Expanding Contraceptive Options

Experiences of users and providers with progestin only injectable contraceptive-DMPA

Findings of a Multi-Centric Study

October 2004

United Nations Population Fund, India

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Preface

Fertility is falling in all developing countries as use of modern contraceptives is rising. Findings from Demographic Health Surveys being conducted in different countries suggest that family planning programmes are helping people who wish to have smaller families thereby achieving their reproductive intentions.

Injectable contraceptives are increasingly becoming a popular option among married women in developing countries. Experience with injectable contraceptives for more than 40 years suggests that the most successful programmes have attempted to provide accurate and balanced information, emphasized counseling, ensured reliable supplies and avoided unnecessary barriers.

There has been a long felt need for understanding the perceptions of users and providers of injectable contraception in India. Paucity of information in an organized manner to understand the dynamics of injectable contraceptive use in India has been acknowledged.

This document presents findings from three multi-centric studies in India. Several service delivery issues highlighted in the studies deserve attention. Findings also provide important feedback on providers' perceptions and issues related to improving quality of counseling.

I would like to thank all the Principal Investigators and their colleagues for undertaking these studies.I would also like to put on record appreciation for the members of the Technical Advisory Group for providing necessary guidance and suggestions throughout the work.

I take this opportunity to thank Dr. Dinesh Agarwal, Technical Adviser (Reproductive Health), UNFPA for synthesizing the study findings and for the finalization of this report. Most importantly I express heartfelt gratitude to all the users and providers who took time off from their daily routine to interact with the research teams. I welcome any feedback and suggestions on this work.

Hendrik van der Pol

October 2004

UNFPA Representative, India

Executive Summary

The National Reproductive and Child Health Programme aims to address unmet contraceptive needs through increasing access, expanding choices and improving the quality of family planning services. Over the past thirty years there have been significant advances in the development of new contraceptive technologies, including Progesterone Only Injectables (POI). In India, POIs are available through commercial and social marketing channels since 1994, and have not yet been introduced in the public sector programme.

UNFPA along with the Government of India commissioned multi-centric users and provider perspectives study with respect to POI contraceptives. It was envisaged that access to information on user's perspectives would help in understanding the dynamics and complexities of decision-making, experience with side effects and overall satisfaction with the use of this method. It was also felt that availability of such information would help in focusing on key service delivery issues, keeping in mind the need to upscale the method in the future. These studies were undertaken in three cities, viz., Ahmedabad, Vadodara and Hyderabad, by three research institutions.

One hundred and sixty current users of POI (only Depot Medroxy Progesterone Acetate – DMPA) were included in the study during a period of nine months beginning from June 2002. Study respondents were approached through providers, and ethical guidelines were adhered to during the course of the study. Normative ethical principles were followed during data collection. In the three cities, providers were also interviewed to get information on their perspectives. Qualitative data collection tools in the form of in-depth interview schedules were used and the analysis was based on key study domains and sub domains.

A significant proportion of clients was using ICs as a long-term reversible option, and had past contraceptive exposure. Very few users accepted the method for delaying the birth of the first child. Many users had also undergone termination of pregnancy in the past, which could be attributed to contraceptive failure in some cases. The promise of the effectiveness might have motivated these women to use injectable contraceptive, DMPA.

Study findings also point towards the surfacing of a category of 'secret users'. These included women who wished to avoid pregnancy without the knowledge and concurrence of their husbands and other family members. Injectable contraceptives allowed them to practice contraception discretely.

Study findings also reinforced the importance of contraceptive counselling in helping the user to make an informed decision for selection of this method and its continuation. Users were often more concerned with the immediate effects of contraceptives, such as potential changes in menstrual cycle, body weight and mood changes. Lack of any counselling protocol was also an issue. It emerged that the core contents of counselling, i.e., mode of action, side effects and management, were not adequately addressed by the providers. Private providers also required periodic orientation on issues related to medical eligibility, side-effects management and counselling.

DMPA users reported 'problems' in the form of side effects - the most common being excessive (or heavy) and irregular bleeding. These are expected and usually do not need any drug treatment although a few providers do prescribe NSAID (Non Steroidal Anti Inflamatory Drugs) or estrogens for management of some side effects. Clients did not seem to be bothered with amenorrhea, though they needed counselling and reassurance from the providers to rule out the possibility of pregnancy.

The study also provided insights with reference to coping mechanisms, especially in the context of side effects. Many users tried to rationalize these side effects, e.g., changes in bleeding patterns. However, this rationalization was again influenced with the kind of inputs received during counseling for the method.

It is important to note that 70 percent of the users were satisfied with this method. These clients were most likely to continue utilizing this method for the desired duration. Based on the study findings, an attempt was made to develop a decision-making framework depicting key processes and stakeholders involved. A similar framework had been formulated based on the likes and dislikes of the method perceived by the providers, users and both.

Findings from the study also highlighted issues pertaining to providers. Most providers did not propagate the indiscriminate use of this method, barring a few exceptions. DMPA was not offered to everyone and was also not seen as the first choice of providers. For private providers, each client (and the family members!) is a valued patron for their routine clinical practice and they could not risk jeopardizing their practice by 'pushing' this method.

Though injectable contraceptives are very popular for preventing unwanted pregnancies in many countries, in India, the use of this method is highly restricted. One reason could be the limited availability. Findings of this study provide some directions for improving effectiveness of service delivery systems and highlight critical elements that need priority attention. While on one hand, the client's education and counseling support do much to promote the acceptance of menstrual changes that accompany injectable contraceptives, on the other hand, efforts to enhance the provider's capacity for using protocols to select clients, counseling and management of side-effects can help individuals and couples in achieving their reproductive intentions. Programs should also address the issue of pricing of the commodity, as both users and providers expressed their concern regarding the impact of high prices on continuation with this method.

1

Background

This document presents a synthesis of the findings from a multi-centric study on users and providers perspectives. These studies were commissioned in three Indian cities during 2002. The Technical Advisory Group (TAG) established for the study (see annexure) finalized terms of reference for the proposed study and sent out request for proposals to more than 20 organizations/institutions ranging from medical colleges to NGOs engaged in research. Only 7 institutions submitted their proposals. TAG reviewed the proposals and decided to involve the following institutions:

- Dept. of Community Medicine, Medical College, Vadodara
- Foundation for Research in Health Systems, Ahmedabad
- Indian Institute of Health and Family Welfare, Hyderabad

Qualitative methods were used for gathering information from current DMPA users and the providers. In the subsequent sections, an attempt has been made to highlight key observations and analyze implications for better service delivery leading to greater client satisfaction.

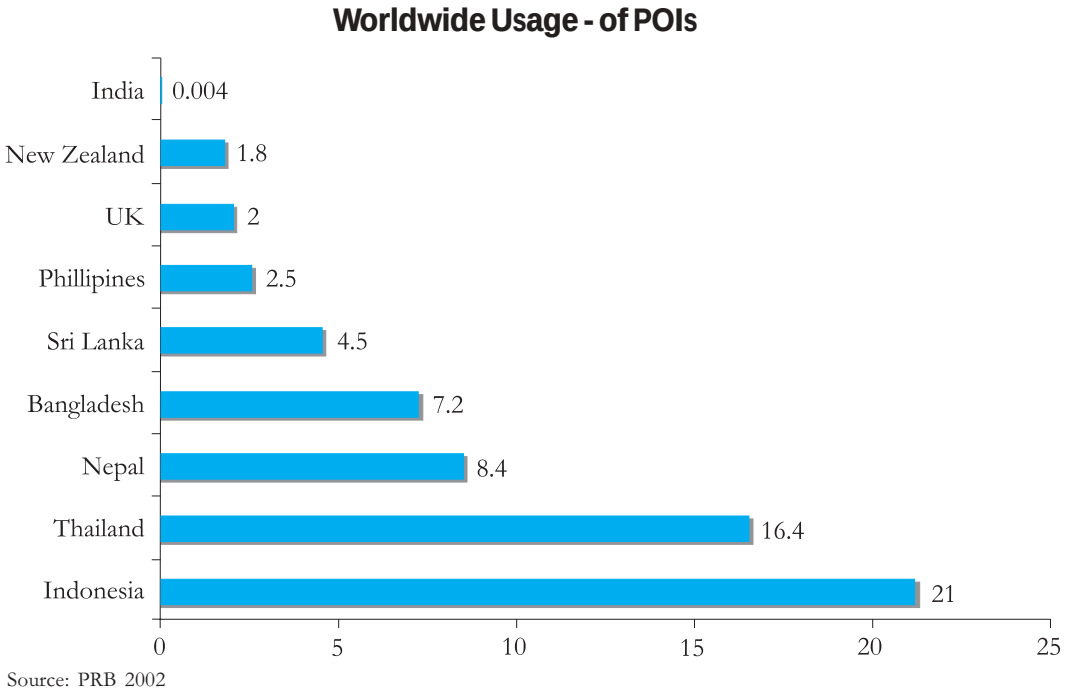
Over the past few decades, there has been a substantial increase in the use of contraceptives in India. As per the Rapid Household Survey results (2002)[1], use of modern contraceptives is nearly 46 percent. Another 6 percent of couples use traditional methods. Despite impressive gains, several issues continue to hinder progress. A significant proportion of pregnancies continue to be unplanned; contraceptive needs of millions of couples remain unmet; several population groups, viz., adolescents and men continue to be ignored and underserved; and contraceptive choices remain conspicuously missing, as is quality care within the programme.[2] The National Population Policy (2000) affirms the Government's commitment to address unmet demands of contraceptives by making safe, effective contraceptives accessible to people.

Perusal of method-mix clearly shows a bias toward female sterilization. Overall, sterilization accounts for three-quarters of contraception use. The current use of reversible methods is low at 10 percent. Use of injectable contraceptives (IC) is negligible, although in many countries in the world, ICs contribute significantly in helping couples to achieve their reproductive intentions.

There is empirical evidence to indicate that addition of any new method in the programme will increase contraceptive uptake. Research suggests that a choice of several contraceptive methods is more likely to result in contraceptive use. As quality improves and more methods become available, more couples use contraceptives For each additional method that is widely available in a country, contraceptive prevalence increases by an average 3.3 percentage points. Recent studies have shown that 28 percent of Indian women do not want more than two children and 9 percent of all recent births/pregnancies are unplanned.

[1] District level HH Survey RCH 2002, IIPS, Mumbai.

[2] Santhya KG.Changing Family Planning Scenario in India: An Overview of Recent Evidence. Population Council, India 2003.



Further, 13 percent women reported that they would like to wait for 2 years[3] before bearing another child. Thus, there is significant unmet need for reversible methods.

The potential for using additional methods for spacing has been acknowledged in India. It is known that an interval of 3 to 5 years between births significantly reduces infant and child mortality. Besides contributing to achievements of policy goals related to child and maternal mortality, such a move will also help in realizing the reproductive rights of people by expanding contraceptive choices.

Depot-Medroxy Progesterone Acetate (DMPA), a progesterone only injectable contraceptive (POI) was approved for use by the Drug Controller of India in 1994. It is estimated that more than 15 million women in the world using progesterone only injectables. DMPA and NETEN are two widely used POIs available. More than 100 countries in the world have approved DMPA since the early 1960s, but political controversy and scientific uncertainty have held back injectables. In India, DMPA is available only through private/social marketing channels, as the method does not find place in the National Family Welfare Programme. However, there are reports of low-priced smuggled products from neighboring countries, which continue to be available in border areas.

In the past few years there have been some attempts to examine the possibility of introducing POIs in the national programme. A study on the operational feasibility of introducing NETEN is already under progress under the aegis of the National Institute of Research in Reproductive Health, Mumbai and results are likely to be made available by the end of 2004. Post-marketing surveillance studies at ten sites were conducted for DMPA after its introduction in 1995-97. Results of the post -marketing surveillance study indicate a very high continuation rate. These studies provide substantive information on user perspectives, service delivery issues and continuation rates, although there are some concerns articulated about methodological issues.[4]

[3] District level HH Survey RCH 2002.

[4] Satyamala C: An Epidemiological Review of Injectable contraceptives, Depo-Provera, MFC: Forum for Women's Health 2000.

Transition from the demographic orientation to more client-centered, need-based and quality-oriented programme demands that user perspectives are taken into consideration in the design of service delivery interventions. The acceptability of a particular method, despite very high effectiveness, will determine its use. The groups resisting introduction of injectable contraceptive in the national programs have expressed several concerns and apprehensions. Most of these concerns are related to service delivery issues especially quality of contraception provision. On the other hand, there are groups and networks, which feel that restricting access to injectable contraceptive to the commercial sector will deny expanded choice of methods for poor women who primarily rely on public systems for contraceptives. The present study is an attempt to 'listen to the users'. This necessitates the conduct of qualitative studies to understand the user's experiences with the method. Since the method involves services from a qualified provider, it will be of interest to map the provider's experiences in terms of its acceptability, side effects and their opinions on likes and dislikes.

2 Objectives & Methodology

2.1 Objectives

UNFPA in consultation with the Government of India commissioned a multi-centric study to assess the perspectives of users and providers on injectable contraceptives. Since the use of NETEN is still limited, the study was focused on DMPA alone. The objectives of the study were as follows:

- To identify users' perspectives vis-à-vis injectable contraceptives. This also included understanding the evolving perspective of clients at different times of use.
- To analyze providers' views on service provision with reference to injectable contraceptives.
- To identify individual, social, gender and cultural issues related to decision-making in the use of POI and its continuation.
- To identify policy and service provision implications that may emerge from research findings.

A Technical Advisory Group comprising eight members, representing academics, NGOs and the Government, was constituted to guide and monitor the multi-centric study. Following were the terms of reference for this group:

- Review Terms of Reference for research and suggest any modifications if necessary.
- Advising identifying agencies that could be invited to carry out the research and appraising the proposals.
- Advise on processes to ensure that the study is carried out in a transparent manner.
- Monitoring the work of research agencies.
- Guide UNFPA on dissemination of the findings of this research.

a. Suggested Categories of Respondents

A cross-sectional study design was proposed to incorporate perspectives of different groups from diverse settings. Thus, it was proposed to include current users as well as those who discontinued use in the last three months of the interview. Only ten users from one site were enrolled as those who discontinued use in the past three months. For the ease of analysis, all these users were also included in the category of current users. Amongst providers, doctors from public/private/social marketing sectors (prescribing and non-prescribing) were included to gauge their perspectives.

b. Time Frame

All clients accepting injectable contraceptive from identified public/private clinics or social marketing organizations, during the study period, i.e., (June 2002 to March 2003) were included in the study.

c. Methodology

Sampling - It was visualized that at least fifty current users and ten providers (both prescribing and non-prescribing) would be enrolled at each site. The three sites followed different methods to enroll providers in the study. However, a uniform protocol was followed for enrolling clients. They were enrolled through providers and providers were identified using database from professional associations using the snowball technique. Research institutions ensured that any selection bias in terms of enrolling providers are minimized, if not completely eliminated. Thus, providers enrolled were representative of the average, solo practitioners in urban areas and not necessarily the "best" in terms of professional competency and clinical practice.

Study Tools - The data for achieving the study objectives had been gathered using qualitative tools i.e., semi-structured interview schedules. All such interviews were recorded after being granted permission from users and providers, as vocabulary and semantics were important indicators for comprehensive understanding. These study tools were developed in a methodology workshop and were first translated and then pre-tested at the three study sites.

d. Ethical Issues

All three participating institutions had their own institutional ethics committee. These committees reviewed the study protocols. The women who enrolled for the study gave two sets of consents - one to the provider for meeting with the research team and another to the research team consenting to participate and freedom to withdraw herself at any stage during the course of study. The Technical Advisory Group (TAG) monitored the research teams to ensure that ethical guidelines were followed, as reflected in the recommendations of the respective ethics committees.

e. Training

The Post Graduate Institute of Medical Education and Research (PGIMER), Chandigarh, conducted an orientation meeting of the research teams along with the principal investigators from the three centers. This meeting also provided an opportunity to deliberate on the methodology, design of instruments and the analysis plan. Senior faculty from the Department of Social Anthropology, Punjab University, Chandigarh, provided critical inputs in refining qualitative methods for data collection and clarifying ethical issues involved in the research.

f. Analysis

After an initial review of study schedules, dominant themes were identified through colour markings in all the transcripts. Independent interpretative summaries were prepared for each theme. These were reviewed again to check with disparities and agreements.

3

Profile of Users

One hundred and sixty current DMPA users were enrolled for the study at three sites during the study period of nine months. As all the providers consenting to provide access for interview of the clients were located in urban areas, the study findings do not represent the situation in rural India.

After inviting proposals from interested organizations, the TAG selected three organizations to conduct the study. Selection of the sites is justified as Gujarat and Andhra Pradesh report almost 15 and 5 per cent of total DMPA sales respectively, as per sales figures of DKT programme interventions.[5] Table1 depicts salient findings on key socio-demographic variables for the respondents.

Table 1 Socio-demographic Characteristics of Respondents (N=160)

Parameter	Number	Percentage
Age (years)		
15-19	6	4
20-24	51	32
25-29	69	43
30-34	24	15
35-39	8	5
40>	2	1
Literacy Status		
Illiterate	10	6
Primary	19	10
Secondary	54	25
Graduate and above	67	28
Religion		
Hindu	135	84
Muslim	21	13
Other	04	3
Occupation		
Home Maker	129	81
Working Outside	31	19
Income Levels (total income per month in Rupees)		
<3,000	21	13
3,000-6,000	37	23
>6,000	66	41
More than 6000	36	23

[5] DKT India, Contraceptive Social Marketing Quarterly Report Jan - Mar 2004.

These findings indicated that, typically, an urban injectable contraceptive user was in the age group of 20-29 years, did schooling beyond the secondary level and belonged to the middle-income group. It also appeared that the women, who were homemakers, had preferred this method. Though not representative, findings also suggested that a larger proportion of users enrolled for the study belonged to the Muslim community, especially in Hyderabad, where 22 percent women were Muslims.

Injectable contraceptives are positioned as highly effective, reversible contraceptives, most appropriately suited for delaying pregnancy after marriage and also to maintain the desired spacing between two children. During the study, an attempt was made to understand the reproductive behaviour of current users. Table 2 depicts the reproductive profile of users:

Thus, most of the users enrolled in the present study had past contraceptive experience and switched over to IC as they found this method more appropriate. It appeared that past exposure to contraceptives would help women in accessing information about the other contraceptives as well as weigh their risks and benefits. The quality of care in FP demands that clients should make an informed decision before accepting a particular contraceptive on the basis of information available about the different methods and their reproductive intentions. The data also indicated that a significant proportion of users were using the method as a long-term reversible option. Very few users were using the method to delay the birth of the first child. A significant proportion of users had a history of induced abortion. One of the reasons for seeking induced abortion could be contraceptive failure. It is possible that many users were looking forward to accept a highly effective method so as to prevent any unwanted pregnancy and consequently resort to induced abortion in the future.

Table 2 Reproductive Profile of Respondents (N=160)

Characteristics	Number	Percentage
Number of live children		
None	3	2
1	76	48
2	63	39
More than 2	18	11
History of prior abortion		
Natural	15	9
Induced	35	22
Past contraceptive used (multiple methods may be used)		
Used some family planning method	110	69
Used no family planning method	50	31
CuT	33	21
Oral Pills	43	27
Condoms	36	23
Natural	12	8
Others	1	1
Reproductive Intentions		
Spacing	97	61
Don't want more children	63	39

4

Decision Making for Contraceptive Use

The decision to adopt a particular type of contraception can be a complex process. Several studies in the past have probed into the role of personal, family, community and service delivery factors in choosing a particular method. In the following paragraphs, an attempt has been made to analyse factors leading to the acceptance of the injectable contraceptive, DMPA.

The reasons for preferring the injectable contraceptive are shown in the Table 3:

Table 3 Distribution of users as per their reasons for selection

(N=160)

Reasons	Number	Percentage
1. Problems with other contraceptive used in past	48	30
2. Provider's Advice	33	21
3. Negative perceptions of other methods	73	46
4. Medically not eligible for other methods	26	16
5. Secrecy/Confidentiality	18	11

* *Multiple reasons were given by the users*

The reasons reported were either based on personal experience of using other contraceptives in the past or negative perceptions harboured about other methods. The provider's advice for using IC was also cited as one of the reasons to decide in favour of IC. Common negative perceptions about contraceptives as narrated by respondents were as follows:

"**Doctor gave the guarantee for CuT but my husband said it gets displaced so don't take it.** *A 28-year-old woman, AB with 2 children.*

Taking pills every day is a problem and on top of it I feel uneasy, nauseated and even get a headache. *NB, a 29-year-old woman with one child, explained the reason for switching over from OC pills to IC.*

We were both not comfortable using condoms, our skin used to get stretched; there was excessive bleeding due to Cu-T, my body had become weak and there was white discharge also; then by using OC pills also I used to get excessive bleeding so finally I had to take the injection.
Ms SK, 27- yr-old mother of three children.

Insertion and removal of CuT is a painful procedure and pills reduce secretion of breast milk. *JB, a 29-yr-old woman with one child.*"

It also appears that for a significant proportion of users, secrecy in the use of IC is a major consideration. As one user, SB, a mother of one daughter narrated, *'There is no need to convince your husband about the use of the FP method as IC allows you complete secrecy and freedom'*. In fact, several users perceive this as a highly positive attribute of the method. Women's attitudes toward IC largely reflect their own feelings about privacy and convenience of use and assessment of menstrual bleeding disturbances. These feelings in turn, reflect not only the attributes and physiological effects of the method, but also the user's knowledge and understanding of the method, personal needs, contraceptive experiences, partner's attitudes and cultural norms.[6]

Although women bear children and most modern contraceptives are women-centered, child-bearing has an impact on men's lives too. The male partner and other family members do play an important role in decision-making regarding contraceptive use, the number and gap between children.

Several studies[7] have highlighted the importance of inter-spousal communication in the matter of choosing a particular contraceptive. It is generally acknowledged that free communication between spouses will allow them to choose a contraceptive as per their reproductive intentions.

Table 4 shows the involvement of different stakeholders in decision-making leading to the use of IC.

Table 4 Decision-Making Process for IC use (N=156)

Decision-Making	Number	Percentage
1. Own decision	36	23
2. Consultation with husband only	61	38
3. Family members' advice	37	23
4. Provider's advice	22	15

A closer probing of responses indicate that husbands played a prominent role in decision-making alongwith clients as evident from the following quotes:

> " **My husband said do what you feel like doing, I am with you.** *MB, a 22-year old woman with no child.*
>
> **My husband says do whatever you want to, don't ask me to use condoms.** *A 32- year-old working woman with one child.* "

In this context it is crucial to reach out to men with appropriate messages so that they are involved in decision-making in matters of contraceptive choices.

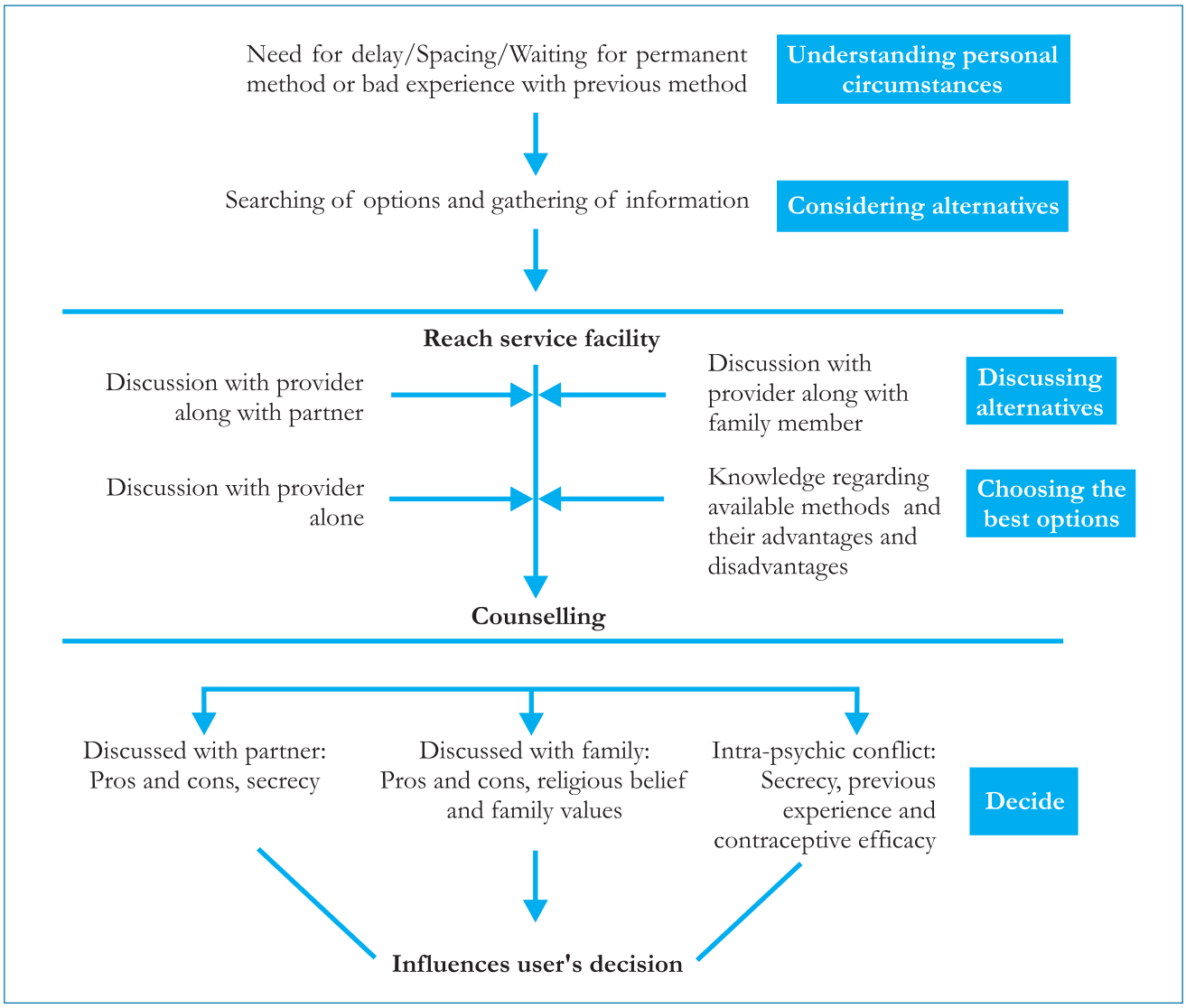
A Provider's role in influencing decisions in favour of a particular contraceptive has been a matter of debate in the past. Study findings shed light on how the providers influenced decision at least at one site.

" **The doctor told me to accept some method. He told me about injections and said he will not advice me to take oral pills, as I was breast feeding or Copper-T as I had undergone ceserean section. He insisted that I should take injection and himself administered it, before discharging me from the hospital.** *Ms N, 23-yr- old, delivered in hospital.* "

[6] Population Reports. New Era for Injectables. Series K5 1996

[7] A Kinriuala Bakale & Susheela Singh: Concepting Fertility & Contraceptive Decision Making in Developing Countries, Hearing the Men's Voices. International Family Planning Perspective: 24 1. March 1998.

Based on the varied inputs involved in the decision-making process as articulated by the users enrolled at three sites, an attempt has been made to develop a decision-making framework. The framework helps in understanding different steps involved in the decision-making process leading to the acceptance of the method. Needless to say, any communication interventions for increased and expanded choices should take these elements into cognizance and try to reach out to different stakeholders with appropriate messages.



The framework highlights a sequence of events culminating in the acceptance of the method. As a first step, contraceptive choices are established based on reproductive intentions of the couple. This is essentially followed by exploring more on the method/s with service providers. Service delivery attributes impact the decision in a big way at this level. This leads to some reflections and iteration back home.

As depicted in Table 3, eighteen women were using the method secretly; i.e., without disclosing the fact to their husbands. Some of these women preferred to call themselves 'secret users' as no one other than

the user and provider knew about it. They expressed fear and guilt for concealing the contraceptive use from their husbands.

" Main injection lay rahin hoon per hamesha dar laga rehta hai ki unko pata na lag jaye. (Though I am taking the injection but am always apprehensive about him knowing.) *'Secret' user, a 24-yr-old women with one child.* **"**

Pervasive and persistent power inequalities in sexual relations lead many women to develop individual strategies to protect their reproductive health and hide these strategies from their partners. The prevention of unwanted pregnancy by using contraceptives secretively is perhaps the best known of these strategies. Injectable contraceptives are seen as methods which enhance women's control over her fertility. In a society, where decisions for contraceptive acceptance are seen as power to control fertility, availability of such methods help women realize their contraceptive choices, albeit in the form of these 'secret users'. Study findings also highlight that women will not like to confront family members openly in matters of contraception. Depending on the autonomy available to them with respect to mobility and access to money, such women will be happy to accept a family planning method, that helps in maintaining secrecy.

The first stage of deciding on the choice of a particular method depends on the availability of information. Family Planning programmes have placed emphasis on informing clients about all available contraceptives through imaginative communication programmes. Ninety nine percent of currently married women in the reproductive age group are aware of at least one modern contraceptive method, though awareness of reversible methods was rather limited amongst men and women.[8] In the present study, respondents were probed about information sources with respect to IC. (Table 5)

Table 5 Information Sources on IC (N=160)

Source of Information for IC	Number	Percentage
Doctors	119	74
Friends/Relatives	32	20
Print Media	9	6

As ICs are not available in the National Family Planning Program, communication activities focusing on ICs are limited to commercial and social marketing sectors only. Moreover, as IC is not offered as an OTC product, promotional efforts by pharmaceutical companies are restricted to private practitioners. Since providers in public systems do not receive any orientation about the method, any counselling for reversible contraceptives does not include injectable contraceptives. In such a situation, a potential client does not have access to sources of information other than private practitioners.

There is need to understand the importance of reaching out through the vast cadre of paramedics working in the private and public sector. Availability of information with these providers will help women to cross check the information received from other sources.

[8] NFHS-2, India, 1998-99, IIPS, Mumbai

5

Counselling Services

Family planning programs have placed emphasis on informing clients about all available methods through communication interventions. Quality counselling helps clients to choose and use certain contraceptives. Counselling protocols and decision-making tools are developed to help providers during the process of counselling.

Injectable contraceptives pose a number of difficult counselling issues, some of which are posed by other contraceptives as well. Providers need to counsel the prospective clients about:[9]

- Range of side effects
- Changes in bleeding pattern
- Breast cancer
- Return of fertility
- Schedule of injections

In the study, an attempt was made to assess the quality of counselling in terms of issues covered during these sessions. WHO medical eligibility criteria has listed some of the key issues regarding– eligibility of women, the right time to begin use, time to repeat the injections and the course to be adopted if there is menstrual disturbance with the use of DMPA. If providers do not take into cognisance some of these issues, there is likely to be a high discontinuation rate and a low level of client satisfaction.

Service Quality Issues:
Table 6 (What was shared with women?)

Counselling Issues	Number	Percentage
1. How effective is it?	134	84
2. How does it work?	12	8
3. What side effects can be expected?	127	79
4. What to do for management of side effects?	87	54

As noted in the previous sections, doctors were the source of information for a majority of the clients. During the counselling sessions prior to the adoption of the method, discussions focused mostly on highlighting its effectiveness, expected side-effects and action recommended for the management of side-effects. It is important to note that most providers did not discuss, in detail, about the mode of action which was not deemed necessary. At one site, not a single user mentioned about any enquiry/ investigation being made about diabetes or hypertension. Many users did not receive information on the return of fertility. Though some women seemed to have received complete information as evident from the following quotes:

[9] Population Reports New Era for Injectables Series K No. 5 March, 1996

“ **The doctor told us about two products and their costs. She gave me the first dose and also gave me an information booklet about the method.** *26-yr-old woman on contraceptive counselling received by her.*

A group of doctors explained to me in detail about the injection and its possible side effects, and told me to call any time in case I had any problems related to its use. *Ms SP, 29-yr-old woman.* ”

Most users do not recall receiving any client information material or take-home pamphlets. In some social marketing programs such client information material has been developed and is being given away to the clients. It is agreed that women are more likely to continue a method if they receive good counselling and know what to expect after accepting the particular contraceptive. Information also helps clients to switch to other methods rather than stop using them. Program experiences from other countries indicate that women often tolerate side-effects that they expect, but may discontinue, if side-effects are not anticipated.

> “ **Doctors must spare enough time in explaining, so that one can understand every thing. Only putting up posters outside will not do.** *A 32-yr- old woman complaining about short duration of counselling.* ”

It appears that there were critical gaps and inadequacies with respect to counselling. Interventions to strengthen skills in interpersonal communication and counselling of providers will go long way in improving quality of services and significantly increase continuation rates.

Poor quality of counselling by providers in the matter of contraception has been a major concern. These concerns range from clients not being given complete and correct information for exercising choices, to non-adherence to counselling protocols. Non-availability of these protocols with providers is a major gap that needs to be addressed.

6

Use and Experiences

Several studies in the past have emphasized the importance of client satisfaction for continued use of any contraceptive. The studies from Bangladesh indicate a higher continuation rate with the DMPA following attention given to quality elements in the program[10]. The Table 7 depicts the distribution of clients per the number of doses.

Table 7 **Distribution of Clients as per Number of Doses** (N=160)

Number of Doses	Number of Users	Percentage
1-3	112	70
4-6	41	26
>6	7	4

The table no. 7 shows that most clients had taken 1 to 3 doses and very few had taken more than 6 doses. As the study was cross-sectional in design, continuation rates could not be worked out. However, data did indicate the possibility of dropouts after the second and third doses. This could be attributed to a sudden alteration in the bleeding pattern, which might not have been acceptable to many clients. Studies have suggested that only over half the number of women would continue using DMPA after 12 months. Analysis of narratives indicated the non-acceptance of side-effects by some users while other users were comfortable with similar side-effects. In the absence of any counselling, these users were likely to discontinue the method. Following quotes sums up users experiences:

" If my bleeding does not come down in a few months, I will have to stop taking injections.

If monthly bleeding does not happen on time, there is burning (*jalan*) in the body.

It comes sometimes in drops only and my relatives advised to stop injections.

Now with no bleeding, there is no interruption in religious activities.

Injection suits me completely. I have no problems.

***Roj roj bleeding thaya kare to bhagwan ni puja pan na thay* (Daily bleeding does not allow to perform worship of God).**

Injection is fine with me (*Favi gayu chhe*). "

It will be safe to conclude that women accept injectables both for spacing and limiting purposes. Even if they start with the intention of using the method for a long duration, in the absence of any counselling they tend to discontinue. Yet there will be some women who would be willing to use this method as a stopgap till the time they were mentally prepared to choose another long term method. Women also acknowledge the delay in return of fertility. Generally, the return of fertility following the discontinuation

[10] Akbar J, Chakraborty J, Jahan N, Philips JF, Satterthwaite AP. Dynamics of DMPA use effectiveness in Matlab family planning health survivors project. Paper presented in annual conference of Bangladesh fertility research programme, Dhaka 1982.

of the IC is measured by the time interval from the last injection to conception or first ovulation. It is a good counselling practice by service providers to explain to women about the variations in return of fertility and that it could not be predicted with any degree of certainty. The median time for those who conceive is 10 months, following the last injection.

Findings from qualitative studies indicated that women had a sense of nervousness regarding the return of fertility, especially those who discontinued its use to have another child. In a study of contraceptive preferences of women, discussions on preferred length of the method's effectiveness were dominated by the responses *'two to three years', 'at least three years'* [11]. These responses clearly indicated that women do prefer a method which gives them sufficient time to keep-off future pregnancies by at least 2 to 3 yrs.

Viewed from the perspective of women's preferences, some users might be taking into account the period of return to fertility in terms of deciding about timing of discontinuation. In case they plan to have a child after two years, four to five injections would give adequate protection for the desired duration.

Though the consideration of long-term safety of hormonal contraceptives is important, users were mostly concerned with more immediate side-effects of the injectable contraceptive. Users were completely dependent on the providers as far safety issues are concerned. It is generally assumed that providers will not promote any method which is not safe.

> "**For us the Doctor is next to God. Whatever he says is final.** *PB, a 23-yr-old woman.*"

Dissatisfaction of users with the existing methods often stemmed from physical discomfort or cumbersome usage. Concerns about such issues could lead to a reluctance to initiate the method or result in premature discontinuation. In-depth interviews focused on eliciting client's responses regarding the problems as perceived by them after accepting injectable contraceptive. Table 8 reflects the responses of users in terms of the 'problems' perceived by them.

Table 8 **Problems Faced by Users** (N=160)

Nature of problems (multiple responses)	Number	Percentage
1. Excessive Bleeding	30	19
2. Scanty Bleeding	11	7
3. Irregular Bleeding/Spotting	33	21
4. Amenorrhea	20	13
5. Pain	19	12
6. Others	04	3

Variation in side-effects was also noticed. Disruption of regular menstrual bleeding and amenorrhea are the most common side-effects of injectables and the main reasons of discontinuation. Few women reported a variety of side-effects for e.g., headaches, dizziness, abdominal discomfort, acne and moodiness.

[11] Rachel Snow, et al – Attributes of Contraceptive Technology. Women's preferences in seven countries. Beyond Acceptability – Reproductive Health Matters 2001

The most reliable evidence of menstrual changes comes from a WHO coordinated multi-centric study. Only about 10 percent of the DMPA users had normal cycles in the first year of use. They could expect irregular bleeding in the first six months followed by infrequent bleeding. Users complaining of excessive bleeding following the first dose, complained of amenorrhea after subsequent injections[12].

WHO guidelines suggest that amenorrhea following IC use does not require any medical treatment and spotting or light bleeding is particularly common after the first injection and is not harmful. If the bleeding is persistent, gynaecological conditions need to be excluded. Similarly, excessive bleeding may be present after the first injection. But if heavy bleeding (more than 8 days and twice as much as the usual menstrual bleeding) persists, she may be advised to choose another method.

In this qualitative study, women's perceptions of problems were mapped and rigid clinical– domains in terms of side-effects were not followed. Thus, it was noticed that a very high percentage of users reported excessive bleeding, although most studies suggested that irregular bleeding (breakthrough bleeding and spotting) was more common in the initial cycles. Invariably, clients experienced a gradual decline in irregular bleeding and increase in amenorrhea after one year.

There are major methodological issues concerning measuring effects of ICs on bleeding patterns, especially inconsistent definitions and non-standardized reporting of the incidence of side-effects. Regional, cross-cultural and individual differences in tolerance or acceptance levels of menstrual bleeding are also important issues. In a multi-centric study to assess contraceptive preferences, women frequently described the 'trade-offs' they made, to use highly effective methods. A woman in FGD said, *'There is pain in these methods but there is at least no danger that women will conceive'*. Women at all sites were intolerant of heavy bleeding and associated it with extreme fatigue, ill health and inability to work or carry out domestic chores. Frequent bleeding not associated with heavy bleeding appeared to be a tolerant bleeding disturbance for many women in USA, although women in India and Pakistan seemed to find this disturbance problematic.[13]

Several studies in the past used menstrual diaries to assess the variations in bleeding patterns. In the present study, menstrual record diaries were not given and the women were encouraged to narrate their own experiences with respect to any changes in their bleeding patterns in the post injection period.

Severity of bleeding is largely determined by a combined set of factors that include socio-cultural intensity of symptoms and its effect on the user's marital life. In the study there were following viewpoints as articulated by some of the users:

" **There was no problem in monthly bleeding not taking place, but there was anxiety about any problems in the uterus.** *RB, a 26-yr-old woman.* "

These were women who were more worried about their health rather than concerned with bleeding changes.

" **Bleeding does not take place, only drops come out.** *JS, a 32-yr-old woman.* "

[12] World Health Organization [WHO]. Special Programme of Research, Development and Research Training in Human Reproduction. Contraception 1986a.

[13] R Snow et al Attributes of Contraceptive Technology: Women's Preferences in Seven Countries. Beyond Acceptability; RHM, 2001.

Scanty bleeding also worries most women. Their comfort levels with menstruation were linked with the amount of bleeding. A few drops during bleeding reminded them that they might yet have to 'purge' themselves.

" **Sometimes periods are on and sometimes off. I am afraid.** *SB, a 20-yr-old woman.*

I have to be cautious so as not to touch others when bleeding is taking place. *CP, 22-yr-old woman.* "

Unpredictability of bleeding changes created problems for some women. It appeared that health concerns were of paramount importance for women and any method-specific counselling would have to address these concerns. These women faced a real dilemma. While they were not sure if the spotting or irregular bleeding was akin to the monthly periods, prevailing cultural norms did not allow them to violate established rituals and practices.

Women who were counselled about the side-effects were comfortable with the method. As one woman in Ahmedabad said, *'I was told that there will be some weight gain and changes in my periods and there was nothing to worry about. So I don't find my irregular periods problematic and don't take any medicines for it.'* Such observations further confirmed the need for effective counselling. These findings also lead to the conclusion that women appreciated the benefit of pregnancy-prevention with this method and tended to accept temporary inconvenience.

Though women in Hyderabad were comfortable with amenorrhea, in other sites, women wanted to be educated on the safety of amenorrhea and also rule out unplanned pregnancy. Providers did resort to sonography or pregnancy tests to assure them that they were not pregnant, and this increased the cost of service in some instances.

Most women experience side-effects after IC, in terms of change in their bleeding patterns. Also, women have their own ways of reconciling with these changes. Responses of women to bleeding changes are again shaped by a variety of factors which includes a combination of socio-cultural beliefs and practices, marital relations, perception of health and future pregnancies.

In case of excessive bleeding after the first dose, the women did not have any medication and went ahead with the second dose. They felt that after the first injection, a lot of bad blood had gone out and hence, there would be much less bleeding after the second dose. Generally, menstrual blood is considered 'impure' and there are certain rituals that need to be adhered to within the context of 'impurity'. The framework of pure and impure blood is deeply embedded in the psycho-socio-cultural environment. Many women were worried about impure blood collecting inside the uterus when experiencing amenorrhea. Since almost all clients have access to their doctors, it appears that doctors' assurance that *'impure blood will not get accumulated inside the uterus'* helped them cope with such worries.

In case of scanty bleeding, most women followed the advice of doctors and did not take any medication. They also strongly relied on the provider's assurance of restoration of normal periods after the initial cycles. As one woman said, *'Bleeding was so less that I did not need any thing'*. Such a response appeared to be an outcome of effective counselling received by the woman.

Similarly in cases of spotting, a doctor's opinion that *'you have not conceived'*, is reassuring to most women.

Since women don't want any risk, they then decide to continue with the method.

Almost all women experiencing irregular bleedings did consult the provider. For most women no medication was given. After weighing the risks and benefits, such women continued with repeat injections.

" My doctor told me not to worry about irregular bleeding and that periods will be regular after some time. *MB, a 26-yr-old woman.* **"**

Many women also reported amenorrhea after use of injectable contraceptives. Changes in the menstrual patterns are common and expected with hormonal contraceptives. These could be bothering to some clients and cited as the main reason for discontinuation. It is expected that approximately seventy percent users will be amenorrhic[14] within 12 months of use. Other menstrual changes such as spotting/irregular bleeding and longer duration of bleeding are relatively common in the first three months. These decrease over time.

The role of counselling is clearly evident with respect to coping in the event of side-effects.

" For fifteen days after taking the injection, I did not face any problem. But after that I had a burning sensation in the vagina. I went back to my doctor for advice. She prescribed some medicines which I took and was okay in two days. But from the third day, I developed abdominal pain. I again went back to the doctor. I asked her whether all this was due to the injection, but the doctor said it was not so. She asked me to get some tests done. Now I am waiting for the test-reports which might throw some light on these problems. *A woman from Ahmedabad.* **"**

It appears that protocols for management of side-effects were not followed in such cases.

" I had very scanty menstrual flow, and that too only for a day, after taking the injection. I consulted my doctor, but he assured me that there was nothing to worry about and that it was due to my feeding the baby. I have not taken any medicine as I was told that I will be OK. *JB, a 27-yr-old woman.* **"**

These finding have implications in terms of designing counselling protocols for method-specific IC counselling. The conventional GATHER approach[15] for counselling is based on the bio-medical elements of contraceptives provision and management of side-effects. In a differing socio-cultural milieu, it will be useful to explore client-specific concerns regarding bleeding patterns and a more personalized approach could be followed.

" At first I was not told about the injection side effects. When my second injection was due I had giddiness and high blood pressure. When I complained to my doctor about it, she said that it was not because of the injection. So I took the second injection. In the meantime, I consulted another gynaecologist and our family doctor. Both of them told me not to take the injections and advised me to use some other method. So three months after the second injection I started taking oral pills. *SM, 32-yr-old woman.* **"**

[14] Carolyn Westroff: DMPA: A Highly Effective Contraceptive Option with Proven Long-term Safety. Contraception 68 (2003) 75-87.

[15] Population Reports GATHER Guide to Counseling J-48 Feb.2000.

Proper screening and counselling of clients is important for making an informed choice and deciding the desired duration of use. Counselling is important for the management of prolonged, heavy bleeding resulting from the use of injectable contraceptives. In specific situations, medical options may be required for the management of bleeding.

Discontinuation of the injections after initial doses has been reported in many studies, which could be due to the fact that providers do not share complete information about the method. Although one of the users was fortunate to receive advice on switching to oral pills, initial counselling about possible side-effects could have saved her from the ordeal she had to undergo. Clearly there is a need to organize orientation programmes for providers so as to enable them to adhere to service delivery guidelines.

In a study of Chinese women,[16] those who received detailed structured counselling, continued its use for a longer duration as opposed to women receiving routine counselling.

Continued use of IC by the study respondents helped them to develop specific opinions on what they liked or disliked about the method. In the semi-structured interview guide, questions were specifically framed for what was liked and disliked most. Table 9 depicts responses as given by the users.

Table 9 Likes and Dislikes as Perceived by the Users (N=160)

Nature of problem	Number	Percentage
LIKES (Multiple responses possible)		
Amenorrhea	20	12.5
Secrecy	10	6.2
Convenience	62	38.7
Highly Effective	48	30
Safety during lactation	17	10.6
Others	45	28
DISLIKES (Multiple responses possible)		
Changed bleeding patterns	62	38.7
Amenorrhea	10	6.2
Body Ache	16	10
Weight Gain	20	12.5
Weakness	7	4.3
Cost	27	16.8
Problems in going to religious places	6	3.7
Other dislikes	10	6.2

The responses given by the users very clearly indicate that the method was highly valued for its effectiveness, convenience and secrecy. The most disliked side-effects were changed bleeding patterns and weight gain.

[16] ZW WUSC et al: Effects of Pre-treatment Counseling on Discontinuation Rates in Chinese Women as DMPA. Contraception 1996 53:357-61

After menstruation side-effects, weight gain was the most common reason for the discontinuation of DMPA. Women of all ages were concerned with weight gain for good reason.

In the US, given the obesity problem, weight gain is often cited as a reason for the discontinuation of hormonal contraception. There is little evidence though that DMPA causes weight gain, when compared with non-hormonal contraceptives. The overall data regarding weight gain with DMPA, suggests that responses are individualized, and while weight gain is observed in some clients, there would also be clients losing or maintaining weight.[17]

However, in the study, regional differences were observed, as more women in Ahmedabad complained about weight gain as compared to women in Hyderabad. These findings again emphasize the importance of counselling during the client-provider interactions where clients were regularly explained about weight gain.

Analysis of the responses within this domain as well as with reference to problems perceived and narrated earlier, clearly pointed out differences. Many women disliked weight gain, yet this was not reported as a problem earlier. Since users had to pay for the contraceptive and as it is not subsidised, some users felt the pinch. Hence, a significant proportion of women did not like expenses incurred for availing the method.

The role of satisfied users in promoting contraceptives has been acknowledged in the past. Programmes have relied in involving satisfied users so as to demolish any myths and misconceptions about contraceptives. In the present study, overall satisfaction of users with the injectable contraceptives was ascertained. It was presumed that the opinion expressed by the users would provide a balance between the problems encountered and benefits perceived. It is generally agreed that clients would consider issues related to the behavior of the service providers, convenience, side-effects experienced, perceived benefits in terms of secrecy and privacy and even costs (both direct and indirect) while articulating their views on satisfaction. (Table 10).

These findings indicate that almost three-quarters of the clients were completely satisfied with the method. Only five percent of the clients were partially satisfied and twenty-five percent were not happy with the method. In terms of the likelihood of discontinuation, these clients are most likely to discontinue the method.

Table 10 **Overall Client Satisfaction** (N=160)

Level of Client's satisfaction	Number	Percentage
Fully satisfied	112	70
Partially satisfied	8	5
Dissatisfied	40	25

It is important to note how users framed their responses on satisfaction:

" To me IC is preferable to other methods as this gives me the benefit of secrecy and a tension-free three months. I am not happy about bleeding changes, but my doctor's assurances are helpful. I feel that this should be made easily available at all government facilities free of cost so that poor women like me can use it regularly. As it is, going to hospital costs me 10-15 rupees each time, I don't want to spend more money. *Ms SY. 23 yrs* **"**

[17] Carolyn Westhoff: Depot-medroxprogesterone acetate injection (Depo-Provera): A Highly Effective Contraceptive Option with Proven Long-term Safety- Contraception: 68 (2003) 75-87.

Similarly, there were unhappy users. As one user said, *'Though the method is very effective, yet unpredictability of bleeding disturbs me very much. I am using the method only for some time.'*

These findings are significant, as despite the observations about changed bleeding patterns, in totality women appear to be satisfied with its use. Thus, there appears to be a potential for engaging these satisfied users to allay fears and apprehensions about ICs.

Injectable contraceptive DMPA is currently available through commercial channels and as a subsidized product in few social marketing programmes. The current market cost is nearly a hundred and fifty rupees. Thus, the affordability of the method appears to be one of the issues for its acceptance and continuation. In the study it was found that in most instances ICs were being dispensed by the providers and the consumers did not need to buy them directly from the chemists.

In Ahmedabad, the commodity was made available free through a public hospital. However, supplies ran out of stock very soon and women were asked to buy the product from the market. This abrupt transition from free to paid product was not appreciated by many women and might be responsible for dropouts. Here, women from the lower socio-economic groups opined that the method was expensive and at times non-availability of free supplies in hospitals forced them to seriously consider switching to other methods. These women were also concerned about losing wage labour for the day and incurring expenses on transport to reach the hospital. Considering the average income in the lower strata of society, cost of the injection appeared to be prohibitively high.

In Vadodara, 90 percent of the users felt that the cost is affordable, given the three months protection offered by the method. In Hyderabad too, 76 percent felt that the cost was affordable.

One of the main reasons cited by the users regarding the affordability for the method was related with three months of foolproof protection. Some clients wished to rationalize that there was almost 6 to 8 months for return to fertility and thus favoured the extended period of contraceptive protection. Women in Hyderabad felt this was a small price for secrecy in using the method.

In an analysis of IC users by Parivar Seva[18], (a service delivery social marketing organization) high commercial cost was identified as one of the deterrents for large-scale use by women belonging to lower socio-economic groups. Since the method is not available through public systems, most women accessing services from private sectors would have to pay for the service charges as well. Hence, initiatives for upscaling will have to address the pricing issue, so that the method is accessible to poor women.

[18] PSS. Experience of Providing DMPA Services: An Occasional Paper, 2004.

7

Providers' Perceptions

Most qualitative studies in the past have tried to analyse perspectives of users alone and there is very little information on providers' perspectives. Semi-structured interviews were conducted for providers at three study sites. The main purpose of engaging providers was to ascertain their views on likes and dislikes of injectable contraceptives. Discussions also focussed on practices adopted for the selection of clients, counselling and their opinions about incorporating ICs in public systems.

All three sites followed different procedures to enroll providers in the study. More often, information was gained from the local IMA, FOGSI and other professional associations for the doctors prescribing ICs.

In Vadodara, a telephonic interview was also conducted with gynaecologists listed in the doctors' directory published by the local Lion's club. Information was gathered by using semi-structured tools from ten prescribing doctors.

In Ahmedabad, eight doctors were contacted for information. All these eight providers were practicing and prescribed ICs. Out of these, four were from the public sector, three from the private sector and one from an NGO facility.

In Hyderabad, providers were chosen using the 'snow-ball' technique. Ten doctors were enrolled for the study six of whom were private practitioners.

Providers' likes and dislikes were largely shaped by their own experiences of recommending/prescribing ICs or on the basis of information gathered through their collegues prescribing ICs. The providers prescribing ICs were favorably disposed towards this method and narrated its positive qualities. Some of the likes of these providers also matched with what was revealed by the users. However, a significant majority of providers who were either currently not prescribing the method or had never prescribed it, harboured negative views about the method.

> "**Once you take, you don't need to worry for three months. That is the best thing.**
> *A Vadodara based senior gynaecologist.* "

Most providers felt that amongst the available -reversible contraceptives, IC was a better option especially for short-term reversible use. According to them, the method was best suited for clients who wanted complete contraceptive protection and did not want to remember to take pills every day. There were some doctors who were seriously concerned with the anaemic status of most Indian women and felt that by virtue of amenorrhea, the method was a blessing in terms of not further aggravating anemia.

> **" Those women who are from the poor class and are anemic, if they get scanty bleeding or amenorrhea, it is profitable to them as anemia gets reduced.** *An Ahmedabad based doctor.* **"**

ICs appeared to be liked by women due to the very high effectiveness of the method. As agreed by a doctor, '*Amenorrhea is acceptable to women while pregnancy is not.*'

Most clients and providers were attracted to the method for its privacy in use and convenience factors. In the multi-centric study, there were some secret users who did not want to take spousal consent for using a contraceptive.

> **" IC was very convenient for use by secret users, who were not articulate and could not convince their family members about using contraceptives.** *A Hyderabad based doctor.* **"**

According to these providers, IC was a women-controlled method as it was they who initiated the method and they could be off the hook whenever they want to discontinue by not returning for a repeat injection. But these views were not shared by all doctors.

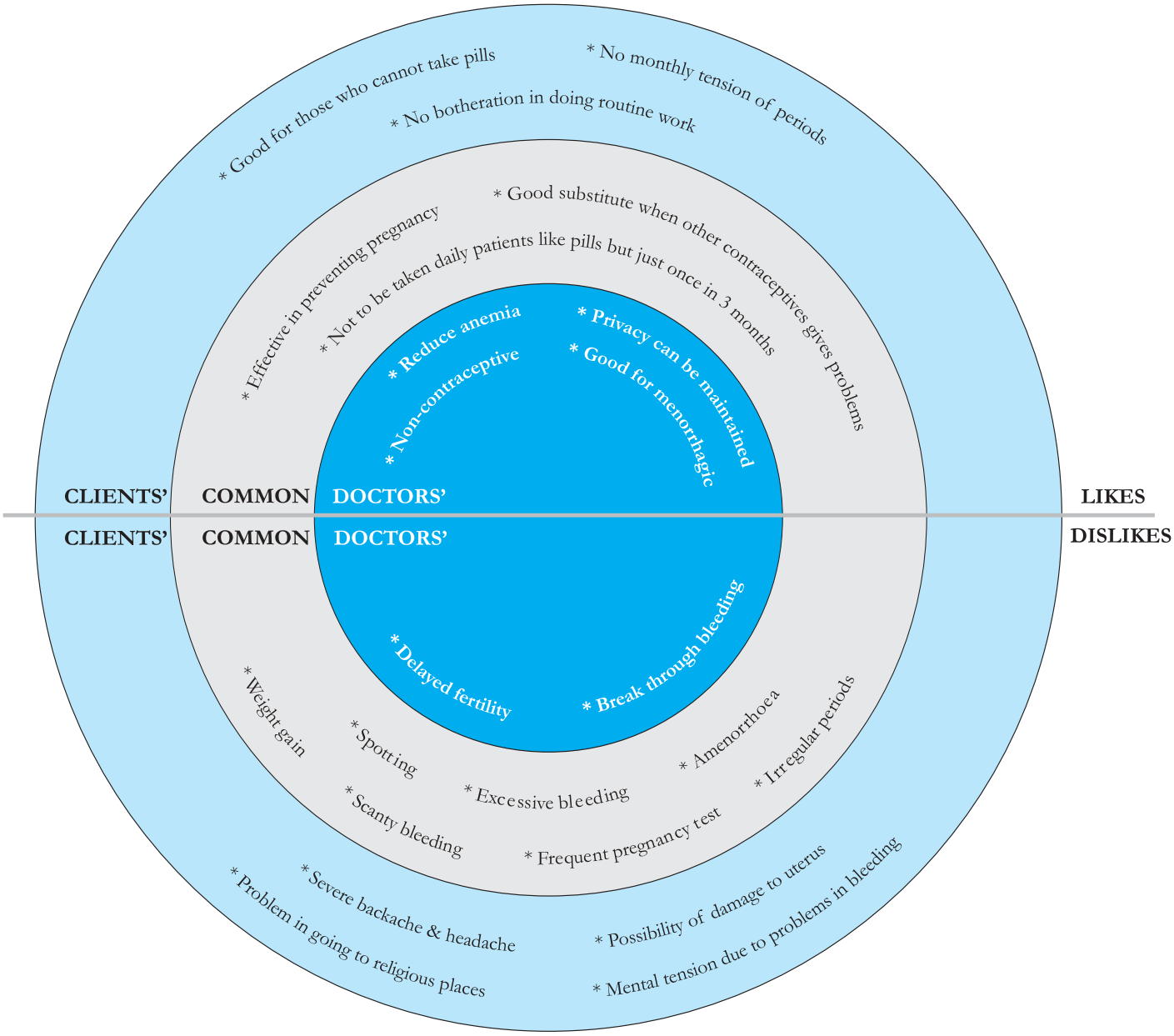
> **" Promoting use of IC without the consent of the husband can be counter-productive and can also affect long term compliance. Therefore, I insist that the person resisting the use of the IC in a family should meet me. I can spend some time with the person explaining the action, etc. I have a very strong faith in transparent practice and the efficacy of good counselling.** *An Ahmedabad based doctor.* **"**

Such responses by the providers indicate a very high degree of patronising attitude, which may jeopardise confidentiality and can also attract violence at home.

Analysis of the responses of doctors also indicated that most of them felt that injectable contraceptives were preferable for women who were in the lactational period when other hormonal methods could not be started for fear of suppression of lactation and passage in the mother's milk to the newborn baby. Considering the fact that exclusive breast-feeding was often compromised, there was going to be very little chance of any protection to be offered by the Lactational Amenorrhea Method. Doctors were also convinced about the safety and effectiveness of the method. They felt that all complications with Cu-T, including heavy bleeding and possibility of PID were comparatively less with ICs. Doctors were also favourably disposed about this method on account of the non-contraceptive benefits, i.e., reduction in fibroid size and reduction in endometrial and ovarian cancer. A few providers also felt that by talking too much about side effects was like *'putting seeds of self-doubts in the client's mind which was detrimental to wide-scale use'* of the product. These doctors felt that more discussions on the side-effects or any complications would further dissuade the prospective clients from using the method and deprive them of its benefits.

As there were no training/orientation programmes organised for private providers on a periodic basis, their access to information appeared to be rather limited. Although they were well informed about the mode of action and the side-effects, most providers did not seem to be conscious of quality issues, proper management of side-effects and the importance of informed decision-making by the clients.

Summarizing, providers' responses were mostly influenced by effectiveness, non-contraceptive benefits and privacy issues. Doctors were also influenced by the fact that ICs could be started during the lactation period, and in this respect, these methods scored over the other conventional methods.



The side effects or problems as perceived and articulated by the clients remained a major cause of concern even though these doctors acknowledged the benefits of the method. Most doctors felt that they had to be 'extra cautious' about the clients using ICs. An interesting observation was that many providers felt that IC users were their personal responsibility and they would like to give more attention to these users.

This may stem from the 'seriousness of the problems' as reported by the users. Providers opined that side-effects in terms of change in bleeding patterns were most commonly reported. The problem of amenorrhea and spotting were reportedly higher. The problem of amenorrhea was quite acute as women were not sure if they had conceived or if this was a side-effect of the method. This resulted in stress. Providers were also frequently pestered by users on timing and regularity of withdrawal bleeding. '*Sometimes clients keep on calling us about the absence of withdrawal bleeding, despite repeated counselling*,' said a provider.

Other doctors felt that socio-cultural beliefs about regularity in menstruation, shaped user responses to a great extent.

" If I just examine them and say they have not conceived, they do not believe me. For their satisfaction I recommend a pregnancy test to rule out pregnancy, but there is an additional expense. *A senior Gynaec. based in Vadodara.*

In our society it is strongly believed that menstrual cycle should be regular. Our psyche is such that if we do not get regular periods, we feel the blood gets accumulated inside the body and this may affect the brain or even lead to the formation of tumors. *A general practitioner.* **"**

Many providers felt that despite counselling, users kept on approaching them with problems of prolonged and excessive bleeding. Providers argued about the clinical parameters of defining 'prolonged bleeding' . At times, the client's psyche got influenced by others and although her bleeding was normal, she started believing that she had excessive bleeding.

" These patients are the only one whom we are unable to tackle, as they keep coming to us and we reassure them everytime that nothing can be done to stop the bleeding which is 'excessive' according to them. *A general practitioner.* **"**

These findings clearly indicated the contrast between providers' and users' perspectives on the incidence and seriousness of side-effects. There has to be better appreciation and calibration of clients' problems and a way to adjust these problems in a purely clinical framework for the management of side-effects.

Doctors in Ahmedabad blamed themselves for the lack of understanding of this method. These doctors lamented the fact that the Government had not included this method in the Family Planning programme. According to them, '*the Government was only keen to promote oral pills and IUDs, and did not realize the importance of adding a new method*.' These providers also felt that non-inclusion of the IC has resulted in poor knowledge about the method amongst the reproductive age group population. Providers in the private sector were also left out of any contraceptive updates organized for public sector personnel.

It appears that messages on choice of methods, quality of care and respecting clients views have not made major inroads, especially among the private sector providers. The RCH program trainings largely bypassed the private sector, which is a major source for reversible contraceptive services. According to a private doctor in Ahmedabad, '*Cafeteria approach cannot be implemented in entirety. We do tell about all the methods, but we promote and offer only those methods that are suitable to women sitting across us*'. The judgemental attitude of providers dictate the client's choices. Many current users in the study felt that they accepted the method as per the provider's suggestion.

Cost of IC appears to be a widely contested issue. Many doctors felt that the cost was affordable, considering that contraception protection was offered for an extended period after the last injection. Some providers felt that costs were unaffordable for women from low socio-economic groups. However, given the huge unmet demand for reversible contraceptives aiming women from lower sections of society, concerns related to the cost seem to be real.

8

Conclusions

Available evidence suggests that the choice of several contraceptives, rather than restriction of choices , is more likely to result in the use of a contraceptive method. As quality improves and more methods become available, more couples with unmet needs start using contraceptives and realize their reproductive intentions.

Multi-centric study findings provide us with similar pointers. From clients' perspectives, interventions to expand the package of contraceptives by including IC are essential. Women feel strongly about secrecy in use, the effectiveness of contraceptives and the lack of any botheration for three months. The study pointed out that there is a segment of potential users with unmet needs, who would use ICs with satisfaction, should the method be made widely available.

The study also brings out the perspectives of unhappy users. These women were worried about unpredictable bleeding patterns affecting their daily routine, pregnancy in amenorrhea and delayed return of fertility. Costs also seemed to be a concern, especially for women from the weaker section of society.

There is no substitute to quality method-specific counselling. Women are more likely to continue the method after initial problems, provided they have received good counselling and know what to expect. Providers should make sure that clients comprehend the information given to them. Counselling about side-effects will require time that needs to be invested on each client. Availability of counselling protocols, audio-visual aids and client information material will help in understanding side-effects and remedial measures.

The study findings indicate that providers were not indiscriminately promoting the method, barring exceptions. Each user was 'valued' by the provider and seen as a personal responsibility, something not reported for other contraceptive methods. This could be particularly true for private sector settings, as providers were worried about the long-term relationship with the client and family members. There was an overriding concern for loss of family practice, if anything went wrong with the client during the course of using ICs.

Users of any given method will have predisposing factors for the method, and their own likes and dislikes cannot adequately represent the concerns of the majority of non-users. There are many positive attributes with the injectable contraceptive, viz., a higher measure of safety and efficacy, convenience and improved compliance, and if needed, empowering women to contracept without husband's knowledge. The challenge is to empower women for making an informed choice to achieve her reproductive intentions and ensure the quality of injectable contraceptive services in different service delivery settings.

However, any upscaling programme for increasing access to ICs will have to focus on allaying apprehensions about quality of services especially in public systems. There is need for effective capacity-building interventions with providers in health systems.

It is important to emphasise that the qualitative nature of the study limits the generalisation of findings. These results do not emerge from any random sampling and cannot be a representative of the opinions of users in other regions. Barring these limitations, the data does tell us about the common perspectives and the level of satisfaction with this method.

Annexure 1

1. ***Dr. (Mrs.) Lalrintluangi***
   Deputy Commissioner
   (Research Studies & Standards)
   Government of India
   Ministry of Health and Family Welfare
   Nirman Bhawan, New Delhi 110 011
2. ***Dr. Rajesh Kumar***
   Professor and Head
   Department of Community Medicine
   Post Graduate Institute of Medical
   Education and Research
   Chandigarh 160 012
3. ***Dr. Leela Visaria***
   Director
   Gujarat Institute of Development Research
   Gota, Ahmedabad 380 060
5. ***Dr. Sharad D. Iyengar***
   Secretary
   Action Research and Training for Health (ARTH)
   39 Fatehpura, Udaipur - 313 004
6. ***Dr. Laxmi Lingam***
   Reader
   Women's Studies Unit
   Tata Institute of Social Sciences
   Post Box No. 8313
   Deonar, Mumbai – 88
   (Discontinued due to other commitments.)
7. ***Ms. Renu Khanna***
   Director
   SAHAJ, 1 Tejas Apartments
   53 Haribhakti Colony
   Old Padra Road, Baroda - 390007
   (Discontinued due to other commitments.)
8. ***Francois Farah***
   UNFPA Representative
9. ***Ms. Ena Singh***
   Assistant Representative, UNFPA
10. ***Dr. Dinesh Agarwal***
    TSG Manager & Technical Adviser, UNFPA

Annexure 2

1. ***Dr. Alka Barua***
   Executive Director
   Foundation for Research in Health Systems
   6, Gurukrupa, 183 Azad Society
   Ahmedabad 380 015

2. ***Dr. V. Uma Devi***
   Indian Institute of Health and Family Welfare
   Vengalrao Nagar
   Hyderabad 500 038

3. ***Dr. Prakash V. Kotecha***
   Professor and Head
   Department of Preventive & Social Medicine
   Government Medical College
   Vadodara 390 001