing logistics (80%), as shown in Table 8.

However, when it came to handling complaints of side effects from users and dealing with rumors about DMPA, roughly 40 percent of the providers reported at least one problem. In fact, when asked further to identify one major problem they had to deal with, these two topics/areas were the most frequently mentioned. "How to effectively handle rumors about DMPA" was reported to be the most pressing problem encountered by 27 percent of the providers, while "managing the side effects of DMPA" was a major difficulty for 22 percent of them.

The following are the specific problems reported by the service providers along four major areas:

Table 8. Problems Encountered in DMPA Service Delivery

PROBLEMS	Percent of Respondents Mentioning Problem [a]
MANAGEMENT OF SIDE EFFECTS	
Insufficient knowledge on side effects treatment	26.7
No back-up physician at the health center	6.7
No medicines for treatment of side effects	5.0
Supervisors are not knowledgeable about side effects management and treatment	3.3
No problem	61.7
DEALING WITH RUMORS ABOUT DMPA	
Insufficient knowledge to counter rumors	26.7
Low acceptance/use of DMPA because of rumors	13.3
Difficult to trace source of rumor	3.3
No problem	60.0
LOGISTICS	
Inadequate supplies of DMPA reminder cards	11.7
Inadequate supplies of DMPA leaflets	8.3
Late arrival of DMPA supplies (vials/syringes/needles)	8.3
Inadequate copies of DMPA logbook	3.3
No problem	80.0
FOLLOW-UP OF CLIENTS	
Lack of staff to follow up clients	15.0
High drop-out/discontinuation rate	5.0
No problem	83.3
REPORTING	
Form was "confusing" at the start	3.3
Ran out of envelopes	1.7
No problem	93.3

[a] Totals exceed 100% due to multiple responses.

1. Management of Side Effects

In general, the most common complaints of clients about DMPA, according to the providers, are menstruation irregularities. A little over half (52%) of the service providers cited "spotting" along with other complaints such as amenorrhea (38%) and bleeding (30%). Headaches and dizziness (35%), weight gain (8%), abdominal pain (5%) and irritability (5%) were also mentioned. To handle such cases, a good number of the providers (70%) reinforced information given to the client. They also reassured the clients (40%) that these effects will eventually be minimized. Some (17%) prescribed medicines to help relieve pain.

When asked what problems they have encountered in this area, 27 percent of the providers felt that they still lack adequate knowledge on how to effectively treat the side effects reported by DMPA users. Other problems include the absence of a back-up physician to help the service providers deal with the side effects experienced by users (7%); lack of medicines with which to treat side effects (5%); and their observation that the supervisors themselves do not seem to have adequate knowledge about the treatment of DMPA's side effects (3%).

2. Dealing with Rumors About DMPA

At times, rumors about the safety of DMPA will circulate throughout the community, creating fear and anxiety among users. Twenty-seven percent of the providers said that they do not feel that they have adequate knowledge and skills to deal with this problem. Thirteen percent said that such rumors may account for the problem of either low DMPA acceptance or increased incidence of DMPA drop-outs. A few providers (3%) said that the source of rumors was difficult to ascertain.

3. Logistics

Reported problems with logistics include inadequate supplies of DMPA reminder cards (cited by 11% of the providers) and DMPA leaflets (8%), late arrival of DMPA vials and syringes (8%) and inadequate number of DMPA logbooks provided for the DMPA-dispensing facilities in the communities (3%).

4. Follow-up of DMPA Clients

The most frequently cited problem with regard to following up DMPA clients is that the health centers do not have enough staff members to help the midwife follow up the DMPA clients, especially those who have not returned for their scheduled reinjections. This was cited by 15 percent of the providers. As a result of this limitation, five percent of the providers said that they had to face the problem of increasing number of DMPA drop-outs.

G. STRATEGIES EMPLOYED TO SOLVE PROBLEMS IN DMPA SERVICE DELIVERY

To deal with the problem of helping women manage the side effects of DMPA, almost half (47%) of the providers employed "better counselling" techniques which included "reassuring" women that side effects are to be expected and that risks to their health are minimal. For complicated cases such as severe bleeding, five percent of the providers referred the DMPA users to a doctor for appropriate medical treatment (see Table 9).

Forty-seven percent of the providers also tried to counteract rumors about DMPA with "proper dissemination of accurate information" about the injectable. Reading up on DMPA and referring back to their information kits proved particularly helpful in preparing the service provider for this task. Providing clients with copies of DMPA leaflets also helped to correct previously held misconceptions about DMPA. Availability of these materials was limited, however.

Table 9. Problem-solving Strategies Employed by DMPA Service Providers

STRATEGY	Percent of Respondents Mentioning Item [a]
Better counselling (including reassuring clients)	46.7
Proper information dissemination	46.7
Organizing women in communities	8.4
Conducting home visits to follow up clients	6.7
Training other midwives on DMPA service delivery	5.0
Referring clients to a doctor	5.0
Delegating responsibilities to BHWs	3.3

[a] Total exceeds 100% due to multiple responses.

Other problem-solving strategies which were employed included: 1) conducting home visits to follow up DMPA users who have not returned for their scheduled reinjections (7%); 2) organizing groups of women in the communities so that information on DMPA could be disseminated through these entities (8%); and 3) training other midwives in the health center (5%) or delegating some responsibilities to the barangay health workers (3%) to help service providers meet the demands of their job.

When asked if they think these strategies helped, 40 percent of the providers said that they believe that they do helpto increase levels of DMPA acceptance.

H. SUGGESTIONS TO IMPROVE DMPA SERVICE DELIVERY

Based on their experience with service delivery, providers were asked how best to improve the delivery of DMPA services could be improved. Four out of ten providers (38%) said that there should be more information dissemination activities so that more couples will be made aware of DMPA's advantages and disadvantages. These will also help to correct current misinformation about the method.

One out of five respondents suggested that more training courses for DMPA providers should be conducted, especially emphasizing the area of side effects management.

Seventeen percent also said that steps should be taken to improve counselling and screening procedures so as to ensure quality DMPA service.

Concern about the availability of DMPA supplies was aired by 15 percent of the providers, who suggested that measures be taken to ensure that health facilities have continued supplies of DMPA vials and syringes in the future. Logistical support for transportation costs to help providers follow up their clients was also suggested by eight percent of the respondents.

Other suggestions include: conducting home visits to follow up clients (7%), continued monitoring of clients (5%), providing incentives to service providers (3%) and training more doctors on DMPA service delivery (3%).

Table 10. Suggestions to Improve DMPA Service Delivery

SUGGESTION	Percent of Respondents Mentioning Item
More information dissemination activities	38.0
Continuous training of DMPA providers (including refresher courses)	20.0
Improve counselling and screening of clients	16.7
Ensure continuous supply of DMPA	15.0
More logistical support (i.e., vehicles)	8.3
Conduct home visits to follow up clients	6.7
Continued monitoring of clients	5.0
Train more doctors on DMPA service delivery	3.3
Give incentives to DMPA service providers	3.3

PROGRAM IMPLICATIONS

A. On Training

While the service providers' assessment of the training courses have generally been positive, survey data strongly indicate the need for future training courses to put greater emphasis on two major issues: 1) management and treatment of side effects resulting from the use of DMPA, and 2) ways of correcting and effectively counteracting rumors and misconceptions about DMPA. Related to these are such topics as DMPA's "safety", contraindications and the health risks associated with its use.

Another important area that needs to be emphasized during the training is client screening and assessment. While many of the providers who were interviewed feel confident about their skills in counselling, the same cannot be said about their role in screening potential clients. Data showed that this is one of the least remembered task of a DMPA service provider. It may well be one of the least performed duties as well. Given the importance of providing quality care to DMPA users, training in this particular area should be strengthened.

Adequate and clear instructions regarding these three topics should be provided during the training courses to ensure that the trained DMPA service providers will be able to render quality services to both potential and actual users of DMPA.

Training methodologies such as role-playing, return demonstrations, use of audio-visual aids, and distribution of DMPA information kits to service providers were well-received. Trainors should therefore continue employing (and improving) such strategies in future training courses. In particular, the role-playing technique could be used more often to assess how well the trainees will be able to screen potential users, handle women's complaints of side effects or counteract rumors about DMPA.

B. On IEC Materials Development and Distribution

There was a strong consensus among the service providers that more information and education activities are needed especially at the local level, not only to make more couples aware of the DMPA injectable as another contraceptive option, but also to provide complete and correct information about the method.

Considering this need, the program could work towards establishing a wider and more effective distribution of existing IEC materials on DMPA. Even non-users of the method or potential DMPA acceptors could be included in this effort. It would also help to develop new IEC materials on such topics as "Answers to the Most Commonly Held Misconceptions about DMPA" or "What to do When Side Effects are Experienced", using the local dialects. Another alternative is to integrate these two topics into the existing DMPA leaflet (see Appendix C). This new and updated version could then be distributed to the different DMPA-dispensing facilities. As for the DMPA information kit, this proved to be a helpful reference material to the DMPA service providers. Steps should be taken to ensure that all trained DMPA providers are given one of these during the training.

REFERENCES

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APPENDIX A

Questionnaire

1. Information on the Health Facility

    a. Name of Health Facility:_____
    b. Location (Province, Municipality and Barangay):_____
    c. Type of Facility (RHU, BHS, NGO, Hospital): _____

2. Background Information on the Respondent

    a. Name of Service Provider: _____
    b. Sex: _____
    c. Age (years): _____
    d. Civil Status:_____
    e. Occupation (doctor, nurse, midwife, others): _____
    f. No. of children (if any): _____
        Age of eldest child: _____
        Age of youngest child: _____
    g. Current user of FP?: Yes ____ No _____
        If yes, what method? _____
    h. Date of DMPA training (Month/Year): _____

3. Perceived roles of DMPA providers

    a. What do you think are the roles/responsibilities of DMPA providers to their clients/DMPA users?

    _____
    _____

    b. How would you assess yourself vis-a-vis such responsibilities?

    _____
    _____

    c. What would you consider as your strong and weak points as a DMPA provider?

    _____
    _____

    d. How did you cope with these weaknesses?

    _____
    _____

4. Assessment of DMPA training

a. How would you evaluate/assess your DMPA training in terms of:

- CONTENT

: mechanism of DMPA's action _____
_____

: administration of DMPA _____
_____

: safety/health risks/contraindications _____
_____

: counselling/management of health risks _____
_____

: quality of care indicators _____
_____

- METHODOLOGY

: effectiveness _____
_____

b. What areas do you feel you need more training on or should be emphasized more during trainings in order to provide better quality of care to DMPA users? _____
_____

c. What should be emphasized in future DMPA trainings now that you have experienced administering DMPA? _____
_____
_____

5. Problems encountered in DMPA service delivery

a. What problems have you encountered in the delivery of DMPA services?

- logistics/availability of supplies _____
_____

- monitoring/reporting _____
_____

- management of health risks/side effects _____
_____

- dealing with rumors/misconceptions about DMPA _____
_____

- low acceptance/high drop-out or discontinuation rate _____
_____

b. Which of these are major constraints affecting service delivery?

_____
_____

c. What strategies/courses of action were taken to solve these problems?

_____
_____

d. What were the outcomes of such problem-solving strategies?

_____
_____

e. What can you suggest to improve service delivery and quality of care for DMPA users?

_____
_____

6. Clients' major complaints about DMPA?

a. What were the major complaints of DMPA users about the method?

_____
_____

b. How did you deal with these clients' problems/complaints about DMPA?

_____
_____

7. Providers' attitudes towards DMPA use

a. Do they personally approve of DMPA? Yes _____ No _____
Why/why not? _____
_____

b. Are you currently using DMPA, or do they plan to use DMPA in the future? Yes ____ No ____
Why/why not? _____
_____

c. Did you ever have to deal with conflicts between your personal/religious beliefs/opinions about DMPA and you responsibility as a DMPA provider?
Yes ____ No ___
If yes, how did you resolve such conflicts? _____
_____

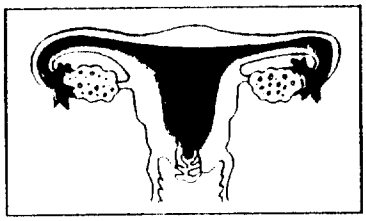
What were the outcomes? _____

APPENDIX B

Sample DMPA Reminder Card

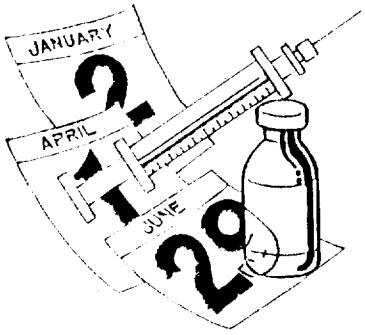
APPENDIX C
Sample DMPA Leaflet

Ang Depot Medroxyprogesterone Acetate (DMPA) ay isang paraan ng pagpaplano ng pamilya na iniiniksiyon sa babae tuwing ikatlong (3) buwan. Ito'y paraang pang-agwat na maginhawa. Wala nang tatandaan pa ang gumagamit liban sa petsa ng muli niyang pagpapainiksiyon tatlong buwan makalipas ang huli niyang iniksiyon.



PAPAANO AT KAILAN IBINIBIGAY ANG DMPA?

- Bago iniiniksiyon ang DMPA sa isang babae, iiksaminin muna siya ng doktor, nurse o [illegible] para malaman kung angkop sa kanya
- [illegible] babae sa DMPA, siya'y [illegible] unang pitong



Sa paepapainiksiyon ng DMPA, mapipigilan ang obulasyon ng babae. Walang itlog na lalabas sa kanyang obaryo kayat walang makakatagpo ang semilya ng lalaki sa panahon ng pagbubuntis. Pinakakapal din ng DMPA ang uhog sa loob ng liig-liigan ng babae na siyang nagsisilbing balakid sa pagpasok ng semilya patungo sa matris ng babae.

DMPA
Depot Medroxy-Progesterone Acetate

Ligtas...
Mabisa...
Pangmatagalan...

MGA KABUTIHANG DULOT NG DMPA

- Tunay na mabisa (99%)
- Ligtas
- Pangmatagalan ang epekto (3 buwan)
- Pansamantalang paraan lamang. Paglipas ng bisa ng DMPA, babalik ang kakayahang magbuntis ng babae.
- Naiiwasan nito ang anemia o kakulangan ng dugo ng babae.
- Naiiwasan ang ectopic pregnancy, o pagbubuntis sa labas ng matris.
- Naiiwasan ang PID o impeksyon sa pelvis.
- Nagsisilbing proteksyon laban sa kanser sa endometrium at obaryo.
- Sa regular na pagpapainiksiyon, magagawa ang check-up nang regular at mabibigyan ng maagap na lunas ang babae sa anumang problemang pangkalusugan na mararanasan niya.

Isang Paraan ng Pag-aagwat sa Pag-aanak Para sa Babae