Philippine Population Journal, Volume 9, Numbers 1-4, 1993

FP CLIENT-WORKER INTERACTION AS AN INGREDIENT OF QUALITY OF CARE [1]

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Abstract

This paper attempts to make a contribution in understanding and improving the quality and effectiveness of the PFPP through an assessment of the provider-client transaction. More specifically, the quantity and quality of the interaction is found to affect the effectiveness of the program in improving services and eventual client acceptance of and compliance to the services offered by the program. The role of the family planning worker in the interaction from various perspectives but more importantly as seen by the clients is highlighted. The action segment of the study concerns the identification of areas for improvement and those that serve as barriers to effective interaction.

INTRODUCTION

The Philippine Family Planning Program (PFPP) has always set ambitious objectives. There is a large demand among women for its services and a large proportion of this need is unserved. This situation occurs against a familiar backdrop: population growth rate remains high; substantial infant/child and maternal morbidity and mortality exist side by side with poverty; there is gender inequality in matters relating to childbearing and child care; and more. It was only in the 1990s or after three decades of the PFPP that a 40 percent prevalence rate was reached and the program entered the so-called consolidation phase in the development of the family planning (FP) program framework (Townsend, 1991). This is a stage where management efforts need to be focused on strengthening operational systems and knowing the Philippine socio-political and economic environment. Understanding the sources of tension to FP program growth is also an inescapable thrust even at this level of acceptance.

Many innovations and strategies have been adopted towards improving the effectiveness of the PFPP. At the planning level, the concern for strengthened capacity for implementation and resource augmentation are usual concerns. Very recently, the substantive and technical character of the PFPP is being oriented within a broader perspective of women's reproductive health. This is expected to improve quality, coverage and effectiveness of the program in addition to making FP an important strategy

for gender-based human resource development.

At the operational level, the appropriate handles of a program manager are the program components which operate in an integrated fashion and intimately affect the quantity, quality and cost of services (Townsend, 1991). Interventions in the content, frequency and extent of IEC, training, and logistics are possible. It must be remembered, however, that these actions are still one step removed from the client. In the end, it is the process of service delivery, where all of the program components are funneled via the provider-client transaction, which serves as the link between the program inputs and the program outputs. Service delivery is arguably the linchpin of the PFPP.

Operations research studies show that quality of interpersonal communication of service providers influences attendance at FP clinics as well as the initiation and continued use of family planning (FP). The strength of the interaction as a program component lies in its effectiveness in drawing attention to the client's needs, beliefs, expectations and preferences regarding FP. This then allows for more responsive information and service provision.

CLIENT-WORKER INTERACTION

The face-to-face transaction of workers with clients plays a critical role in a service provision setting. At the moment of the exchange, all the program components are interpreted and given life by the worker. Thus an effective or good interaction is expected to have a net incremental effect on the acceptance of the program and eventually compliance to its standards. It is important to clarify, however, that a client's response to the intervention of the worker is determined not only by that interaction but by a complex set of factors which serve as the underlying milieu for most other concerns of both the client and the worker (Simmons, Koblinsky and Phillips, 1986).

Thus the previous knowledge, formulated attitudes and experiences of the client on one hand and the worker's skills, attitudes and own experiences on the other are important elements that the dyad brings to any decision or action relating to contraception. However, the program formulates the rules and standards, makes commodities and supplies available, defines and sets up a structure for service delivery that culminates in the actual provision of service.

Studies elsewhere have identified certain types of transaction and the characteristics/environment of these transactions conducive to either increased or longer use of contraception. In many FP programs worldwide, house visits or worker-initiated interactions have become important add-ons to medical service because of their effectiveness in recruiting new users (e.g. Gallen and Lettenmaier, 1987). More personal, careful and emphatic approaches to counselling have also been seen to yield more program adherents. In more spe-

cific terms, workers who take time to understand their clients' personal needs and circumstances, treat them with sympathy, courtesy and respect perform better than authoritative service providers and those with harsh, rude and uncaring attitudes (Schuler, et. al, 1985; Tucker, 1986). The frequency of and the time spent during interaction together with the provision of complete, clear and accurate information have also positively influenced contraceptive use.

Korea's successful FP program has been largely attributed to a pool of visiting workers and a national network of mothers' clubs which serve as a mechanism that ensures a high degree of interpersonal communication for FP and other population issues (Woo Han, et. al, 1977). Their FP home visits effectively reduce problem group membership in the following areas: dropout; unmet need; use of ineffective methods; and those with problems regarding supplies, opposition by relatives, and choice of methods. In the same vein, the pre-pregnancy health workers of Taiwan composed of Mrs. Chins and Mrs. Lins who conduct house-to-house visits and sip tea with clients have been cited as a leading factor in the high acceptance of FP (Kenney, et. al, 1970).

Important predisposing worker-specific factors for fruitful interactions include credibility and acceptability to clients. Credibility is a function of basic individual characteristics such as age, sex, skills and the degree of the worker's integration with the people and culture of the community. Women have been found to exhibit more effective interaction styles as it is more culturally appropriate for women to talk to women about highly private issues such as family planning (Rao, 1977). With increasing age, a woman's opinion carries more weight as she is perceived to have more authority and control of her own life. Her kin and her known network in the community define the number of people whom she can rely upon for spontaneous influence and support.

The status of her husband is another source of influence as this can facilitate her work by providing access to certain people and facilities and also allow her time to do her public service work. Workers who use contraception are more credible and serve as role models to their clients. In Malaysia, workers who have been contracepting for some time are more productive in recruiting acceptors (Chee and Chan-Onn, 1980). The level of competence of workers as indicated by the type and amount of their relevant training has been known to contribute to an improved client-worker transaction.

DATA AND METHODS

The primary data collected for the study focused on 107 FP workers. Of these, 43 were clinic-based (CW) including nurses, midwives and doctors while 64 were community-based (MW) including Barangay Health Workers (BHW), CBDs and Full-Time Outreach Workers (FTOW). The 1,440 clients included ever-married women (EMW) of reproductive ages, 15-49.

Data were collected using a purposive sampling procedure. The first stage of the selection process required choosing provinces on the basis of their FPP performance in service delivery and practice.[2] This procedure yielded three high performing (HP) provinces (Tarlac, Misamis Oriental and Davao del Norte) and two low performing (LP) areas (Iloilo and National Capital Region - NCR). The second stage involved the selection of 4 municipalities per province and 2 for NCR. The former municipalities were selected to represent their urban and rural areas. For each municipality, a sample of 80 clients and 7 workers (4 MW, 2 CW and 1 district hospital worker) was randomly drawn with an equal split between the GOs and NGOs except in two project areas (Iloilo and NCR) where no NGO clinics were found in the selected study areas. Three types of NGO-FP clinics were included in the study. These were the Institute of Maternal and Child Health (IMCH), Family Planning Organization of the Philippines (FPOP) and Integrated Maternal and Child Care Services Incorporated (IMCCSDI).

Sample clients were randomly selected from the FP workers' listing of clients. The scheme was designed to approximate the national distribution of FP acceptors as follows: 25 percent past users (PU), 40 percent never users (NU) and 35 percent current users (CU).[3] In the absence of an existing list of NUs, it was assumed that all EMWs in the catchment area who were reported to be not currently using nor having ever used any method of FP were NUs. To prevent bias, the sample of NUs was selected from among the neighbors of the CU and PU samples. This sampling scheme therefore excluded areas which were hardly reached by the program.

The study combined both quantitative and qualitative data collection methodologies, i.e. survey, in-depth interview and actual observation. The in-depth interviews and observations were conducted immediately after the survey to provide a more thorough account of the interaction process. For these procedures, a checklist and a guide questionnaire were prepared and utilized to standardize the data collection process.

For the purpose of the study, at least 27 client-worker interactions from the 4 project sites were observed as unobtrusively as possible and were followed by separate in-depth interviews with each party involved in the interaction. These interviews were limited to CUs because of the recency of their FP transaction.

The field work of the study was conducted during the period May-June, 1990.

RESULTS OF THE SURVEY

Client Profile: The sample FP clients were on average 30 years old and married for 9 years at the time of the survey. The mean number of living children was 3.1, slightly short of their reported desired fertility of 3.4.

A large proportion of the respondents came from the poor sector of the society as evidenced by their mean household monthly income of P1,934 (Table 1). This was well below the poverty line established by the 1988 Family Income and Expenditure Survey (FIES) of P2,709 as the minimum monthly requirement to meet the basic needs of a family of six in rural areas. The corresponding FIES figure for the urban areas/cities was higher at P4,037.

Less than a fifth of the respondents were working. Educational attainment was decent by any standard as 70 percent of the sample EMWs reported to have attended at least high school. What is apparent here is the inability of the society to translate the educational attainment of women into jobs once they get married and begin raising their own families (Figure 1).

The NUs were the youngest among the three types of clients in the study and were also the most disadvantaged in socio-economic terms. They reported the lowest annual household income and the lowest level of education attained. Only 17.7 percent of NUs had ever attended college as compared to 24.2 percent among the CUs. They were also the least employed.

Overall, the respondents presented a highly positive attitude towards FP and a receptivity to new modes of thinking and technologies. For example, 4 out of appreciated the presence of a linkage between the number of children and other family development factors like 5 of the women believed that people have control of their own lives and could change its course. Practically everyone health and education.

The gender-role stereotype within the house where the husband is pictured as the breadwinner and the wife as the house manager is no longer being subscribed to by the majority of married women. More than half of the respondents (56.3 percent) actually disagreed with this statement, in spite of the very low reports of their own participation in income-generating activities. The NUs were consistently the more conservative segment of the clients in this regard.

A woman's own attitude about family planning was somehow manifested in her perception of how others view FP. Two-thirds of the sample clients believed that most people were in favor of FP with those who have used FP themselves being more likely to think of the general acceptability of FP than those who never used FP at all.

FP Worker Profile: For this study, the grassroot FP worker could be characterized as a married woman in her early 40s, a Roman Catholic and a resident of the municipality of her workplace. Their total household income was much higher than wpoverty either that of their clients or the line level. Owing to their higher occupational rank, the clinical workers earned twice as much as the motivational workers. It must be noted that the study selected specific types of workers like doctors, nurses and midwives. The

Table 1. Characteristics of Client According to FP Use

CHARACTERISTICS	CURRENT USERS	PAST USERS	NEVER USED	ALL CLIENTS
Demographic				
Mean age (years)	29.7	31.4	28.8	29.8
Socio-Economic				
Mean annual household income	P24,459	P23,316	P22,041	P23,213
Percent not working	84.2	86.7	82.7	82.4
N	(509)	(358)	(573)	(1440)

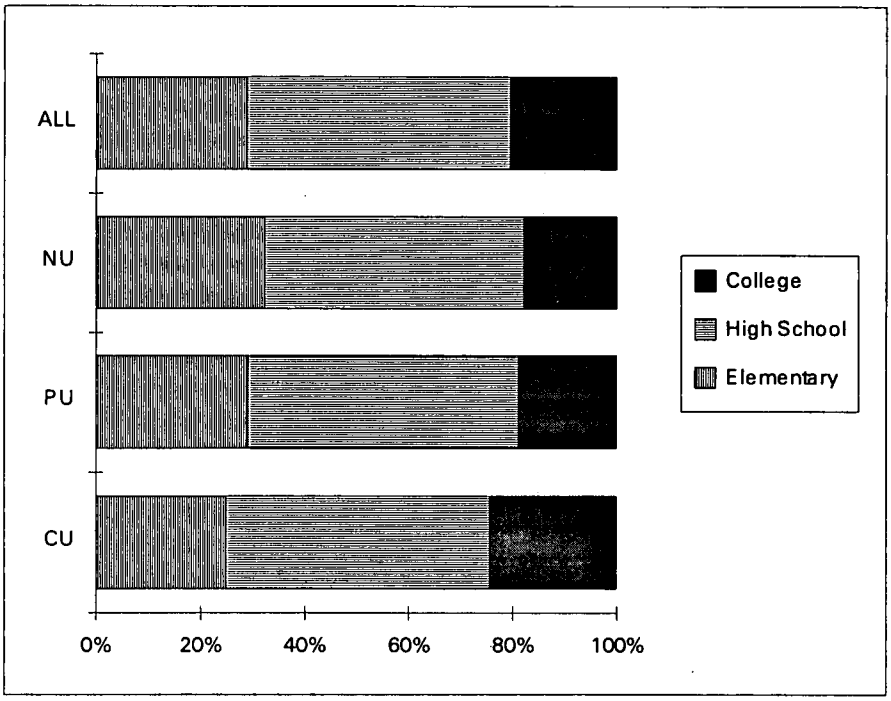
sample workers were highly trained both academically and in FP technology. More than a third had postgraduate education and practically everyone, especially the motivational workers, had attended two training programs, on the average. The most common types of training attended were Basic FP and Comprehensive FP, in that order.

The women had been practicing health workers in the sample communities for a long time; 15 years on the average for the clinical workers and 7 years for the motivational workers.

Like their clients, the FP workers professed a highly positive attitude towards certain developmental issues. Most of them believed that FP is important for the welfare of the people and the community as a whole and that it is not just a poor people's issue. They were FP practitioners themselves with a combined ever use and current use proportion much higher than what was known for the total population of women. The current users among them patronized modern methods more than the traditional ones, with the distribution disproportionately in favor of the former compared to the known method distribution in the general population. It could be said therefore that they sincerely believed in the services that they offered.

Marriage was considered by the FP workers as not incongruent with work outside the home. This was due to the recognized need for wives to augment their husband's income to meet family needs. While they adhered to a belief in the equality of the sexes, this claim appeared to weaken when it came to some FP-related concerns. This was particularly true among the MWs compared to the CWs. Even as the majority (88.1 and 68.8 percent of CWs and MWs, respectively) agreed that both the husband and the wife should be approached

Figure 1. Education Level of Respondents by FP Use



for FP adoption, they tended to put the burden of actual contraceptive use on the wife. Although this could be attributed to the fact that most FP methods are female-oriented and that it was easier to reach the wives, this should not diminish the importance of training programs geared towards creating a more gender-fair attitude towards FP use.

All motivational workers in the sample had been trained in family planning. For 60.8 percent of them, the most recently attended program was within the previous two years. The clinical workers were not far behind with 83.7 percent having been trained, 53 percent being recent training sessions (Table 2). It is important to note here that the study was conducted prior to the massive training program of health personnel during the early years of the nineties.

CLIENT/WORKER INTERACTION

Quantity: The study revealed a high level of interaction between clients and FP workers. Over two-thirds of ever married women claimed to have met an FP worker in their community with the ever users (CU + PU) exhibiting a clear edge. It was also clear that there was some amount of motivation for recruitment purposes going on in the communities as shown by the 30 percent of never users claiming to have met an FP worker. During the three months preceding the study, clients met with the FP worker 1.8 times on average, the CUs having an

Table 2. Profile of FP Workers By Type of Worker

CHARACTERISTICS	CW	MW
Demographic		
Mean age (Years)	40.4	41.3
Percent female	93.0	100.0
Percent married	81.4	76.6
Percent resident of municipality	76.7	95.3
Socioeconomic		
Average Household Income	P58,336	P27,831
Skills/Training		
Percent trained in FP	83.7	100.0
Average number of trainings received	1.8	1.7
FP Practice		
Type of FP user		
- CU	31.0	35.1
- PU	47.6	42.1
- NU	21.4	22.8
N	(43)	(64)

average of 2.6 meetings for the period as compared to 1.4 and 0.9 for NUs and PUs, respectively (Table 3).

On the basis of the information on the last meeting held, interactions lasted for an average of 38 minutes. FP workers spent more time with NUs than either the CUs or PUs. The differential in time spent on clients could be explained in part by the nature of meetings which were basically for contraceptive resupply for the CUs and for motivation and counseling for the NUs.

Qualitative Characteristics: The majority (59.8 percent) of the last client-worker interactions were clinic-based, suggesting a higher preponderance of client-initiated meetings. There was also a substantial proportion (21.5 percent) of clients whose most recent meeting was a home visit by the worker. The current users were visiting the clinics for maintenance services while the motivation of never users was largely due to outreach services. This was validated by the statistics on the initiator of the last meeting (Table 3).

Eighty-five percent of all interactions had been conducted using the clients'

Table 3. General Characteristics of Client-Provider Interaction (As Reported By Clients)

INDICATORS	CU	PU	NU	TOTAL
Location of the last meeting with FP worker (%)				
Center/clinic	63.2%	53.3%	55.3%	59.8%
R's residence	15.4	28.9	33.3	21.5
Other public place	3.9	8.1	6.5	5.3
FP workers place	13.5	4.4	2.4	9.6
Others	3.9	5.2	2.4	3.9
(N)	(408)	(135)	(123)	(666)
Who initiated last meeting:				
Respondent	77.8	61.5	52.0	69.7
Worker	22.2	37.0	47.2	29.9
Other person	0.0	1.5	0.8	0.5
(N)	(405)	(135)	(123)	(663)
Dialect FP worker uses in meetings:				
R's dialect	84.6	82.2	89.6	84.7
Worker's dialect	4.5	3.4	1.2	3.5
Mixed	10.9	14.3	9.2	11.6
(N)	(494)	(321)	(173)	(988)
Type of meeting				
Individual	73.8	68.1	61.8	70.5
Group	26.2	31.9	38.2	29.5

own dialect. While this might seem short of the ideal, it must be remembered that some of the study areas were heavy in-migration areas and the use of a common language like Filipino would still seem to be the best arrangement.

Interactions were typically conducted in dyads (70.5 percent). While this strategy was considered more time consuming, particularly on the part of the FP worker, it was likely to yield a more desirable and long range impact by ensuring a more personal and in-depth discussion of sensitive and personal subjects.

Indicators pointed to more emphasis on motivating new acceptors rather than winning back program drop-outs or past users. This was suggested by the less frequent and shorter meetings reported by the PUs compared to the NUs. While the last meeting was generally conducted

in the clinic, a larger proportion of NUs (33.3 percent vs 28.9 percent for PUs) were sought by the workers in the convenience of their own homes, again indicating the presence of a significant level of worker-initiated encounters. Moreover, workers were more likely to meet NUs individually and use the latter's own dialect during meetings than with PUs (Table 3).

The Client's Perspective: This section focuses on the clients' own views about their last interaction with the FP worker. The study took into account selected quality of care indicators including waiting time, competence of staff, worker's concern for client's privacy and courtesy/respect accorded to clients. The discussion was limited to the experiences of the CUs and PUs who had generally experienced more in-depth interaction with FP workers.

Clients in general and the CUs in particular were highly positive about their experience during their last clinic visit. Clients commended the good service provided them by the physician and the clinic personnel. This positive assessment appeared to be a composite of their views regarding clinic personnel competence, satisfactory reception attitude for clients, provision for their privacy and the presence of a waiting area for clients. There was a small but significant proportion of clients who felt they had to wait unnecessarily before they could be attended to (16.2 percent for CUs and 11 percent for PUs) and who were not sufficiently satisfied with the treatment provided by the doctors (21.4 percent for CUs and 22 percent for PUs) and other clinic personnel (22.1% for CU and 24.7% for PU).

FP workers were perceived to be friendly, respectful of clients, explaining topics in simple language and paying attention to the questions of the client. These and similar findings noted in Table 4 were validated by having few reports of workers who did not seem to be interested during the interactions with the clients. On more specific items during the transaction, such as giving details on contraceptive methods, the workers were still graded fairly high (70.1 percent), although significantly lower than the more general items (Table 4).

This positive feeling about the worker was further reinforced by the high marks given by clients on selected aspects of their personality. On a three-point scale (very much, just okay, not at all), there was only slight variation on the high marks given across characteristics but with the never users giving slightly lower marks than the other two types of clients. The workers were seen to be compassionate towards the clients, showing no negative signs in their dealings with the clients, hardworking, competent and commanding respect of the clients. The clients also reported having no reason not to trust the intention and capability of the worker.

The only evidence of possible complaint against the workers was the tendency of some of them to be

Table 4. Clients Assessment of FP Workers' Performance/Actuation

AREA of ASSESSMENT	CLIENT FP USER TYPE			
	CURRENT	PAST	NEVER	TOTAL
Friendly	85.5%	80.7%	80.2%	83.0%
Respectful	85.0	86.6	82.0	85.0
Pays attention to questions	81.6	85.7	70.8	81.1
Explains in simple language	85.0	86.3	80.8	84.7
Provides details of contraception	71.9	70.8	63.4	70.1
Acts like school teacher	52.5	55.0	48.8	52.7
Makes decisions for R	11.7	13.0	6.4	11.2
Acts uninterested	6.7	6.8	3.5	6.2

authoritarian or perceived as acting like a teacher who tends to tell the clients what to do (52.7 percent). In fact, 11.2 percent of the clients felt that the workers always made the decision for them in contraceptive matters. Fully a third of the clients claimed that their workers were advocating a contraceptive method and of this proportion, the method being advocated were reported in the following order: pills 49.5 percent; IUD 33 percent; and sterilization 10.9 percent.

The FP Workers' Perspective: The FP workers felt positively about their motivation and counselling work, this being derived from their feeling of satisfaction and confidence in their ability to do their job. However, there were 10 percent or more of the workers who were not so confident in discussing client problems relating to sex preference, and religion and FP.

In discussing family planning needs with their clients, workers preferred going directly to the topic rather than resorting to preliminaries that purportedly establish rapport with the client. This could be due to many of the clients coming for resupply. Those coming for the first time were presumably already motivated and had some ideas of what they wanted.

Like their clients, the workers were very positive about these interactions. The sources for this generalization are two-fold: one was their favorable assessment of their clients' attitude and the other was self-derived. They were par-

ticularly pleased about the friendliness and show of respect by the clients. A lower but still high level of satisfaction was mentioned regarding the level of attentiveness and feedback. The workers also felt that approximately half of the time the clients acted like students and waited for the worker to tell them what to do. This was corroborated by the significant proportion of workers who felt that the clients did not want to make decisions for themselves.

Interaction and FP Performance: The analysis in this section was carried out at the areal or province level with the tests of significance between the aggregated interaction characteristics and the provinces dichotomized into high and low performing ones. The results are shown in Table 5.

Interactions had been more favorable in the high performing (HP) provinces compared to the low performing (LP) ones. In terms of quantity of interaction, a higher proportion of clients in the former have already met an FP worker in their municipality. There were also more frequent meetings in the HP (average of 2 during the three-month period preceding the survey) against 1.5 for the LP areas. Although the mean duration of the last meeting was longer in the LP, this was mostly due to Iloilo (an LP) where there was a preponderance of group meetings.

More interactions in the HP regions had been conducted in the client's residence (28.9 percent in HP vs. 4.4 percent in LP), thus implying greater worker-initiated meetings. Moreover, 77.6 percent of interactions in the HPs had been on a person-to-person or individual basis as compared to 54.2 percent in the LPs.

This study was not as successful in differentiating the low and high performing provinces in the more qualitative aspects of the transaction, particularly in the assessment of the personality and other worker-specific aspects of the transaction. Although the directions of the behavior of the factors were generally according to expectations, most clients graded the workers generously. As such, there were no significant variations between the areas.

Nonetheless, clients from the HP regions had a better impression of their FP workers. More of them were satisfied with the kind of treatment received from both the physicians and other clinic personnel during the visit. Significantly, a higher proportion of PUs in the HP provinces claimed to have been sought out for remotivation to the program by their FP workers. In addition, the study attested to the finding that women (PU and NU) who were approached by the FP worker were more likely to declare an intention to use in the future (Table 6).

Interviews and Observations: In addition to the survey of clients and workers, the project employed two other methodologies of data collection: actual observation and in-depth interviews conducted immediately after an interaction. A

Table 5. Interaction Indicators By FP Performance

INTERACTION INDICATORS	PROVINCE	
	Low Performing	High Performing
Have met FP worker (%)	66.0	70.5
Average no. meetings in last 3 mos*	1.5	2.0
Duration of last meeting (minutes)*	44.2	35.1
Location of meeting (%)**		
Clinic	91.1	46.0
R's residence	4.4	28.9
Who initiated meeting (%)**		
Respondent	89.7	60.9
Worker	10.3	38.5
Nature of meeting (%) **		
Individual	54.2	77.6
PU persuaded by FP worker to use after stopping (%) **	21.4	37.3
Never Users approached by FP worker (%)	24.1	24.5

**Significant at <.05 level*

***Significant at <.001 level*

positive interaction was reported by these two methodologies, substantiating the results of the survey. Interactions were generally found to be effective and acceptable to clients. Workers were appropriately dressed during interactions and were able to establish good rapport with their clients. As had been the finding of the survey, results only suggested an average performance in the use of a language understandable to clients.

The survey results showed a good proportion of interactions which were not carried out using the client's own dialect. Workers were given high marks for providing immediate response, for showing concern to clients as well as for their ability to control discussions. However, relatively lower marks were given in terms of encouraging their clients to ask questions. Clients' participation in the discussion and workers' degree of open

Table 6. Percent Distribution of NUs and PUs By Future Intention To Use FP

User Types	Percent	FUTURE FP INTENTION				
		Will Use In Future	Will Not Use	Undecided	T O T A L Percent/Number	
Never User	100.0					
Approached by FP worker	24.4	71.3	28.7	-	100	(136)
Not approached by FP worker	75.6	53.6	46.4	-	100	(422)
Past User	100.0					
Persuaded after stopping FP	32.1	69.6	21.7	8.7	100	(115)
Not persuaded	67.9	50.8	33.5	15.7	100	(243)

ness with their clients were likewise judged as average. Moreover, researchers noted some room for improvement insofar as workers' patience to listen to their clients is concerned.

Observers reported an atmosphere of friendliness and informality prevailing in the interaction but that these were still wanting in terms of providing clients comfort, privacy and freedom from distractions or undivided attention. Content-wise, the interactions sufficiently provided for an explanation of the follow-up procedures but required additional information to give clients confidence in making an informed choice of methods. This observation was made in light of the assessment that workers needed to explain further the different contraceptive methods and their possible side effects.

DISCUSSION

In essence, this study found client-worker relationships to be an important component of successful FP programs. However, given what is known about the larger socio-cultural contexts where these interactions and the FP program operate, other information collected by the study but not reported in the findings section of this paper require clarification.

First, the study sites had been purposively selected and therefore represented areas of active operation by the clinics. This could partly explain the high level of contact with FP workers by all types of clients, even the never users.

Still, the positive association of the quantity of interaction with the level of performance by the study sites remains valid as both LP and HP areas had similar selection criteria for sample sites.

The study sites were poor areas with people reporting low income levels. The women had limited opportunities to join the work market in spite of their high educational attainment. Their educational level could be partly responsible for their non-conservative views about fate, sex difference among children, and family planning as well as their ability to relate family size and other development concerns. Consequently, their desired family size was low but not firm as indicated by higher numbers of expected children than their desired number of children.

Perhaps the highly positive views of both the clients and the workers regarding each other and their transaction need to be examined more closely. The FP workers were also the same workers in the public health service who in turn were residents of the same community and had been servicing the other health needs of the community for years. While this could have both a positive and negative side, in the study sites this seemed to work positively. The public health network catered mostly to the poor in the area who essentially had no or low purchasing capability particularly for health services. It would therefore be more difficult for the residents to see those servicing their needs in a bad light and it would be highly possible that the tendency would be to err on the positive side in describing them. Likewise, for people who had no basis for comparison, standards could be determined by what they are used to see and avail of. Making bad remarks could be interpreted as "biting the hands that feed you" which is culturally undesirable.

The inadequacies of the government health facilities are well-known. Ocular inspection of the clinics included in the study confirmed this in at least two aspects: the presence and adequacy of the waiting area and the facility to provide privacy to the client. Cramped waiting areas with inadequate seating facilities were seen yet almost all the respondents perceived the waiting areas as comfortable. Basic inadequacies in a particular clinic visited in rural Davao compromised the privacy of its patients during physical examination. More specifically, the examination table was situated near the windows in order to harness natural lighting (there was no electricity in the clinic) but with the consequence of unduly exposing the client to the passers-by during internal examination. While this was a single case, the absence of electric power in rural health facilities would not be a rare occurrence. Yet, 99 percent of our respondents felt that their privacy was respected. It would not be unusual to find women in dire need of free services who have learned to accept existing conditions and relax their standards in the process.

We can therefore conclude that the marks given by the clients or even the workers could err on the high side. However, the overwhelmingly high marks and

their consistency among items and across graders could not remove the fact that the interaction was, on balance, positively viewed. In the final analysis, the favorable assessment of clients of their service providers could have value added to their FP attitude and behavior.

Shifting to possible improvements in the interaction component of the FP program, there was a tendency for some workers to shorten the duration of the interaction, such as: being authoritarian and making decisions for the client; inability to explain the details and possible side effects of methods; lacking the patience to listen to and taking time to respond to the questions of the client; and having the client wait for an extended period of time. It was highly possible that these were part of the worker's coping mechanism to attend to the requirements of their clients at existing conditions. At the clinic level, the health workers provide service for 27 different health programs, notwithstanding their administrative functions like recording and reporting. The daily patient-worker load for the sample clinics averaged 16 for motivational workers and 23 for clinical workers; workers regarded motivation and counselling as their most important job yet they had insufficient time to devote to this.

In view of all these, it is quite impressive to find the client-worker interactions to be satisfactory and an effective component of the program.

RECOMMENDATIONS

This study was specifically conducted to draft an agenda for action to improve the management of FP programs at the clinic level. These specific recommendations directly emanate from the findings of the study and cannot be isolated from the bigger issues confronting the Philippine Family Planning Program. They should therefore be put within that context.

(1) The FP program has been beset by high drop-out rates and the lack of information on how to address this issue. The study has shown some worker preference for recruiting new acceptors instead of remotivating past users and the effectiveness of worker-initiated visits in this aspect. Local government efforts in providing health workers a travel allowance and time to do home visits should be encouraged to bring women back into practice.

(2) The training courses designed for FP workers need some special modules to address the following indicated training needs: enhancing the skills of the worker to create a more informal environment where the client will be encouraged to ask questions and talk about her personal concerns; more effective ways of handling questions and actual problems regarding side effects of specific methods; enhancing the training curriculum on handling sexuality

issues and concerns of clients; and guidelines in handling the accusations/objections made by the leaders of the Catholic Church against contraception in general and the FP program in particular.

(3) The clinic setting needs to conform to the standards of quality of service to improve the flow of services and to provide privacy for clients, including clean equipment in good working conditions and ready availability of supplies. It must be noted that this study was conducted in 1990 when the logistics component of the PFPP was still in disarray.

(4) Clinic management should make conscious efforts to ensure that the clinic visit of clients will be as hassle-free as possible, particularly as they go from one desk to another. This does not only mean efficient service but a visit that is personally satisfying as well.

(5) There should be more conscientious and systematic efforts to bring about more worker-initiated meetings. This could hold the key to transforming present latent or unmet demand into action.

NOTES

1. This paper is part of a UNESCAP intercountry project involving Bangladesh, India, Pakistan, Thailand, Republic of Korea and the Philippines. In the Philippines, this was implemented by the University of the Philippines Population Institute where the study is also one of the core studies of the UNFPA-funded Comprehensive Operations Research for the Philippine Family Planning Program.

2. Per evaluation of the Family Planning Service, Philippine Department of Health.

3. Based on the 1988 National Demographic Survey

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