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PERCEIVED FACTORS OF FAMILY PLANNING CLINIC PERFORMANCE AND SERVICE QUALITY[1]

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Abstract

This article presents and compares the results of two related surveys. One survey focused on 100 FP clinic managers and 100 FP clinic support staff in the four selected provinces of Davao, Iloilo, Tarlac and Metro Manila. The other survey was on 800 FP acceptors from the same four areas. The surveys gathered data on clinic performance and service, service quality perceptions, and acceptor expectations and patronage intentions. The two sets of data were analyzed separately and then compared on common items. Specific and practical recommendations for FP clinic management are drawn, particularly with regard to means for improving clinic performance and service quality.

INTRODUCTION

In August 1988, the Department of Health (DOH) took over management and implementation of the Philippine national family planning program from the Population Commission (POPCOM). Defining its program management objectives, DOH chose to be "facility-based" rather than "community-based". Believing it could not do everything at once, the DOH elected to focus and to do well where it was strong. The DOH saw its strength in its clinic facilities, and concluded that the ideal was to concentrate on and provide services directly within the community.

DOH believed that, by adopting a clinic facility- based strategy, its FP clinics would become the program's critical success instrument. This study measured and analyzed how those FP clinics performed in attaining the DOH mandate to act as "the lead government agency among both government and non-government organizations in the delivery of FP services to all target FP clientele" (DOH, 1990: p. 1). In its measurements and analysis, this study tried to identify the key management and program implementation problems of the clinics and the DOH as well as the possible solutions to those problems.

STUDY OBJECTIVES AND DESIGN

This study was part of a larger endeavor called "The Family Planning Operations Research" (FP-OR) project, funded by the United Nations Fund for Population Activities (UNFPA) and managed by the University of the Philippines Population Institute (UPPI). It specified the following study objectives:

1. To determine and measure clinic

performance levels in terms of (a) FP acceptor targets, (b) clinic servicing capacity utilization, (c) clinic outreach to its unserved FP acceptor population, and (d) managing clinic costs or financial resources.

2. To determine from clinic service providers what they perceive as causes of high and low clinic performance.

3. To determine from clinic service providers what are the indicators which they use for assuring service quality.

4. To determine from FP acceptors their expectations, sources of satisfaction, and quality perceptions relating to (a) FP clinic personnel, (b) the clinic as the FP service outlet, (c) FP service processing, and (d) FP service quality.

The sample survey method was the primary instrument used to gather the required data in 1990 . UPPI specified the four study locations as Davao, Iloilo, Tarlac, and Metro Manila. These areas included a mix of both high performing and low performing FP clinics.

For the sampling of service providers, the study gathered data from a quota sample of 25 clinics per survey location. In each sample clinic, interviews were conducted with one clinic manager and one clinic support staff. For each of the four survey locations 25 clinic managers and 25 support staff members were thus interviewed.

The study worked on a quota sample per survey location of 200 qualified FP acceptor respondents from the previously sampled clinics. Eight of these respondents were randomly selected from each sampled clinic to constitute the 200 quota sample (i.e., 25 clinics x 8 respondents /clinic).

Equal numbers of current and former clients were interviewed.

Data gathering for the first and third study objectives used both clinic record retrieval and personal interview technique. The clinic record data gathering made use of the recording portion of the survey questionnaire. Field researchers used a structured pretested survey questionnaire to conduct the interview. One questionnaire was developed and pretested for clinic manager respondents and another for support staff respondents.

The study gathered data for the fourth study objective from the sample of FP acceptors, using the personal interview method with a structured pretested questionnaire.

FP SERVICE PROVIDER RESULTS

The service provider survey had two sets of findings. One set focused on service providers' perceptions about clinic planning decisions affecting their clinic performance. The other concerned their perceptions of other factors influencing clinic performance and service quality.

Planning Decisions. The survey gathered data on six planning decisions: (1) setting FP acceptor targets; (2) setting norms for a satisfactory target attainment; (3) setting the clinic's servicing capacity; (4) setting a

norm of satisfactory servicing capacity utilization; (5) setting a norm for the satisfactory servicing of unserved FP acceptors; and (6) setting of a norm for costs per FP acceptor.

The data on setting of FP acceptor targets showed that both clinic managers and support staff held different perspectives on deciding about targets. The most commonly mentioned ways were: (1) based on a formula, and (2) as "given by DOH". Clinic managers and support staff felt they actively participate in setting targets and have a say even when following a DOH formula.

Setting targets is a different story from their attainment. The survey data indicate that clinic service providers regard a very low target attainment as acceptable. In addition, only half of the clinic managers knew what their clinic's new FP acceptor targets were. Among these managers, the past year saw their clinics meeting an average target attainment of 64 percent. To 42 percent of these managers, this attainment ratio was good enough or "satisfactory". It was only when the target attainment ratio went down from 64 percent to 52 percent that these clinic managers found performance as unsatisfactory.

Data in Table 1 explain why personnel are tolerant of low level clinic performance. The survey asked what clinic personnel considered as enabling and disabling factors in attaining targets. Clinic managers and support staff primarily referred to resources for generating and maintaining acceptors as such factors. These included, among other things: (1) outreach efforts and home visitations; (2) information dissemination; (3) adequate contraceptive supplies; and (4) well trained staff for FP activities. Long absence of supply and delayed availability of resources are a given and a continuing reality to these service providers.

The survey found that clinic personnel wanted their clinic servicing of FP acceptors to attain 80 to 85 percent capacity utilization. Actual servicing levels, though came to only 25 percent of capacity. Even so, clinic managers and support staff said they did not find this rate to represent an unsatisfactory performance level.

Clinic managers placed their clinic's target for average weekly FP acceptors served at 15 to 16. The clinic staff's estimate was 12 to 13. Being open for an average of five days per week, this implies a daily servicing of only about three FP acceptors per day. When asked how many days a week they believed they should be offering FP services, the clinic managers gave an average of 3 to 4 days, i.e., 1 to 2 days less than the current average.

Most service providers did not know how many unserved FP acceptors there were in the area covered by their clinics. For example, 40 percent of clinic managers said they did not know while 30 percent said there were no unserved eligibles. Those claiming they knew, when pressed for an estimate, turned out to not really know.

Aside from data about decisions which affect clinic performance, the survey also asked service providers what "clinic perfor-

Table 1. Perceived Major Enabling and Disabling Factors in Attaining Targets according to Clinic Personnel

Perceiver/Factors	Percent of Base Mentioning*
Clinic Managers' Perceptions:	
1. **Enabling Factors:**	
Outreach program/home visitations	41
Ability to convince clients/acceptors to use family planning	35
Adequate supplies of contraceptives	19
Info disseminations/info drive	16
Well-trained staff for FP	11
2. **Disabling Factors:**	
Lack of contraceptive supply	28
Wrong concepts/beliefs of patients	28
Lack of personnel, midwife, FP outreach	21
Side-effects of FP methods	15
Personnel's lack of training	9
Limited time for lectures and info drive	8
Lack of follow-up	8
Clinic Support Staff's Perceptions:	
1. **Enabling Factors:**	
Ability to convince clients to accept to use FP	44
Outreach program/home visitations	42
Info dissemination/info drive	18
Maintain adequate supplies of contraceptives	16
2. **Disabling Factors:**	
Lack of contraceptive supplies	32
Wrong concepts/beliefs of patients	24
Side-effects of FP methods	22
Lack of personnel, midwife, FP outreach	11
Lack of follow-up	10

*Only those with 10 percent or near 10 percent mentions were included.

mance" meant to them. The concept was perceived differently by the different respondents but their answers can be generalized into the following four meanings: (1) effectively motivating and persuading FP acceptors; (2) performing FP services; (3) reducing fertility and raising demographic and contraceptive impact; and (4) clinic personnel performing their assigned tasks.

Finally, the survey gathered data to assess clinic performance with respect to the use of financial resources for reaching FP acceptor targets. The survey found that, at the clinic level, costs of servicing FP acceptors were not a significant consideration for clinic management as far as assessing clinic performance is concerned. Most clinic managers did not know the costs of running their clinics. The others were typically hard pressed to give specific cost figures. Most said the DOH or some other office in DOH handled costs.

Clinic Performance. FP clinic managers mentioned 34 major determinants of clinic performance. Over half of these (18) felt very little control in determining clinic performance and implied that power is in the hands of their clients. This becomes clear from considering the four most mentioned "determinants": "When there are a lot of acceptors" (24 percent); "Being above or below targets" (20 percent); "When there are few pregnancies or defaulters" (12 percent); "When acceptors and continuing users keep coming back" (10 percent).

In reference to service quality, clinic managers and support staff named various aspects to define it. The most mentioned of these are: (1) continuation of users; (2) decreasing rates of fertility and maternal mortality; (3) patient satisfaction; and (4) availability of supplies. The two things noteworthy from this list is that it focuses on the client as the ultimate judge of service quality and the perception that clinic personnel are in control of service quality and client satisfaction.

The survey data suggest that at the clinic level there is service quality if clinic managers and support staff perceive at least these three things: (1) There are quality clinic personnel; (2) There is quality in the clinic as a service outlet; (3) There is quality service processing.

Clinic managers and support staff see personnel quality in terms of personal traits yet define these traits by what clinic managers and staff feel acceptors like. For example, a quality FP doctor is a knowledgeable doctor if he "clearly explains" things to a patient. A quality FP doctor is also an approachable doctor if he "does not shout at his patients".

Concerning the quality of a clinic, both managers and staff think of quality in terms of clinic characteristics. For example, the top 6 of the 49 to 52 of such characteristics mentioned include "complete equipment," "continuous availability of supplies," "separate private rooms for FP service," "is clean overall inside and outside," "spacious" and "well ventilated". These characteristics have one thing in common: they are the minimum physical requirement characteristics of a functioning FP clinic.

Quality service processing was spoken of by clinic managers and staff in terms of processing properties and procedures, with the most cited of these pertaining to the processing of first-time FP acceptors; namely, "examining the patient" (48 percent); "explaining family planning to the patient"; "getting the patient's history"; "asking the patient's preferred family planning method"; and "giving the advantages and disadvantages of the different methods."

Aside from being once more very basic and elemental expectations, these render the perception of quality service processing as equal in effect to the perception of quality service personnel. This means that having quality clinic personnel also satisfies the need for quality service processing.

FP ACCEPTOR SURVEY RESULTS

Our analysis now shifts to the views of FP acceptors. Survey results provide information on the FP acceptors' expectations, service quality perceptions and satisfactions, and perceived determinants of their overall FP service satisfaction and FP clinic patronage intentions.

Service Quality. The 200 acceptors interviewed for the survey provided information on clinic personnel and FP services. FP acceptors were more concerned with their relationship with clinic personnel than with technical or medical qualifications. For example, the three most mentioned FP doctor expectations were: "does not shout, therefore kind and approachable" (24 percent), "attends to and entertains patient's problems" (19 percent), and "entertains patient well and therefore accommodating" (18 percent). The first two expectations for the clinic support staff were similar to the preceding ones (21 and 25 percent respectively) while a third dimension brought out in this case was "not snobbish or unkind" (24 percent).

Acceptor expectations about the clinic as a service outlet are simple and basic. On the outside, the clinic must be clean and free of trash. It should be also "well set-up with trees, gardens and shade". On the inside, cleanliness again ranks as the highest expectation.

Acceptors are equally limited in their expectations of services provided during first-time processing. The most cited expectation about the interview step was that "the patient should be asked about her purpose for the visit and her needs" (22 percent). For the physical check-up and examination step, clinic personnel "should get the patient's blood pressure" (15 percent) and for the prescription step "they should explain family planning, the details of the various methods, and the proper use of each" (18 percent). Acceptors focus on the mere provision of services in a proper and orderly fashion.

Acceptor Satisfaction. The survey data on acceptor satisfaction of clinic service elements is provided in Table 2. Across all four study locations, acceptors are satisfied with seven items all ranking approximately

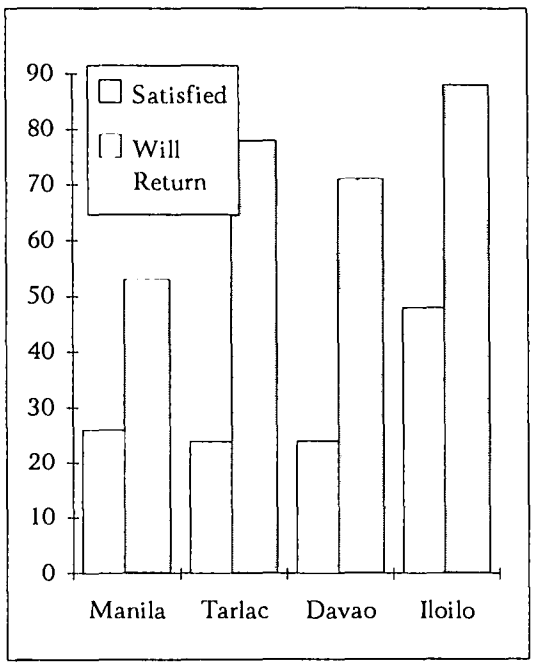
Table 2. Percentage of Clients Satisfied With Clinic Service Elements

SERVICE ELEMENTS	MANILA	TARLAC	ILOILO	DAVAO
Service Personnel				
Doctor	35%	33%	59%	30%
Nurse	18	41	55	29
Midwife	22	36	66	33
FP Volunteer	-	-	-	18
Clinic As Service Outlet				
Location	41	43	64	27
Sructure/Appearance	18	9	49	8
Interior Layout	17	6	51	12
Equip/Instruments	16	8	51	15
Service Processing				
First Visit	31	27	66	31
Yearly Follow-up	30	29	57	42
Supply/Resupply	21	23	66	33

equal. These are: (1) the doctor; (2) the clinic location; (3) processing for yearly follow-up visits; (4) the midwife; (5) first visit processing; (6) the nurse; and (7) processing for contraceptive supply and resupply. However, individual locations show great variation in the satisfaction of their clients with specific aspects of the clinic. In general, clients in Iloilo appear to be more satisfied with aspects of their clinic than those in Metro Manila, Davao, and Tarlac.

The three areas receiving the least satisfaction among clients are the clinic's outside structure and appearance, its interior layout, (including waiting room, exam room and tables), and its equipment and instruments. Again, only basic requirements for a clinic are being focused upon by the acceptors. It is noteworthy that only in Iloilo do we find a majority of clients being satisfied with every one of the dimensions inquired into by the survey.

Figure 1. Percentage of Acceptors Satisfied With Clinic Elements



The survey data on overall FP acceptor satisfaction and clinic patronage intentions provide an additional perspective in this case. Chart 1 shows that overall satisfaction with the clinic and the intention to continue patronizing it are highest and strongest among the Iloilo acceptors. Even though satisfaction levels are only half again as high in Metro Manila, Tarlac and Davao, a majority of the respondents from these locales (and almost 90 percent of those from Iloilo) do say that they will be returning to the clinic at some future date.

The graphic analysis of what determines FP acceptors' overall satisfaction and clinic patronage intentions consisted simply of comparing frequency distributions of data sets. The frequency distributions of overall satisfaction, for example, were compared with those of the satisfaction ratings of specific clinic service elements. The specific element obtaining the most acceptor satisfaction is then assumed as the key determinant.

Multiple regression analysis was also carried out on data concerning the overall satisfaction of clients with clinic elements. As measured by the size of the regression coefficients, the strongest and key determinant of FP acceptors' overall satisfaction came out to be the acceptors' experience with clinic location. The second and third ranking determinants were the elements of acceptor processing for contraceptive supply or resupply and of acceptor processing during the first visit.

This ranking of overall satisfaction determinants challenges the ranking that the comparative frequency distribution analysis gave. This analysis, it maybe recalled, identified seven specific service elements as equally key determinants of overall satisfaction. In addition, the comparative frequency distribution analysis identified three clinic aspects as the acceptors' least satisfied elements. We conclude that these elements constitute the FP clinic system's three most serious weaknesses. The multiple regression analysis also shows the same three elements (clinic equipment and instruments, clinic interiors, and outside clinic structure and appearance) as having a significant impact; in fact they constitute the fourth, fifth and sixth strongest determinants of the overall satisfaction measure. Clearly then, it will also be helpful to institute further improvements along these lines.

The major FP clinic management implications of the above results thus say that, under present conditions, attaining overall acceptor satisfaction is a matter of satisfying four criteria: (1) having a physically near, easy to access or a nicely set-up clinic location, (2) high personal-contact contraceptive supply or resupply processing, (3) high personal-contact first visit processing, and (4) improved clinic infrastructure, (i.e., equipment, interiors, exteriors).

CONCLUSIONS AND RECOMMENDATIONS

Survey data indicate that clinic personnel lack a common understanding of what clinic performance should mean for effective and efficient clinic management. Survey information on planning decisions also showed a lack of consistent or agreed upon goals and action patterns among FP clinic personnel. The situation indicates that in clinic management practice, a language of clinic performance is yet to be developed. If a performance orientation is a desired clinic manager's managing style, then the DOH must move its management system toward creating a set of conventions of "generally accepted clinic performance management principles". A key item which these principles must address is the establishment of a generally accepted singular meaning of "clinic performance".

Clinic performance begins with setting targets, yet survey data show an absence of clear target setting or maintenance among service personnel. The very low level of satisfactory target attainment derives from the clinic personnel's sense that they lack control over the factors determining actual achievement. One such determinant is access to resources. The field level reality is one where the repeated absence or else delayed availability of resources is practically a given. Continuing experiences with this reality have led clinic personnel to accept very low target attainment as "good enough".

Clinic personnel take a similar attitude of resignation with regard to utilization targets in clinic servicing capacity. While they wish for an 80 to 85 percent capacity utilization, actual usage rate comes to only 25 percent. It seems that this is as much as their heavy workload of other health care tasks will allow. For some, the target of 25 percent is more than they can satisfy. This has even prompted some providers to think about reducing their frequency of weekly FP service offerings.

Low service capacity utilization is acceptable to these personnel because of their present workload . For example, according to Feranil (1989), the Barangay Health Worker has 28 daily and weekly responsibilities. Only four of these are related to FP or MCH. This kind of workload makes it impractical to expect the clinic personnel to perform as if their only job is to render FP services.

Two things must happen for priorities to shift in favor of coverage and prevalence. The first of these is that the clinic personnel's workload will be lightened. Secondly, clinic-level FP services must be given the resources and personnel required to carry out a community-based orientation.

Managers also seem to lack a feeling of control over important aspects of their clinics. Management experts (e.g., Geneen, 1984; Drucker, 1974) say that managers succeed when they believe they can make a difference because their company's performance is well within their control. Given that only a third of the surveyed managers felt some degree of control, DOH must at least begin providing management training programs for clinic managers.

In related findings, the lack of information among managers as to how much FP services cost is critical because costs represent scarce resources and a manager is a resource allocator (Szilagyi and Wallage, 1987). If cost consciousness is absent or low in a clinic manager, it is hard to expect him to be an efficient resource allocator. This weakness is also strategic. Hosmer (1982) defined the essence of strategy as the ability to make choices. The choice is to apply a resource for one use instead of another. A clinic manager who functions with low cost consciousness and therefore with low resource value consciousness is wanting in the most basic skill of strategy making.

The lack of knowledge among service personnel about the unserviced population can be traced in part to DOH's FP service definition. DOH took a firm stand that the FP program is going to be "a facility-based, not a population-based or community-based program" (PFPP Info Updates, 1991: p. 4). Operationally, this meant that clinics will not place their priority on "coverage, incidence or prevalence". The facility-based orientation pushed clinics to place their priority on serving those who will come to the clinic rather than going out to the community to serve. It is recommended that this definition be modified and incorporated into future training for outreach and community needs assessment.

The absence of clear and explicit pricing policies has serious adverse implications for today's move toward financial sustainability of FP clinics. The idea of empowering clinic managers must include appraising them of their responsibilities for efficiently managing financial resources and costs.

Both acceptor expectations and service providers' definitions of acceptable clinic personnel behavior and a quality clinic service outlet are clear and basic. Clinic personnel are expected to be polite, professional in their behavior and trained in their field of specialization. The clinic must be clean, well maintained, and stocked with adequate supplies to meet community needs. Unfortunately, both acceptors and personnel have become so used to substandard clinic conditions and facilities that mere availability of this basic minimum has come to represent the "ideal". This situation hints at how readily DOH can make an impact on acceptors and clinic operations if it attends to just giving the basics.

A similar basic needs requirement characterizes FP acceptors' expectations and service providers' concept of quality service processing. Quality service processing concerns carrying out very routine steps and matters. Once more, the basics have yet to be met or to be adequately met.

FP acceptors were asked which specific items in the three service quality components they were least satisfied with. Their answers concentrated on aspects of the clinic as a service outlet. Three clinic elements were particularly stressed as least satisfactory: outside structure and appearance, interior layout, and equipment and instruments. This finding only reinforces the previous call for DOH to place first things first: meet the simple basic minimum acceptor expectations about clinics and do something about their current less than satisfactory conditions.

It is the author's contention that the DOH must provide further resources and training to FP clinics if they are to succeed. Under the current DOH clinic management system, there is nothing to motivate or pressure clinic managers to want to know their area's unserved FP acceptors. DOH's decision to define its FP program as "facility-based" rather than "community-based" has encouraged this situation. Resources should be national in coverage and require minimum basic physical and service capabilities from all clinics. Improved definitions of personnel work requirements must take into consideration the time and energy needed for adequate community outreach and client relations. Training programs covering efficient resource allocation and service capacity utilization should be given on a regular basis and required of all managers. Likewise, staff must be provided with trainings that will help them understand the objectives of their work and how best to provide services in a friendly and efficient manner. The DOH should also be looking to local managers and staff for ideas and feedback as to how best to improve service capacity and quality.

In conclusion, it must be agreed that while FP clinics are an excellent method of providing needed services to different communities, much can be done to improve and enhance these services. The survey information provided in this paper provides a very clear direction for the DOH in terms of both strengths and weaknesses of the present system but the DOH must act decisively to undertake the specific steps needed for change to come about. Finally, it would be a fundamental error to think that once the basics are provided, the problem ends. Experience and motivation theory both say that this is not so, principally because needs change. Maslow's (1954) still popular motivation model says that a satisfied need will no longer motivate. Once their basic needs have been met, we can expect FP acceptors will move on to other needs that have not yet been satisfied or not adequately satisfied.

NOTES

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