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QUALITY OF CARE AND FAMILY PLANNING DROP-OUTS IN BUKIDNON PROVINCE: A SURVEY STUDY

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ABSTRACT

Analyses of the Philippine Family Planning Program have generally concluded that a large proportion of family planning acceptors soon become program "drop-outs." The present study goes deeper into this issue by looking into (1) the actual extent of the problem in one Philippine province, (2) reasons given for dropping out and (3) factors associated with the drop-out phenomenon. The study was undertaken by means of a follow-up survey of 400 family planning acceptors from Bukidnon province. Findings support the quality of care perspective, particularly with regard to the nature and content of client-provider interactions and the need to reduce frequent return visits to the clinic. Several implications for the family planning program are discussed.

INTRODUCTION

If the Philippine Family Planning Program has encountered only partial success since its inception in 1970, a major reason for this must surely lie in the large number of family planning (FP) acceptors who eventually become "drop-outs." One review of the Philippine program concluded that "records show that around 50 percent of users drop out of the program yearly. Despite this, very little time is devoted by motivators to the remotivation of drop-outs. This is due to the overemphasis in the past on generating new acceptors" (POPCOM, 1989).

The situation in the Southern Philippine province of Bukidnon, site of this diagnostic study, is apparently even worse. Data from the Northern Mindanao office of the Department of Health (DOH) indicate that more than half (60 percent) of all acceptors in this setting subsequently become drop-outs. The present diagnostic study represents an attempt to examine this issue by measuring the actual extent of the problem, determining the reasons given for dropping out, and identifying the factors most strongly associated with this problem.

Previous Studies. Several studies have already confirmed the importance of the drop-out problem. Surveys have shown FP acceptors to be frequently dissatisfied with the contraceptive methods available to them, highly conscious of their alleged side effects, and prone to method discon-

tinuation (e.g. Ballweg and MacCorquodale, 1974; Cabigon, 1980; Valera-Cabigon, 1985). Comparisons with other countries in the region also indicate that the drop-out phenomenon is particularly problematic in the Philippine setting.

Even so, there are at least some indications that the service statistics on FP dropouts may not be fully accurate, and may, in fact, be giving a somewhat inflated estimate of the problem. This can occur insofar as the program categorizes all persons who fail to return to the clinic for contraceptive resupply as drop-outs. Upon reflection, however, it seems likely that at least some of these women may have simply moved to another community or found another source (e.g. a private physician or pharmacy) for their resupply needs. Indeed, one Philippine study estimated that 62 percent of all program drop-outs were still using one or another method, thereby indicating that "not visiting a clinic does not necessarily imply contraceptive discontinuation" (Anonymous, 1988).

To date, relatively little work has been done towards determining the factors which are most closely associated with dropping out. Broadly speaking, we can view such variables as falling within three major categories, namely (1) individual/household factors (e.g. income, education), (2) program-level factors and (3) the type of FP technique originally accepted. To illustrate the latter dimension, at least one report (Anonymous, 1988) has indicated that drop-out rates are somewhat higher among women using such less effective methods as rhythm or condoms.

A program factor which has received particular attention during the past decade relates to the "quality of care" available from local FP providers. Whereas earlier concern about rapid population growth had led to a heavy emphasis upon the short-term goal of recruiting an ever-growing pool of family planning acceptors, it is now acknowledged that greater attention must be accorded to the quality of FP services provided to clients after they have enrolled in the program. Following Bruce (1990) we may classify such factors as comprising six major dimensions: (1) an expanded choice of methods; (2) access to greater FP information; (3) heightened levels of technical competence; (4) improved interpersonal relations between providers and clients; (5) greater attention to mechanisms that encourage continuity of use; and (6) an appropriate constellation of services.

The role that quality of care factors can play in helping FP programs to attain such widely accepted goals as improved medical standards and the provision of a more free and informed choice on the part of clients is apparent. Beyond this, however, it has also been claimed that improved quality of care may also have a favorable impact upon levels of contraceptive prevalence and of dropping out:

"Improvement in the quality of

services will result in a larger, more committed clientele of satisfied contraceptive users. Over the long term,.. this will translate into... sustained use" (Bruce, 1990, p. 61).

One may hypothesize that FP clients who experience better quality of care from their local DOH clinic will be less likely to subsequently drop out of the program. The present study focuses largely upon this thesis, with particular attention being paid to method choice, FP information, interpersonal relations and mechanisms for ensuring continuity.

SETTING AND METHODOLOGY

This study was conducted in Bukidnon, a large, landlocked province in Northern Mindanao. Fertility levels are high in the study area. One demographic analysis, which used census data and an indirect estimation technique, found Bukidnon's TFR to stand at 7.03 in 1980, thereby making it the fourth highest-ranking province in the country at the time (Pacheco and Engracia, 1985, Annex 3). As we have seen, the FP drop-out issue has also been found to be particularly problematic in this setting.

Data for the study were collected with the use of a structured interview schedule. Rigorous field procedures (pretesting, training, backchecking) were used in preparing for and conducting the survey. Respondents were currently married women, 15 to 49 years of age, who had been officially recorded as a DOH family planning acceptor (whether for pills, the IUD or condoms) at some time during 1992. The data gathering process was carried out by experienced interviewers from the Research Institute for Mindanao Culture (RIMCU), Xavier University.

Sample barangays were selected in accordance with a probability-proportionate-to-size (PPS) sampling design. The universe for this first stage of the sampling procedure consisted of all barangays in the province of Bukidnon. In all, twenty barangays were selected for observation.

Sample size was originally set at 400 cases.[2] The "ideal number" of respondents under the PPS design was thus 20. Lists of all 1992 FP acceptors were then obtained from the local clinic (i.e. the Barangay Health Station) and used for selecting individual respondents by means of systematic random sampling. A fair number of these women had already been categorized as program drop-outs by the DOH along with a few more who were officially listed as method switchers. In all, the DOH records showed a total of 280 current users, 123 dropouts and 3 switchers.[3]

STUDY FINDINGS

This paper will concentrate on correlates of the drop-out phenomenon with regard to associations between current FP status (whether a continuing user or a drop-out) and the quality of FP

services which were offered to the respondent. Readers interested in a more detailed presentation of the study's findings may be referred to the final project report (Palma-Sealza, 1994).

Extent Of The Problem. Both the DOH records and the actual follow-up survey of FP acceptors revealed that a little less than a third of the women in question (30.3 percent for the DOH records, 29.6 percent for the follow-up study) had stopped using FP as of the survey date (September-October, 1993). It is interesting to note that these figures are only half as large as the 60 percent dropout estimate originally given for Bukidnon province. It is possible, therefore, that the problem has become less acute of late than it was in earlier years.

However, the amount of time which transpired between the date when our respondents were first entered onto the DOH records and the time when they were interviewed for the present study (15 months, on average) was not particularly lengthy. No doubt the recorded drop-out rate would have been greater if the RIMCU interviews had been held at some later date.

Some idea about the accuracy of the DOH recording system can be obtained by comparing the actual FP status of each respondent, as determined during the interview process, to that found in the local clinic's records. The overall agreement level in this case was found to be 73.4 percent. Among those women who were thought to be program drop-outs, a fairly high proportion (22.0 percent) were still practicing family planning, albeit by using a different method than that originally accepted. In comparison, 70.7 percent had in fact stopped using FP, while 4.1 percent were still using their original method (whether at the same or a different clinic) and 3.3 percent claimed that they had never been FP acceptors in the first place.

A careful inspection of the master table on current FP status also revealed that drop-out rates were by no means constant across the three major types of contraceptive techniques. Indeed, the follow-up study failed to find even a single case of an IUD acceptor who had completely dropped out of the program. In all, 91.7 percent were still using the IUD as of the survey date while the balance had switched to another FP method. In comparison, 34.3 percent of the pill acceptors and 37.8 percent of the condom users had become drop-outs, which is to say that they were not using any FP method at all as of the survey date.

One reason which might be advanced for the above-noted differential concerns the added time costs for the pill and condom acceptors as compared to those who chose the IUD. In general, pill and condom users have to keep returning to the clinic for a monthly re-supply whereas IUD users will not have to do this. This would appear to support the quality of care perspective. More specifically, these findings suggest the need for a more user-friendly distribution system to encourage greater continuity of use.

Reasons for Dropping Out. More than half (59 percent) of all drop-outs said they had stopped using FP because of "side effects". This response was particularly common among women who were using contraceptive pills.

Other reasons were given much less frequently. These included the desire to have another child (5.0 percent), objections on the part of the husband (5.0 percent), poor health status (4.2 percent) and "too old now" (3.3 percent). As for method- and clinic-related reasons, six of the 120 dropouts said that their clinic lacked either a midwife or regular FP supplies, two said that their clinic was too far away, and four found the method accepted to be either ineffective (i.e., they became pregnant while using it) or inconvenient to use.

Program Dropout Characteristics. A number of bivariate tables were constructed in order to investigate the association between drop-out status and the socioeconomic circumstances of the respondents. The comparison in this case was between current FP users (both those who had retained their original method and the method switchers) and program drop-outs (women who were no longer using any FP technique at all.)

Six factors were found to be statistically related to the dependent variable in these comparisons. These six factors involved parity, education, labor force participation, employment status, income, and consumer goods ownership. These data show the drop-out problem to be greatest among some of the very women most in need of a safe and reliable FP method (i.e. poorer, less educated, high parity cases).

Some evidence was found to support the idea that sustained patterns of contraceptive use will be more likely to emerge when the husband, as well as the wife, has participated fully in the FP adoption process. A moderately strong ($p < .10$) and negative relationship was thus found between the frequency of interspousal communication on FP matters and the probability of becoming a drop-out. Findings also revealed that the husband's support for FP (both in general and with reference to the specific method involved) was actually a better predictor of sustained FP use than was true when comparable attitudinal questions were posed to the wife.[4]

Role of Program Factors. The expectation that improved or expanded program services would be associated with reduced drop-out levels was confirmed by the study. In some cases, however, differences between continued users and drop-outs were too small to attain statistical significance.

This was particularly true for the data on exposure to IEC materials, home visits by FP providers, and the length of waiting time experienced in the local clinic. These findings are presented in Table 1.

Table 1. Percentage of Clients Dropping-out by Program Level Factors

	Percentage Dropping-Out
Exposure To IEC Materials	
Some	29.4%
Limited/None	35.5
(x^2 = 1.23, p = n.s.)	
FP Provider Home Visits	
At least once	29.5
Never	31.3
(x^2 = 0.11, p = n.s.)	
Waiting Time In FP Clinic	
No Wait	30.8
Short wait	31.7
Long wait	26.3
(x^2 = 0.23, p = n.s.)	

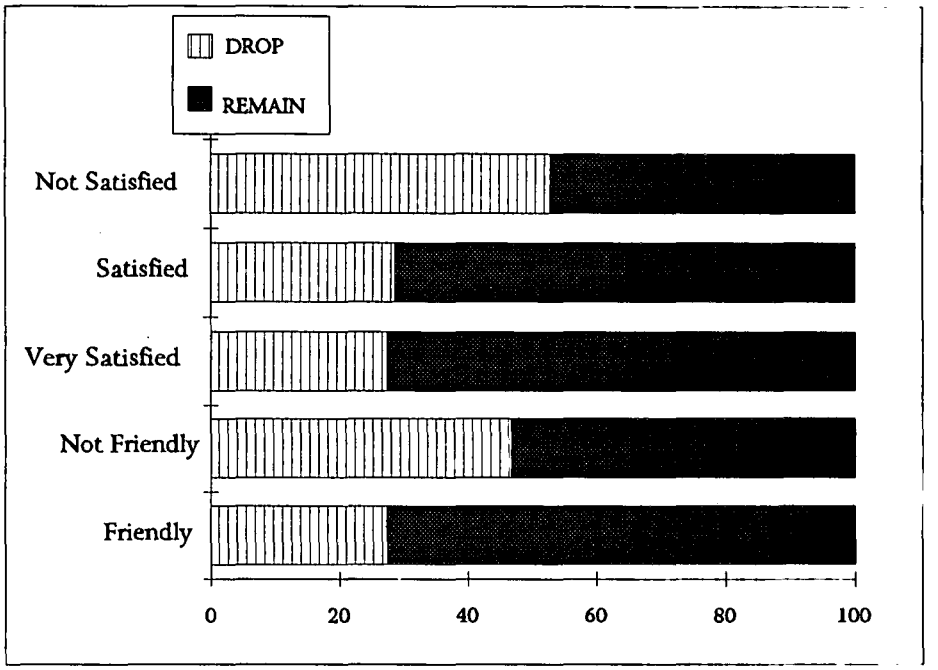
Program efforts appear to be adequate for at least two of the three dimensions presented in Table 1. Only 23.9 percent of the respondents were found to have not been exposed (or to have been minimally exposed) to IEC materials on family planning. So also do we find a mere 4.9 percent saying that they had to wait a "long time" at the FP clinic before they could be attended to. However, more than three out of every four respondents (75.6 percent) admitted that they had never experienced home visits by FP providers. Most DOH midwives are too busy with their many responsibilities to do this on a regular basis. A more practical approach might therefore be to encourage more home visits on the part of the volunteer health workers (BHWs).

Figure 1 presents findings on the role of improved interpersonal relations in helping to sustain FP use. Clients who felt that their FP provider had not been "friendly and approachable" to them were considerably more likely to become program drop-outs than those who had experienced a more pleasant and supportive relationship. Drop-out rates were almost twice as high among clients who said they were not satisfied with their visits to the clinic than for those who were either "satisfied" or "very satisfied."

While the Philippine family planning program models itself upon the so-called "cafeteria" approach to method selection, data from the present study indicate that FP clients (in Bukidnon province at least) are not in fact afforded a wide range of choices. We have already seen how the methods made available in the DOH clinics are limited almost exclusively to pills, condoms and the IUD. Indeed, even this threefold set of choices was not always available insofar as half of the clinics visited during the course of this study were not offering IUD insertion services.

According to program guidelines, FP acceptors are assigned to a "trainor" who is supposed to give them an orientation lecture on the different FP methods available. About one out of every ten respondents (9.5 percent), though, claimed that they had never been given

Figure 1. Percentage of Acceptors Dropping-out by Client/Provider Interaction



such a lecture. Another 60.9 percent had only been informed about one FP method during their orientation session. FP clients in Bukidnon province are thus not being given a truly "cafeteria-like" range of choices with regard to the different methods now available.

Further still, this situation does seem to be connected to the drop-out problem. Among women who had received no lecture at all or a lecture on only one FP technique, 33.6 percent became program drop-outs. The comparative figure for women who had been informed about two or more methods was only 24.3 percent.

Additional information was gathered through six separate indicators of the depth of client-provider interaction found for current users and drop-outs. Comparisons show drop-outs to be receiving less detailed information from their trainor, with two of these (discussions about the advantages and about possible side effects of the method in question) being large enough to attain statistical significance. Comparisons for a summary index of client-provider interaction also show that the drop-out group had experienced a significantly less detailed orientation session on average than was true for the continuing users.

It has already been noted that the most frequently cited reason for dropping out of the program is the experience

of side effects. Explicit attention to the side effects issue by FP trainors could be of some help along these lines, e.g. by informing women about the problems that they are likely to experience, by assuring them that these symptoms are in no way dangerous, and by suggesting measures for their relief.

Table 2. Drop-out Rates by Frequency of Clinic Visits

Frequency	Drop-Outs
Once a month	34.8% (N=233)
Every 2 mos.	35.5 (62)
Every 3 mos.	13.5 (52)
Every 6+ mos.	23.8 (42)

A final comparison between the two groups under observation may be made with regard to the frequency with which respondents were required to revisit the local FP clinic. (See Table 2.) We have already speculated on the role which this factor might play in explaining the higher drop-out rates found among clients who were using either pills or condoms. Some confirmation of this reasoning may be found by comparing the percentage of respondents who had become program drop-outs according to their frequency of visiting the clinic, as shown in the table.

Two points are evident from these data. First, the requirement of returning to the clinic on a monthly basis is by no means an unusual obligation. Indeed, it is virtually "standard operating procedure" in Bukidnon province, where about two-thirds of all respondents were following this pattern. Secondly, such revisits do appear to be functionally linked to the drop-out problem. As a rule, it was the clients who had been told to return most frequently to the clinic who were most likely to become program drop-outs. Further still, the difference in this case is significant at the .01 level.

While frequent client-provider interaction might at first seem to be an indicator of heightened quality of care, this will not necessarily be true when the FP client must bear the time costs associated with such visits. Greater attention to this problem may be provided by using the Barangay Health Workers as re-supply agents or by allowing pill and condom users to bring home at least a three-month supply of contraceptives after every visit to the clinic.

SUMMARY AND POLICY IMPLICATIONS

The study found that 29.6 percent of the former FP acceptors had stopped using any form of family planning as of the survey date. This is only half as large as the official estimate for Bukidnon reported earlier by the DOH. At least two reasons may be advanced for this discrepancy. First, the time elapsed between the date of FP acceptance and of the survey was fairly short (15 months of average). No doubt a higher drop out level would have been recorded if a lon-

ger period of observation had been used.

A second possibility is that the DOH estimates of the drop-out problem are too high. Indeed, the study found several instances in which respondents who had been officially categorized as DOH drop-outs were still using some form of family planning.

In general, the role played by quality of care factors in affecting drop-out rates has been successfully demonstrated by this study. The quality of interpersonal relations found to exist between the respondent and her FP trainor exemplifies this conclusion. Women who felt that their trainor had not been "friendly and approachable" were considerably more likely to become a drop-out than were those who held a more positive view on this. In like fashion, the minority of respondents who reported themselves as "dissatisfied" with their visits to the DOH clinic were also significantly more likely to eventually disaffiliate themselves from the program.

The provision of clear and detailed information was also found to encourage a more sustained pattern of FP use. Women who had been given an orientation lecture on two or more FP techniques and who had been informed beforehand of the advantages and potential side effects of their particular method were all significantly less likely to become program drop-outs. Continuing FP users were also found to score significantly higher on an overall index of client-provider interaction.

More than a quarter of all respondents reported that they had not been given any information on side effects. In addition, a little more than 70 percent had either received no orientation lecture at all or had only been given a lecture on a single method. There is room for further improvement on these two dimensions.

Another potential weakness in the current program would appear to be the frequency with which woman are required to return to the clinic for a new supply of pills or condoms. Well over half of the study's respondents said that they were expected to do this on a once-a-month basis. This seems to be too often, particularly insofar as those who had been allowed to come back less frequently were found to be significantly less likely to drop out of the program. The comparatively low drop-out rate found among IUD acceptors (who are not, of course, required to make repeated visits to the clinic) also supports this conclusion.

Program implications derived from the study are as follows:

1. The problem of perceived side effects on the part of many FP acceptors, most especially those who are taking contraceptive pills, continues to serve as a major obstacle to the goal of attaining high and sustained levels of FP use.

   Further study is needed on the nature of these side effects, on possible mechanisms for coping

with them, and on the role which additional program methods (ranging, perhaps, from NFP to injectable contraceptives) might play in helping women find a more personally compatible contraceptive.

2. Further efforts to reach out to women who belong to groups which are characterized by high levels of FP discontinuation (in particular, high parity women of low social and economic status) should be given immediate priority. Campaigns to encourage more favorable opinions toward FP on the part of husbands, as well as wives, are also to be recommended.

3. Orientation lectures on family planning techniques must provide women with a greater range of information on the options available to them. At present, a majority of acceptors are not being informed about a wide variety of methods, while a substantial minority are not being given a suitable orientation on the side effects issue.

4. Greater emphasis on high quality FP services (quality of care) will help to reduce FP drop-out rates. Providers should be both competent and friendly, and concerned as well with fulfilling client expectations. They should offer a wider variety of FP choices, being sure that a clear and objective discussion of the advantages, disadvantages and possible side effects of each method has also been provided.

5. Increased use of the IUD should help to bring about declines in the drop-out problem. However, efforts to convince more women to use this method should not run counter to the goal of free and informed choice of method by the client.

6. Program rules and procedures which have the effect of requiring pill and condom users to return every month to the clinic for a re-supply should be reviewed. If women could be given a three-month supply at every visit or if community-based health workers could be allowed to serve as resupply agents, it is likely that the drop-out problem would be alleviated somewhat.

NOTES

1. A rough index of the national prevalence of dropping out may be computed by taking the ratio of current users (as reported by large-scale demographic surveys) over those who have ever used contraception and multiplying the resulting figure by one hundred. The lower this ratio, the more substantial the drop-out problem would appear to be.

Using comparative data from a recent regional analysis (Tsuya, 1991), the following current-to-ever user ratios were computed: Hongkong (88.9), Korea (83.3), Singapore, (82.6), Thailand (76.8), Japan (75.0), Indonesia (68.4), Malaysia (66.2) and Philippines (62.1).

(68.4), Malaysia (66.2) and Philippines (62.1).

2. For discussion of the means by which a desired sample of 400 cases had been decided upon, see the original project report (Palma-Sealza, 1994, p. 10).

3. Note that the sum of these three categories comes to 406 cases rather than an even 400. This occurred when the first six women who were interviewed within a certain barangay were found to be non-users. Further verification showed that the listing of FP acceptors in that locale was completely fictional. To avoid further delays, the barangay was replaced.

4. Four separate attitudinal items were included on the survey, with each being asked to both the husband and the wife. These consisted of (1) attitude toward FP in general, (2) attitude towards pills, (3) attitude towards the IUD and (4) attitude towards condoms. In general, current users were associated with more favorable opinions on these items than were the program drop-outs. Findings further revealed that all four comparisons for the case of the husband were statistically significant as contrasted to only two of four comparisons for the wives.

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