Quality of Family Planning Counseling

Lens from Stakeholders

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Abbreviations and Acronyms

AIDS	Acquired immune deficiency syndrome
AVSC	Association for Voluntary Surgical Contraception (EngenderHealth)
BBT	Basal body temperature
BHWs	Barangay health workers
BSPOs	Barangay service point officers
BTL	Bilateral tubal ligation
CDLMIS	Contraceptive Distribution and Logistics Management Information System
CHO	City health officer
CPI	Client-Provider interaction
CPR	Contraceptive prevalence rate
CWs	Clinical workers
DMPA	Depot Medroxyprogesterone Acetate
DOH	Department of Health
FHSIS	Field Health Service Information System
FP	Family planning
FPOP	Family Planning Organization of the Philippines
GATHER Approach	**G**reet, **A**sk, **T**ell, **H**elp, **E**xplain, **R**eturn Approach
HC	Health center
HIV	Human immunodeficiency virus
IEC	Information, Education, and Communication
IMCH	Integrated Maternal and Child Health
INC	Iglesia ni Cristo
ITR	Individual Treatment Record
IUD	Intrauterine device
JHU	Johns Hopkins University
LAM	Lactational amenorrhea method
MHO	Municipal health officer
MWs	Motivational workers
NFP	Natural family planning
NGO	Nongovernmental organization
NSO	National Statistics Office
NSV	Nonsurgical vasectomy
OCPs	Oral contraceptive pills
PHN	Public health nurse
PHO	Provincial health officer
PTB	Pulmonary tuberculosis

QA	Quality Assurance
QIQ	Quick Investigation of Quality
RH	Reproductive health
RHM	Rural health midwife
RHN	Rural health nurse
RHU	Rural health unit
RM	Registered midwife
RN	Registered nurse
SDA	Seventh-Day Adventist
STDs	Sexually transmitted diseases
STIs	Sexually transmitted infections
TCL	Target Client List
UNFPA	United Nations Population Fund
USAID	United States Agency for International Development
WFMC	Well-Family Midwife Clinics

Preface

Today's concern for "client-oriented" health care and service provision emphasizes the importance of peoples' needs and expectations. Communication interventions, such as counseling and interpersonal communication, are therefore essential in ensuring clients' right to informed choice and in promoting the philosophical view that recognizes health care clients as decision-makers. Effective client-provider communication and counseling are therefore central to a move toward a client-centered and quality of care-focused program strategy.

This volume is a great leap in the history of research in family planning counseling service provision. Albeit the scant research efforts along the line of family planning counseling service provision in the country, such a taken-for-granted phenomenon is examined comprehensively in this book. Empirical data and analysis of the quality of family counseling service provision within the context of the primary health care setting, specifically in selected public rural health centers and private clinics affiliated with and/or managed by nongovernmental organizations, are detailed in this book.

Researchers and observers of family planning in the Philippines are familiar with many of the situations described in this book, some of which have also been characterized and discussed in past researches and articles featured in local and foreign journals. However, an analysis of the quality of family planning counseling service provision that is as detailed and comprehensive as the material presented here has yet to be seen. No publication in the past has paid adequate attention to the realities of family planning counseling service provision and to the views as well as

perspectives of the many stakeholders, namely, the centers'/clinics' family planning clients, nonclients residing in the community, frontline health service providers, supervisors/managers, elected local government officials and civil servants, and community-based leaders. Moreover, aside from describing the manner in which nonhealth care factors account for the quality of family planning counseling service provision, the volume also describes in detail both the "undesirable" and "best" practices in family planning counseling in the country.

The scientifically documented data provide an essential baseline description and diagnosis for policymakers, program managers, and implementers interested in advancing the provision of quality care family planning counseling and services. Given the current reorientation and mind-set toward a quality of care approach to family planning care as well as service provision, this is a fitting time to publish and thereby disseminate the information to an audience other than the health care sectors. Indeed, family planning and population issues are not merely a private marital issue but a public concern as well.

This book is also relevant not only to researchers but also to medical and health sciences students interested in the study of quality of care and the connections between program implementers and the people and their community. Demonstrated in this book is the value of both quantitative and qualitative data analyses to adequately capture a specific social reality. With this material, researchers, policymakers, practitioners, and program implementers can now move forward in the continuing search for new ways of bridging research and action leading to the attainment of a much more improved quality of people's lives.

The research work from which this book was drawn was carried out by a team from the Social Development Research Center (SDRC) of De La Salle University consisting of myself as the project team leader, Dr. Loyd Brendan Norella, M.D., Dr. Jose Alberto Reyes, Ph.D., and Cristina Rodriguez, M.A., the research fellows and project associates, and the following research assistants: Avelita Lapitan, Jesson Butcon, Evelyn Hernandez, Lyndon Bolo, and Divinagracia Colar. Some SDRC core staff have also helped in the process of implementing the research project, specifically Ma. Aurora Esquejo, Lyndia Navarro, and Reynaldo Porsuelo.

The project team benefited from the technical assistance provided by the consultants from the Johns Hopkins University Center for Communication Programs, Baltimore, Maryland, U.S.A.—especially Ms. Jennifer Bowman—which then commissioned the team of the SDRC to undertake the research on the "Assessment of the Quality of Family Planning Counseling within Selected Reproductive Health Services." The financial

support which made the research possible came from the United States Agency for International Development (USAID), Washington D.C. The research report from which the present manuscript was drawn was reviewed by a team of evaluators from the Johns Hopkins University Center for Communication Programs. The manuscript was also polished by a pool of editors—Alejandro D. Padilla, Alexander de Juan, Michael Francis Andrada, and Camilo M. Villanueva Jr.—from De La Salle University Press. All their comments and suggestions have enriched the present material. To all of them, we extend our greatest gratitude and appreciation.

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Foreword 1

Millions of Filipino women practice family planning. According to the *2002 Family Planning Survey*, almost half of all women currently of reproductive age (about 5.6 million of them) use contraceptives. Majority of these women are using the modern methods. This is good news.

Of those who are not practicing family planning, more than 20 percent have an unmet need for it. This means about 2.3 million married women either do not want another child in the immediate future or ever at all, and are not using any form of contraception. A number of reasons have been advanced for the high incidence of this unmet need. Two of the most important reasons cited by the women in surveys are concern for their health when using contraceptives and fear of side-effects. This is bad news because it points to the failure of the Philippine Family Planning Program to properly counsel these women and allay their health concerns and their fears regarding contraceptive safety.

This study by the De La Salle University-Manila Social Development Research Center DLSU-SDRC is therefore very much welcome. It addresses the knowledge gap in the family planning counseling process, how it is actually done, and what possible approaches can make this process more successful. This study on the quality of the family planning counseling process is noteworthy for incorporating data from various stakeholders—program managers at various levels, health service providers, even family planning clients—and for using a variety of research methodologies and instruments. The publication of the study's final output aims to provide

data that can be used by policymakers, program managers, academics, and other groups interested in counseling as experienced by Filipinos.

On behalf of USAID, I congratulate the Johns Hopkins University/ Population Communication Services, which supported this study, and the DLSU SDRC, which carried out the research and published the results. I hope that this study will help improve family planning counseling in the Philippines in order that the health concerns and fears of side-effects of many Filipino women will be effectively minimized and that they will practice family planning as part of a normal, healthy lifestyle.

Carina Stover
Chief, Office of Population Health and Nutrition
USAID-Philippines

Foreword 2

In the field of reproductive health, communication interventions such as interpersonal communication and counseling (IPC/C) are recognized as essential to help ensure informed choice and promote clients as decision-makers. Quality family planning counseling can contribute to overall greater client satisfaction and improved family planning continuation rates. With adequate management support, effective IPC/C in family planning is the centerpiece of a high-quality family planning program.

With support from the United States Agency for International Development (USAID) in the Philippines, under the Population Communication Services cooperative agreement, the Center for Communication Programs (CCP) of Johns Hopkins Bloomberg School of Public Health commissioned the Social Development Research Center (SDRC) of De La Salle University to conduct a highly participatory, multisectoral family planning counseling assessment to explore client and provider experiences and expectations in family planning counseling. The results of this assessment, the first of its kind in the Philippines, are detailed in this report.

It is with thanks and appreciation that I congratulate the SDRC team, which was led by Dr. Exaltacion E. Lamberte and included Cristina A. Rodriguez, Dr. Jose Alberto S. Reyes, and Dr. Loyd Brendan P. Norella. The SDRC team tested and finalized the tools, managed the research teams, and delivered the final report. I would also like to thank the CCP staff members in the Philippines and at our central office in Baltimore—Jose

Miguel de la Rosa, Rosario Nolasco, Michelle Heerey, and Jennifer Bowman—who designed the assessment and adapted the tools using similar processes and methods CCP has used in other countries around the globe. This research contributes to furthering our understanding and outlines recommendations various stakeholders (clients, nonclients, providers, supervisors, and local government officials) have to improve the quality of family planning counseling in the Philippines.

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CHAPTER I

Introduction

Rationale and Research Objectives

The current concern for "quality of care" or "quality service" underscores clients' needs and expectations in family planning (FP) and the bringing of persons/clients back to the center of FP service provision. Communication interventions, such as counseling and interpersonal communication, are seen as essential in ensuring informed choice and in promoting the philosophical view that recognizes clients as decision-makers. The provision of quality FP counseling could contribute to overall client satisfaction and improved continuation rates. Effective client-provider communication and counseling in FP, therefore, is the centerpiece of high quality FP service provision. It is central to a move toward a client-centered and quality-focused program strategy.

Research that is specific to FP counseling and client-provider interaction (CPI) is rather scant in the Philippines in spite of the numerous studies done on FP services provision and utilization. This is clearly seen in the succeeding section of this report. In view of this, a comprehensive study such as this present research is found to be imperative. This study assesses the quality of FP counseling currently provided in both public and private service delivery points, specifically the public city/rural health units and the private clinics managed by and/or affiliated with nongovernmental organizations (NGOs).

This study is significant because of certain features that distinguish it from the few researches previously done on FP counseling in the country: a) it is comprehensive in scope in that it also explores the management support provided to FP counseling provision; b) it considers the viewpoints of the program's stakeholders, specifically those of clients, nonclients, health service providers, supervisors, local government officials, and selected leaders in the community; c) it includes males/husbands as respondents of the study to recognize the importance of male involvement in FP program; and d) aside from assessing the current FP counseling situation and practices, it provides direction for improvement by eliciting inputs from those directly involved in counseling such as the clients, providers, supervisors, and other key stakeholders. Altogether, these features identify the needs and expectations of the major stakeholders as well as map out suggestions and recommendations to strengthen FP counseling provision in the country. Moreover, it has already been a decade since a nationwide study on interaction between clients and FP workers at the rural health units (RHUs) and barangay health stations setting was conducted (Raymundo et al., 1990). It is but timely and appropriate that an updated situationer on FP counseling which is much broader in scope but much more focused in subject domain is undertaken.

This research addresses these nagging questions: a) What is the current status of the FP counseling process and how effective is it in addressing health concerns, fears of side-effects, and rumors and misconceptions?; b) Does the counseling process follow the standard demonstrated and specified in the Greet, Ask, Tell, Help, Explain, Return (GATHER) Approach?; and c) How do stakeholders view their role in FP counseling and what suggestions do they have for improving FP counseling?

Specifically, this study aims to:

1. Conduct a review of past researches done on FP counseling in the Philippines;
2. Review the variants and common elements of the GATHER modules designed by Johns Hopkins University (JHU) Center for Communication Programs (CCP), United Nations Population Fund (UNFPA), and EngenderHealth;
3. Assess the actual FP counseling provision, behaviors, and practices from the viewpoints of different stakeholders, specifically the clients, nonclients, health service providers, supervisors, local government officials, and selected leaders of the community;

4. Identify strengths, weaknesses, and gaps in FP counseling performance; and
5. Make recommendations to strengthen FP counseling performance in both public and private health facilities.

There are many concepts that have evolved with regard to the meaning of FP counseling. For purposes of commonality in perspective and standards, this study adopts the definition provided by the 1997 Department of Health (DOH) Clinical Standards Manual for FP: "FP counseling is a face-to-face communication wherein the FP service provider helps the clients make a decision about their fertility." Specifically, it is a two-way communication process between the provider and the client. The goal of this communication is to assist the client in making a free and informed decision about his/her fertility (DOH, 1997). It is assumed that good counseling enables a health worker to assist clients in choosing a method that best suits them based on their needs. Furthermore, it is expected that counseling helps increase continuation rates and minimize dropouts. It also leads to increased acceptance of FP.

Quality is viewed in this study as a generic term referring to the extent to which FP counseling practice is able to meet the expectations and needs of the clients; the expectations of the providers, health professionals, and supervisors; and the standards set by the health system organization and/or facility. In the same manner, the study adopts Judith Bruce's (1990) operational definition of quality, viewing it mainly in terms of the way individuals (or clients) are treated by the system providing the services.

Research Methods

This study utilized multiple methods involving both quantitative and qualitative research methodologies, thus meeting the requirements in adequately assessing FP programs in relatively low-prevalence countries. Specifically, the study made use of the following data-collection methods: a) face-to-face semistructured exit interviews with clients; b) face-to-face semistructured interviews with nonclients in their homes/residences; c) in-depth interviews with providers; d) in-depth interviews with clinic heads/supervisors; e) structured facility

observation method; f) structured stakeholders' meetings with local managers, providers, clients, supervisors, and barangay leaders/officials; and g) use of audiotapes to capture actual FP counseling/communication process occurring in the facility.

This study adopted the following data-gathering tools and instruments: a) interview schedule for clients, which was used during the conduct of exit interviews in the facilities; b) interview schedule for nonclients; c) interview schedule for health service providers; d) interview schedule for supervisors/heads of facilities; e) the Quick Investigation of Quality (QIQ) Observation Tool; and f) Stakeholders' Agenda and Matrix Tool. These tools were originally developed by the staff of the JHU Center for Communication Programs in Baltimore, Maryland, U.S.A. These were then pretested and later modified based on the pretest results submitted by the De La Salle University Social Development Research Center–Family Planning Counseling Assessment Project Team.

As stated earlier, this study is different from previous studies on FP counseling inasmuch as it gives importance to stakeholders' views and inputs in the process of assessing FP counseling situation and practices. Given this approach, the research included several groups of respondents:

1. **Clients**: Those who sought the health services/care at the city/rural health centers during the time of the conduct of the interviews. Specifically, they are women of reproductive age, 15-49 years old, who at the time of the interview were seeking FP and maternal health care services at the facility. They were considered as the respondents of the exit interviews.
2. **Household Respondents or Nonclients**: Those who were interviewed in the residences/homes. They are men and women of reproductive age, 15-49 years old at the time of the interview. They are either nonusers of FP and/or FP users but at the time of the interview had stopped practicing FP. They are also known as dropouts.
3. **Health Service Providers**: Health personnel/staff basically assigned to provide FP counseling to clients in the city/rural health centers and private clinics.
4. **Supervisors:** Health officers directly responsible for the monitoring and supervision of the health personnel based in and assigned to the health centers/clinics covered by the study.

5. **Community Leaders:** Elected and informal leaders of the barangays and/or areas covered by the study. They were primarily recruited to become participants of the stakeholders' meeting.

The number of respondents/participants per category is shown in Table 1. These were generally predetermined in a process similar to a quota system. The client and nonclient respondents were selected nonrandomly using purposive sampling technique. Furthermore, only those health staff tasked to provide FP counseling were recruited as participants of the study. The selection of the provider is therefore determined using a purposive sampling procedure with an assigned FP counseling task as criterion for selection. To facilitate selection, the referral of the immediate supervisor in the facility was elicited.

Table 1
Number of Participants and Activities Conducted

Participants/Activities	Total
1. Clients	280
2. Nonclients	280
3. Providers	30
4. Supervisors	24
5. Stakeholders' meetings conducted	14
6. Participants of stakeholders' meetings	174
7. Facilities observed	42
8. FP counseling sessions audiotaped	42

In terms of geographical coverage, the research covered 28 public city/rural health offices and NGO private clinics from eight areas in the country. The selection was based on the level performance of contraceptive prevalence rate (CPR) of the provinces, as indicated in the 2000 National Statistics Office (NSO) Family Planning Survey. These areas were:

High-performing Areas:

1. Pampanga, specifically San Fernando City and Angeles City
2. Bacolod City, Negros Occidental
3. Davao City, Davao
4. Quezon City, National Capital Region (NCR)

Low-performing Areas:

1. Rizal, specifically Cainta and Antipolo City
2. Tacloban City, Northern Leyte
3. Butuan City, Agusan del Norte
4. Pasay City, NCR

It must be noted that in each of these study sites, the research covered one public health center/rural health unit and another private clinic managed by and/or affiliated predominantly with NGOs which are nonprofit in character. In general, the private clinics covered were those service-providing NGOs affiliated with the John Snow Research and Training Institute and those clinics under the umbrella of Friendly Care Incorporated, a nonprofit health service-providing NGO, and the Family Planning Organization of the Philippines (FPOP). A privately managed clinic was also included along with one clinic under the umbrella of Marie Stopes.

Both quantitative and qualitative types of data analyses were used. Descriptive statistics such as percentages, mean, and rating/ranking were utilized. Cross-tabulations were also applied to determine the pattern of the responses of respondents with the type of health facility and level of CPR performance of the area being considered. Qualitative analytical method was also employed, specifically process analysis and use of taxonomy or classification system, the basis of which is content analysis of responses.

Review of Related Literature

FP Counseling Module—the GATHER Approach—and Studies on FP Counseling and Client-Provider Interaction in the Philippines

Part of the objectives of this research are to come up with a comparative analysis of the GATHER Approach modules developed by three different organizations, namely, the JHU CCP, the UNFPA, and EngenderHealth, and to undertake a review of recent studies done on FP counseling in the country. This study made a comparative analysis of the GATHER modules in view of the fact that it serves as the standard or device that helps the provider remember with ease the six elements or steps in providing FP counseling to potential and

actual FP users. Trained providers are expected to make use of this device as a guide to individual and face-to-face counseling provision to clients (potential and/or actual users). To better facilitate the presentation, a comparison of the elements of the GATHER Approach is presented in the first part of the discussion. It is immediately followed by a review of the recent researches done in the country.

Comparison of the Content Domain of FP Counseling Module: The GATHER Approach

All the three GATHER modules that have been developed for purposes of FP counseling were available for analysis. One module that was considered, however, was the GATHER model being developed by UNFPA. In this module, counseling has been expanded to cover not only FP but also the various elements of reproductive health. Given this situation, the comparison made by this study has been limited to only two modules, those of EngenderHealth and the JHU. Both modules focused primarily on FP counseling. A brief description of the UNFPA version is provided towards the end of this portion of the review.

A common factor in both modules is the strong emphasis given to clients, particularly in the aspects of the active communication process, informed choice, and respect for clients' privacy and ideas. As a guide, GATHER is generally client- rather than method/technology-oriented. Both FP counseling modules underscore client orientation and client needs as well as the importance of following the sequence and steps specified in the counseling process. Providers are given instructions to be conscious of the tasks involved in every step. However, there are notable differences in both modules, specifically with respect to the content of and/or instructions for each of the GATHER steps:

1. In one module, GATHER as an acronym stands for the six steps of the FP counseling process, while in another module, it stands for the elements.
2. The instructions under "Greet" or the acronym "G" are generally the same except that in one module, an inquiry about reasons for visits is specified in "G" while in another module, it has been included in "A." In addition, explaining what should transpire during the visit was

specified in one module, while in the other, it was not mentioned at all.

3. In one module, "A" stands for "Ask/Assess" and the questions are directed toward assessing the clients' demographic data, health status (since medical history is obtained at the same time), and knowledge on contraceptives and reproductive needs. In another module, "A" stands for "Ask," or for inquiries about clients' reasons for visits; their needs, wants, preferences, and concerns; their reproductive health experience; and what they want to do in relation to FP.
4. In "Tell" or "T," the content of instructions is generally the same except that in one module, explicit articulation on correcting rumors or misconceptions is made to be a requirement in this step. Both modules, however, focus on informed choice and the need to use Information, Education, and Communication (IEC) materials when giving information.
5. Instructions in "Help" or "H" are generally the same, that is, a focus on helping the clients make a decision as to what specific FP method to use.
6. In "Explain" or "E," both modules focus on the provision of an explanation regarding the FP method chosen by the client. The client is assisted in adopting the behavior corresponding to the method requirements such as "warning signs" and in identifying action to overcome possible side-effects. Not much difference among the three modules is seen with respect to this step.
7. "Return" or "R," similarly, stands for continuity mechanisms such as referral, scheduling for next visit, and encouragement to come back in case of warning signs for complication. Clients' satisfaction is dealt with, but only in one module. In addition, one module explicitly encourages the client to invite others to come to the facility for counseling purposes.

The UNFPA Counseling Module (2001) devotes a separate discussion on how the providers will carry out FP counseling with clients. The discussion focuses on the aspects of: a) what it is like to talk about FP to clients; b) what information is to be given to clients; and c) what it is like to assist clients in choosing a method. In the first aspect, the providers are given instructions on how to

ask clients for sufficient time to discuss FP, the importance of providing privacy and understanding, and the provision of a quiet environment where providers can listen to what clients say, ask and answer questions, and respect the opinions of clients yet clarify their doubts. Providers are also instructed to use visual aids in explaining the different birth spacing methods and to correct misconceptions pointed out by clients in a polite and tactful manner. In the second aspect, the providers are instructed to give information about the benefits of contraception, different contraceptive methods available, and where clients can obtain specific FP services. In the third aspect, the providers are instructed to give clients enough, honest, and balanced information to help them make a decision in choosing a method. Providers are reminded that clients themselves must make the decision regarding which method to use and that the role of providers is simply to assist clients in choosing whatever is appropriate for them.

In the UNFPA module, the GATHER Approach has been expanded to cover various elements of reproductive health. Counseling is defined as helping an individual become aware of himself/herself and the ways in which he/she reacts to the behavioral influences of his/her environment. The counseling session helps him/her establish the personal meaning of his/her behavior and to develop and clarify a set of goals and values for future behavior. It should be emphasized that counseling has been described as NOT: information-giving, although information may be given; dispensing advice; influencing attitude, belief, and behavior by persuading, compelling, or threatening clients; selecting and assigning persons for jobs or activities; and interviewing, although interviewing is seen as part of counseling (UNFPA, 2001). Expanding the concept to include the different elements of reproductive health, GATHER, as an acronym, stands for the following counseling steps:

G = Greet clients warmly
Goal: To establish rapport with clients

A = Ask clients about themselves/their health problems
Goal: To assess the reproductive health concerns and knowledge of clients

T = Tell clients about health problems
Goal: To provide reproductive health information based on clients' needs and knowledge

H = Help clients choose alternative solutions
Goal: To help clients make a decision to meet their specific reproductive health needs

E = Explain how to go about the alternative solution
Goal: To explain relevant management of the clients' specific reproductive health needs

R = Return for follow-up
Goal: To ensure continuity of quality of reproductive health services for the clients

It is expected that when carried out in logical sequence, the counseling process results in time saving and client satisfaction. By systematizing the counseling process through the GATHER Approach, the counselor can make use of his/her time and effort more efficiently.

Local Studies Conducted on FP Counseling and Client-Provider Interaction

This section discusses the outcome of the review of recent studies done on FP counseling and client-provider interaction (CPI), and seeks answers to the following questions: a) What is the current state of research on FP counseling and client-provider interaction? b) What have been the findings of these previous studies? c) What are the critical issues that emerged? d) What are the research gaps and unresolved research issues?

This literature review includes only those studies done from 1990 to the present. Since 1990, there has been a dearth of studies focusing on FP counseling in spite of the abundance of literature on FP services and utilization. Research of this nature and on the subject area on client-provider relations and interaction is admittedly scarce, hence, the motivation for this study.

Providers of FP Counseling

Literature indicates that the providers of FP counseling in health centers may be grouped into: a) clinical workers (CWs), that include medical doctors, nurses, and midwives; and b) motivational workers (MWs), consisting of health personnel other than clinical workers, that include barangay service point officers

(BSPOs), barangay health workers (BHWs), and other community volunteers. Specifically, BSPOs, who are under the supervision of the Population Officer, and BHWs, who are under the supervision of the City Health Officer, perform the following tasks in FP service provision: a) motivating potential FP clients; b) following up on potential or current users; c) referring of potential and current users; d) counseling clients; e) resupplying users with contraceptives; f) conducting education drives; and g) doing some clinical work (Raymundo et al., 1990; David & Chin, 1995). A review of the roles of the MWs, however, is seen as being important in the light of the findings gathered by past researchers. First, it was found that some MWs refused to perform their tasks because of lack of confidence on their part (David & Chin, 1995). Second, they lacked training on communication, motivation skills, and knowledge of specific FP methods (David & Chin, 1995; Raymundo & Cabegin, 1992; Raymundo et al., 1990; Bautista, 1985). Third, although CWs and city/rural health officers favorably rated the performance of MWs, they also noted that MWs could not effectively perform their functions and responsibilities primarily because lack of training. Some clients had also shown negative attitude towards MWs and a few did not trust them. Instead of getting the advice of MWs, clients admitted going directly to the health facilities to seek FP services. In one of the studies, a city/rural health officer required MWs to first refer the clients and potential clients to the clinics/centers before giving them commodities/contraceptives. While CWs claimed they were able to handle any topic related to FP, MWs, on the other hand, did not show confidence in discussing such topics as dispelling rumors about and misconceptions on FP, fears of side-effects, and early marriage.

FP Client-Provider Interaction and Counseling Performance and Practices

As mentioned earlier, previous studies indicate that counseling has been viewed from many perspectives. For instance, in the study of Raymundo et al. (1990), counseling, like the task of motivating, has been viewed as a segment of the broad spectrum of client-worker interaction, which is broadly and operationally defined as the "behavior, views, attitudes, and perception of program representatives and clients towards each other as they perform face-to-face or personal level of exchange"

(pp. 1-2). This process involves information-giving, education, and communication which, depending on the quality of interaction, may lead to the establishment of client-provider interpersonal relationship.

Clarifying the term information exchange in their operations research, Jain and Bruce (1999) describe a popular notion of counseling:

> One way to operationalize the client-centered approach is to provide clients and potential clients with better and accurate information....
>
> This means that the family planning programs have to pay attention to the content of the information provided through various channels, including through personal contacts at the time when the client comes in contact with the provider. At times, the word "counseling" is used to describe this encounter. We are intentionally using the phrase "Information Exchange" instead, because the word "counseling" may be interpreted by some as one-way communication from the provider to client.... Information exchange refers to a two-way communication process and could empower women (clients) to share if not take charge of the process of making choices appropriate to their own needs and circumstances. (p. 7)

From the aforementioned notions of FP counseling, one can deduce that counseling tends to be associated with information-giving, education, and communication processes.

The studies of Raymundo et al. (1990) and Raymundo and Cabegin (1992) revealed that a greater proportion of the rural health units and barangay health stations in the country did not integrate FP counseling in the range of maternal and child health care services provided because they did not give priority to counseling in the provision of services. The opportunity to interface FP counseling in pre- and postnatal care was not well maximized. FP counseling had been least integrated in the health centers' services provision.

Towards the latter part of the 1990s, however, studies showed that FP counseling was made part of the safe motherhood and women's health programs. Specifically, the study of Osteria (1997b) in the province of Batangas showed that FP counseling was made

part of the maternal health care services provision. Results indicate that FP counseling is integrated during postpartum care, particularly in the public hospitals. The nationwide quality of care assessment studies, also conducted by Osteria (1996, 1997a) and Lamberte and Rodriguez (1998), indicated the same pattern wherein FP counseling was integrated in the broader spectrum of health services provided in the city/rural health centers and barangay health stations.

Whether or not it is FP counseling or CPI in general that pushes the potential client to practice FP is an issue that has remained unresolved. However, one thing discovered in the study of Raymundo is the fact that frequency, rather than duration of interaction and counseling, has been a great interface in FP practice. Duration of interaction and counseling was found to be much more associated with building up motivation to use FP (Raymundo et al., 1990), although the latter did not warrant direct FP practice among potential clients. The same study also indicated that an average duration of 38 minutes is spent for each of the CPI sessions. Among the types of FP clients, interaction with never users lasted longer with an average of 48 minutes; with past users, it was 38 minutes; and with current users, 35 minutes. It seems that the provider devotes more time to encourage the never users to practice FP and less time to encourage current users and/or convince dropouts to continue practicing FP. This situation may be explained by the tendency of providers to be more conscious of recruiting new FP users since the latter counts more in the performance assessment of the facility.

With regard to the medium of communication, studies showed that FP providers' use of the local language encourages clients to participate in the interaction and counseling process (Raymundo et al., 1990; Osteria, 1996, 1997; Lamberte & Rodriguez, 1998). The use of the local language greatly facilitates understanding and knowledge acquisition.

The evaluation of the providers yielded different results, depending on the domain of the interaction and counseling. The study of Raymundo et al. (1990) indicated that clients from high CPR-performing areas in the country gave a positive evaluation of the providers; clients were then generally reciprocated in a more positive way by the workers. However, clients from low-performing

areas, particularly those coming from the NCR and Iloilo, evaluated the providers less favorably, particularly in terms of friendliness, attention to the clients' questions, simplicity of explanations, and respect for clients. Clients from NCR also negatively evaluated the workers in terms of providing information on the various aspects of the FP program. Providers received the least favorable evaluation in terms of thoroughness of their FP-related explanations regarding contraindications of methods, effectiveness of specific methods, and their availability.

This observation was similarly registered by Yansen (2001) when she reviewed the literature on FP services in the Philippines. She noted the following deficiencies in client-provider interaction: a) management of side-effects, which according to her may be one of the leading causes of discontinuation rates and dissatisfaction among FP users; b) lack of adequate understanding of risk factors, side-effects, and follow-up visits; c) inadequacy in technical competence on the part of the providers, particularly for the Depot Medroxyprogesterone Acetate (DMPA) method; d) lack of information exchange about reproductive tract infections during visits, and the inadequacy in probing the symptoms and potential risk factors; e) lack of emphasis on FP methods that do not protect the users against sexually transmitted infections (STIs) and human immunodeficiency virus (HIV)/acquired immune deficiency syndrome (AIDS); and f) unsatisfactory screening procedures and screening questions.

On the other hand, results of the quality of care study conducted by Osteria in 1996 showed that more than half, if not most, of the centers' staff demonstrated positive action during the CPI, particularly in telling the client about different FP methods, ascertaining clients' preferred methods, asking the client about his/her reproductive goals, and inquiring about the problems relative to the method. Certain information was also given to the clients on: a) how to use the method; b) effectiveness of the method; c) contraindications; d) information about side-effects and their management; and e) use of FP IEC materials. Most of the providers were also noted to have told the clients when to return, what to do when problems arise, and where to go when in need of more supplies of FP devices.

In a quality of care assessment training practicum conducted in 1996 by SDRC, the participants gathered results that were somewhat different (Osteria, 1997a). The assessment outcome

showed that the percentage of providers demonstrating favorable action during CPI decreased when compared to that of the 1996 study. Specifically, the number of providers discussing method preference, status of lactation, and inquiry about problems with method use were much lower when compared to 1996 data. The same observation was noted in the giving of information about contraindications, side-effects, and their management, and the use of contraceptive samples as illustrative educational materials.

Previous studies (Raymundo et al., 1990; Osteria, 1996, 1997a; Lamberte & Rodriguez, 1998) have indicated that clients are generally highly positive and appreciative of their experience in the clinics. They commended the good service and warm treatment accorded to them by the clinic staff and the providers.

The workers, on the other hand, had positive attitudes toward clients especially with regard to friendliness, being attentive to workers' questions, respectfulness, and ability to express oneself using the local language. In general, the interaction process had been positively regarded by both the workers and the clients. Clients also appreciated the time provided by the workers in listening to their personal and family problems. Results showed that distressed clients generally sought the workers' advice and help.

The workers also expressed satisfaction and confidence in motivating clients to practice FP. Nonetheless, while the medical workers expressed confidence in dispelling misconceptions on FP, fears of side-effects and early marriage, the community workers were less confident in discussing these matters. Moreover, studies revealed that, generally, workers themselves have misconceptions about the FP program, and that they have the tendency to ignore salient issues, such as cost of contraceptives, probable side-effects, and disadvantages in the use of different methods during the sessions.

Furthermore, the medical workers expressed concern about their workload at the center. Aside from motivational and counseling tasks, medical workers are expected to provide education, health services, and supplies to clients. They also have to do various tasks required by other programs, in addition to the home visits. The additional facility maintenance and administrative work were also raised by some medical workers as possible obstacles to their effective performance in FP counseling and provision of productive CPI.

With regard to privacy, the study of Raymundo et al. (1990) indicated that most of the clients reported the provision of utmost care by the centers' physicians and the staff despite space limitations in the center. The assessment studies of Osteria (1996, 1997a), however, noted that less than half of the health facilities covered in the study provided auditory as well as visual privacy. The same pattern of findings was gathered in a separate quality of care assessment study done by Lamberte and Rodriguez (1998). The literature made by Yansen (2001) also confirmed the satisfaction felt by the clients in the health centers.

Management and Support System

Observably, there is a dearth of literature dealing with an organizational and management support system for the provision of FP counseling in the health centers. In view of this, the present survey of literature considers relevant findings on factors affecting the provision of quality FP counseling.

An important factor hindering the provision of services and FP counseling is the lack of IEC materials, particularly those written in local languages. This was consistently shown in three major assessment studies done in the country by Raymundo and Cabegin (1992), Osteria (1996, 1997a), and Lamberte and Rodriguez (1998). This is rather disturbing given the observations that negative attitudes about safety and effectiveness of contraceptives remain widespread and that there is a prevalence of misinformation, misconceptions, and fear of side-effects among clients and potential clients which altogether appear as the major reasons for the nonuse of contraceptives.

Other important deficiencies in the health centers are the limited range of FP methods to permit choice of methods and the apparent lack of supplies needed for service delivery, including illustrations or samples of FP contraceptives required for counseling and information-giving (Osteria, 1996, 1997a; Lamberte & Rodriguez, 1998).

Inadequate work force in the health center and lack of training were likewise identified as hindrances to quality service provision (Raymundo & Cabegin, 1992; Osteria, 1996, 1997a; Lamberte & Rodriguez 1998; Yansen, 2001). Studies have shown that not all health staff, including the physicians, were provided training on FP counseling and FP methods in general. Although training had

been provided, service providers still reported a need for FP-related training. A need for continued updates involving the program was likewise expressed. The lack of confidence in one's ability to give information and discuss FP-related topics competently with clients could have been explained by this apparent need for training and updates.

In her 2001 study, Yansen identified the following factors affecting the provision of FP services: a) heavy workload of the personnel; b) need for clarification of job descriptions and performance standards; c) lack of integrated strategic planning at the health centers; d) insufficiency of universal "standards of care" for each of the FP method, with the exception of DMPA; e) deficiency of performance standards for client-provider interaction; f) inadequate recordkeeping; and g) inconsistent or sporadic distribution of supplies and commodities.

Inadequate supervision and irregular monitoring on the part of the heads were similarly identified as obstacles to the effective provision of services. Feedback-giving on the part of the supervisors was likewise raised by the providers (Raymundo & Cabegin, 1992; Lamberte & Rodriguez, 1998; Yansen, 2001).

To conclude, certain salient points emerged in the review of related literature. First, FP counseling has been more popularly associated with information-giving than as a two-way communication process between the client and the provider; it is also viewed as part of the broader spectrum of client-provider interaction. Second, there are variations in the standards for FP counseling, as demonstrated in the GATHER Approach. Although a useful device, the approach differs in content and procedures. Third, FP counseling and client-provider performance in the country have not been at par with expectations. More time, resources and effort must be expended to provide ideal FP counseling, if not a commonly agreed upon standards for FP counseling. Lastly, the performance of providers giving FP counseling are often affected by a myriad organizational and management-related factors.

CHAPTER 2

Profile of Stakeholders and Pattern of Health Service Utilization

This chapter presents the demographic profile of the respondents of the study which include clients and nonclients, providers and their supervisors, and other stakeholders. The pattern of utilization of FP services is also discussed focusing on the FP methods used by clients and methods that nonclients are familiar with. Responses gathered on reasons for clinic visit, length of FP method use, and the type of FP service provider encountered in facilities are also presented.

Socioeconomic and Demographic Characteristics

Clients

The client respondents consist of 280 FP users who are either continuing users or new acceptors [see Table 2]. In general, most client respondents are continuing users (88.57%) and only a few (11.43%) are new acceptors. As expected, there are more continuing users from high CPR areas (91.43%) than from low CPR areas (85.71%).

Clients are generally middle-aged with a mean age of 30 years. Clients from private clinics are relatively older (mean = 31.56), with a greater proportion of them belonging to the age brackets 27-31 years old (30.71%) and 32-36 years old (24.29%) [see Figure 1 and

Table 3]. On the other hand, most of those from public clinics are younger, 32.14% of whom are between 22-26 years old and 26.43% are between 27-31 years old. The mean age of clients from public clinics is 28.79. The data shows that there is no significant difference between the mean ages of clients from high CPR areas and low CPR areas (30.28 vs. 30.10). In both groups, a greater proportion of clients belong to the age groups 22-26 years old (22.86% and 25.00%, respectively) and 27-31 years old (30.71% and 26.43%, respectively).

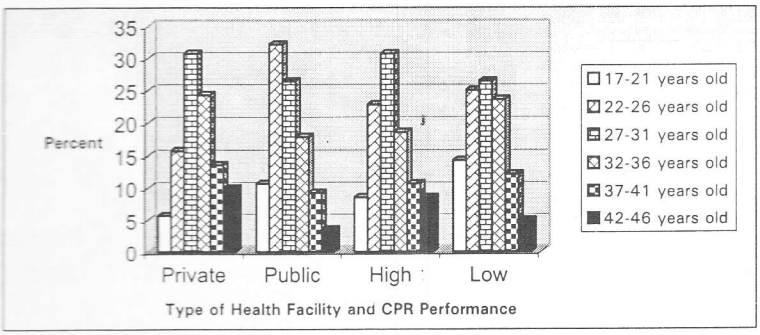
About 4% of the clients are males. Female clients comprise 96.43% from private clinics and 95.71% from public facilities. Similarly, female clients comprise 95.00% from high CPR areas and 97.14% from low CPR areas. Most clients are married (94.63%). The rest are cohabiting (4.29%) or single (0.71%).

Seven out of 10 clients are unemployed (70.70%). There are more unemployed clients from public health centers (75.00%) than from private clinics (66.43%), but the self-employed clients are indicated to be higher in public health centers (18.57%) than in

Table 2
Distribution of FP Users,
by Type of Health Facility and CPR Performance (In Percent)

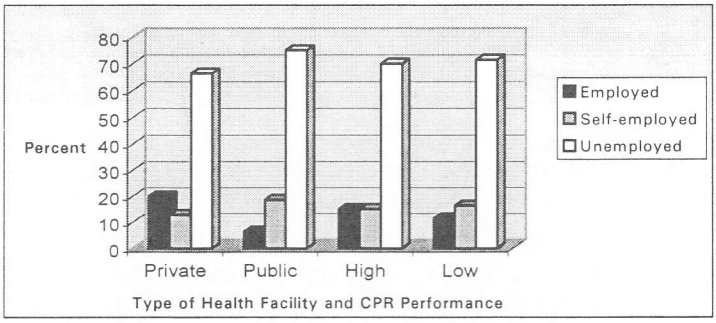
Type of User	Facility		Total	CPR	
	Private	Public		High	Low
Continuing users	89.29	87.86	88.57	91.43	85.71
New acceptors	10.71	12.14	11.43	8.57	14.29
Total	100.00	100.00	100.00	100.00	100.00
No. of Cases	140	140	280	140	140

Figure 1
Percent Distribution of Clients' Age Group,
by Type of Health Facility and CPR Performance



private clinics (12.86%). There is a greater proportion of self-employed clients from low CPR areas (16.43%) than from high CPR areas (15.00%). The proportion of unemployed clients from high CPR and low CPR areas is almost the same (70.00% and 71.43%, respectively).

Figure 2
Percent Distribution of Employment Status of Clients, by Type of Health Facility and CPR Performance



Clients from private clinics are much more highly educated with 27.86% having reached and/or completed college compared to those from the public facilities (23.57%). When grouped according to CPR performance, clients who have reached and/or completed college from high CPR areas (27.14%) are slightly higher in number (27.14%) than those from low CPR areas (24.29%). In addition, many of the clients have reached or completed high school (41.07%). Approximately nine out of 10 clients are Catholics [see Table 3].

Nonclients

Almost all nonclient respondents were nonusers of FP method (95.00%) at the time of the survey; a few (5.00%) were dropouts [see Table 4].

Nonclients are generally middle-aged (mean = 32) and most belong to the age bracket 22-26 years old [see Table 5]. Most nonclient respondents residing within the vicinity of the private facilities are between 27-31 years old (25.71%), while those in public facilities are between 32-36 years old (24.28%). The largest proportion of nonclients from high CPR areas belongs to the 22-26 age bracket (22.86%) while most of those from low CPR areas belongs to the 27-31 age bracket (25.00%). Males comprise 18.20%.

Table 3
Profile of Clients (In Percent)

Age Group	Facility		Total	CPR	
	Private	Public		High	Low
22 - 26 years old	15.71	32.14	23.93	22.86	25.00
27 - 31 years old	30.71	26.43	28.57	30.71	26.43
32 - 36 years old	24.29	17.86	21.07	18.57	23.57
37 - 41 years old	13.57	9.29	11.43	10.71	12.14
42 - 46 years old	10.00	3.57	6.79	8.57	5.00
Total	**100.00**	**100.00**	**100.00**	**100.0**	**100.00**
Mean	**31.56**	**28.79**	**30.18**	**30.28**	**30.10**
No. of Cases	**140**	**140**	**280**	**140**	**140**
Sex					
Male	3.57	4.29	3.93	5.00	2.86
Female	96.43	95.71	96.07	95.00	97.14
Total	**100.00**	**100.00**	**100.00**	**100.0**	**100.00**
No. of Cases	**140**	**140**	**140**	**140**	**140**
Marital Status					
Single	1.43	0.71	0.71	0.71	1.43
Married	94.29	95.00	94.63	92.86	96.43
Cohabiting	4.29	4.29	4.29	6.43	2.14
Total	**100.00**	**100.00**	**100.00**	**100.00**	**100.00**
No. of Cases	**140**	**140**	**280**	**140**	**140**
Employment Status					
Employed	20.00	6.43	13.21	15.00	11.43
Self-employed	12.86	18.57	15.71	15.00	16.43
Unemployed	66.43	75.00	70.70	70.00	71.43
Total	**100.00**	**100.00**	**100.00**	**100.00**	**100.00**
No. of Cases	**139**	**140**	**279**	**140**	**139**
Educational Attainment					
Elementary	8.57	17.86	13.21	9.29	17.14
High School	34.29	47.86	41.07	42.14	4.00
Vocational	2.86	5.00	3.93	5.71	2.14
College	27.86	23.57	25.71	27.14	24.29
Graduate	17.14	5.00	11.07	10.00	12.14
Postgraduate	9.28	0.71	5.00	5.71	4.28
Total	**100.00**	**100.00**	**100.00**	**100.00**	**100.00**
No. of Cases	**140**	**140**	**280**	**140**	**140**
Religion					
Catholic	87.86	86.43	87.14	85.00	89.28
Protestant	6.43	5.00	5.71	6.43	5.00
Iglesia ni Cristo (INC)	5.00	5.00	5.00	6.43	3.57
Moslem	–	0.71	0.36	0.71	–
Seventh-Day Adventist (SDA)	0.71	0.71	0.71	0.71	0.71
Aglipayan	–	1.43	0.71	0.71	0.71
Total	**100.00**	**100.00**	**100.00**	**100.00**	**100.00**
No. of Cases	**140**	**139**	**279**	**140**	**139**

Table 4
Distribution of Nonclients,
by Type of Health Facility and CPR Performance (In Percent)

Type of Nonclient	Facility		Total	CPR	
	Private	Public		High	Low
Nonuser	95.71	94.29	95.00	95.00	95.71
Dropout	4.29	5.71	5.00	5.71	9.29
Total	**100.00**	**100.00**	**100.00**	**100.00**	**100.00**
No. of Cases	**140**	**140**	**280**	**140**	**140**

Eight out of 10 nonclient respondents are females. Approximately nine out of 10 nonclients are married. Cohabiting respondents comprise a small percentage of 7.14% [see Table 5].

More than half of the nonclient respondents are unemployed (60.71%). More than two-thirds of the nonclient respondents living within the vicinity of the public health centers are unemployed (67.14%) while a little more than half (54.29%) of those in the private centers are jobless. The employment distribution differs according to the level of CPR performance. The percentage of unemployed nonclient respondents living within the vicinity of low CPR communities is higher (63.57%) than those in high CPR areas (57.86%). On the other hand, the self-employed nonclients comprise 20.00%; the proportion of those living near the private facilities is slightly higher than those in public facilities (20.71% vs. 19.29%). When grouped according to CPR performance, self-employed nonclients from high CPR areas outnumber those from low CPR areas (27.86% vs. 12.14%). The proportion of employed respondents residing within the vicinity of the private clinics is almost twice that of their counterparts in public clinics (24.29% vs. 12.86%). In the same vein, the percentage of employed respondents from low CPR areas is almost twice that of those similarly employed from high CPR areas (23.57% vs. 13.57%).

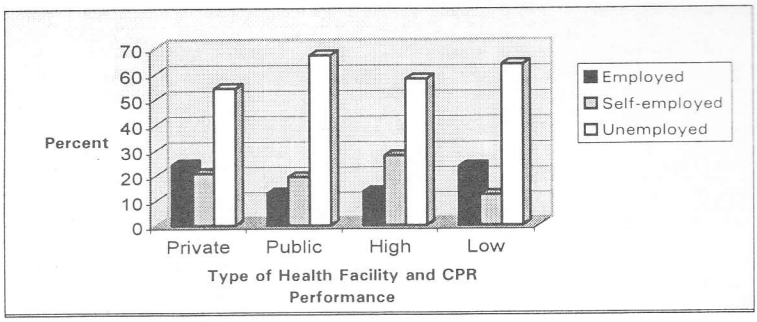
Nonclients residing within the vicinity of the private clinics are more educated than their counterparts from public facilities since a greater proportion of them have reached or completed college (32.14% vs. 29.29%).

The proportion of nonclients who have reached or completed college from high CPR and low CPR areas are the same (30.71%). In general, almost half of the nonclients (48.57%) have reached or completed high school. Approximately nine out of 10 nonclients are Catholics. A few are either Protestants (6.07%) or Moslems (2.50%).

Table 5
Profile of Nonclients (In Percent)

Age Group	Facility		Total	CPR	
	Private	Public		High	Low
17 - 21 years old	7.86	9.28	8.21	8.57	8.57
22 - 26 years old	22.14	20.71	21.42	22.86	20.00
27 - 31 years old	25.71	20.71	23.21	21.43	25.00
32 - 36 years old	20.71	24.28	22.50	20.71	24.29
37 - 41 years old	12.86	10.00	11.43	12.14	10.71
42 - 46 years old	8.57	9.28	8.93	10.71	7.14
47 - 49 years old	2.14	5.71	3.93	3.57	4.29
Total	**100.00**	**100.00**	**100.00**	**100.00**	**100.00**
Mean	**31.12**	**32.09**	**31.60**	**31.53**	**31.31**
No. of Cases	**140**	**140**	**280**	**140**	**140**
Sex					
Male	18.60	17.90	18.20	17.10	19.30
Female	81.43	82.14	81.76	82.86	80.71
Total	**100.00**	**100.00**	**100.00**	**100.00**	**100.00**
No. of Cases	**140**	**140**	**280**	**140**	**140**
Marital Status					
Single	3.57	–	1.79	2.14	1.43
Married	87.14	92.14	89.64	88.57	90.71
Cohabiting	7.86	6.43	7.14	7.86	6.43
Separated	1.43	1.43	1.43	1.43	1.43
Total	**100.00**	**100.00**	**100.00**	**100.00**	**100.00**
No. of Cases	**140**	**140**	**280**	**140**	**140**
Employment Status					
Employed	24.29	12.86	18.57	13.57	23.57
Self-employed	20.71	19.29	20.00	27.86	12.14
Unemployed	54.29	67.14	60.71	57.86	63.57
Total	**100.00**	**100.00**	**100.00**	**100.00**	**100.00**
No. of Cases	**139**	**139**	**278**	**139**	**139**
Educational Attainment					
None	0.71	–	0.36	0.71	–
Elementary	10.00	16.43	13.21	11.43	15.00
High School	47.86	49.28	48.57	50.00	47.14
Vocational	6.43	2.86	4.64	5.00	4.29
College	32.14	29.29	30.71	30.71	30.71
Total	**100.00**	**100.00**	**100.00**	**100.00**	**100.00**
No. of Cases	**136**	**137**	**273**	**137**	**136**
Religion					
Catholic	90.71	85.71	88.21	85.00	91.43
Protestant	77.14	6.43	6.07	7.14	5.00
Iglesia ni Cristo (INC)	1.43	2.14	1.79	1.43	2.14
Moslem	0.71	4.29	2.50	5.00	–
Seventh-Day Adventist (SDA)	0.71	1.43	1.07	1.43	0.71
Aglipayan	0.71	–	0.71	–	0.71
Total	**100.00**	**100.00**	**100.00**	**100.00**	**100.00**
No. of Cases	**140**	**140**	**280**	**140**	**140**

Figure 3
Percent Distribution of Employment Status of Nonclients, by Type of Health Facility and CPR Performance



Providers

A total of 30 health service providers were included in the study. Sixteen of them are from public facilities and 14 are from private clinics. Of these 30 providers, 17 are from high CPR areas and 13 are from low CPR areas [see Table 6].

The providers are middle-aged with a mean age of 39 years. Those from public health facilities are older than those from private clinics (mean = 40 years vs. mean = 37 years). The former generally belong to age brackets 47-51 years old (6), 27-31 years old (4), and 42-46 years old (3), while the latter are from age brackets 27-31 years old (4), 37-41 years old (3), 32-36 years old (2), and 42-46 years old (2). Out of the 17 providers from high CPR areas, six belong to the 27-31 years old age group and three providers each belong to the 32-36 years old, 42-46 years old, and 47-51 years old age group. In low CPR areas, there are four providers belonging to the 47-51 years old bracket and three to the 37-41 years old bracket. Results show insignificant difference between the ages of providers from high CPR areas and low CPR areas (mean = 38.1 years vs. mean = 39.7 years).

Health personnel respondents are predominantly female. The lone male provider is from a private clinic in a low CPR area. Out of the 29 female providers, 16 are working in public facilities and 13 in private clinics. Seventeen female providers are from high CPR areas and 12 are from low CPR areas [see Table 6].

Most providers are married (21) and belong to the Roman Catholic faith (21). They have attained college education in medicine and allied professions. Three have obtained either graduate or postgraduate degrees and are working in private clinics. In public facilities, the greater

Table 6
Profile of Providers

Age Group	Facility		Total	CPR	
	Private	Public		High	Low
22 - 26 years old	1	–	1	–	1
27 - 31 years old	4	4	8	6	2
32 - 36 years old	2	2	4	3	1
37 - 41 years old	3	1	4	1	3
42 - 46 years old	2	3	5	3	2
47 - 51 years old	1	6	7	3	4
52 - 56 years old	1	–	1	1	–
Mean	**37.2**	**40.4**	**38.9**	**38.1**	**39.7**
No. of Cases	**14**	**16**	**30**	**17**	**13**
Sex					
Male	1	–	1	–	1
Female	13	16	29	17	12
No. of Cases	**14**	**16**	**30**	**17**	**13**
Marital Status					
Single	3	4	7	4	3
Married	11	10	21	12	9
Separated	–	1	1	–	1
Widow/er	–	1	1	1	–
No. of Cases	**14**	**16**	**30**	**17**	**13**
Religion					
Roman Catholic	10	11	21	13	8
Protestant	3	5	8	3	5
Iglesia ni Cristo (INC)	1	–	1	1	–
No. of Cases	**14**	**16**	**30**	**17**	**13**
Educational Attainment					
College	11	16	27	15	12
Graduate	2	–	2	1	1
Postgraduate	1	–	1	1	–
No. of Cases	**14**	**16**	**30**	**17**	**13**
Position					
PHN (Midwife)	2	10	12	6	6
PHN (Nurse)	2	4	6	4	2
FP Counselor	4	–	4	2	2
Clinic Manager	4	–	4	2	1
Field Educator	2	–	2	1	1
BHW	–	1	1	–	1
Population Officer	–	–	1	1	–
No. of Cases	**14**	**16**	**30**	**17**	**13**

number of FP providers consists of midwives (10) and nurses (4) while in private clinics, FP is handled mostly by clinic managers (4) and FP counselors (4). In high CPR areas, midwives (6), nurses (4), and clinic managers (2) provide FP services while in low CPR areas, providers are mostly midwives (6).

The providers in public facilities have stayed longer in the service than their counterparts in private facilities (mean = 11.5 years vs. mean = 5.8 years).

Supervisors

Twenty-four (24) supervisors were interviewed in this study. Thirteen are from public facilities and 11 are from private clinics [see Table 7]. Twelve supervisors each were interviewed from the CPR areas. The supervisors from public health facilities are older than those from private clinics (mean = 44 vs. mean = 42) while the supervisors from high CPR areas are older than their counterparts from low CPR areas (mean = 46.5 vs. mean = 40.1). Most of the supervisors belong to the brackets 42-46 years old (7) and 47-51 years old (6).

The supervisors are mostly female. There are only three males, two from public facilities and one from a private clinic. When grouped according to CPR performance, there are two male supervisors from low CPR areas and one from a high CPR area.

Most of the supervisors are married (16) and belong to the Roman Catholic (20) faith. They are either physicians or nurses and 11 of them have attained either graduate or postgraduate level education. Six of the eight supervisors who have reached the postgraduate level are from public facilities.

In public health facilities, the supervisors are either city/municipal health officers (6) or public health nurses (7). On the other hand, those from the private clinics are either clinic physicians (4), area or program managers (4), or program supervisors (3). Most supervisors from high CPR areas are city/municipal health officers (6) while those from low CPR areas are mostly public health nurses and FP coordinators (7). Generally, the supervisors have served an average of 11 years. However, those from public facilities have stayed longer in their position compared to those from private clinics (mean = 10.92 years vs. mean = 7.0 years).

Table 7
Profile of Supervisors

Age Group	Facility		Total	CPR	
	Private	Public		High	Low
27 - 31 years old	1	1	2	–	2
32 - 36 years old	–	2	2	–	2
37 - 41 years old	4	1	5	3	2
42 - 46 years old	3	4	7	4	3
47 - 51 years old	3	3	6	3	3
52 - 56 years old	–	1	1	1	–
62 - 66 years old	–	1	1	1	–
Mean	**42.0**	**44.0**	**43.1**	**46.5**	**40.1**
No. of Cases	**11**	**13**	**24**	**12**	**12**
Sex					
Male	1	2	3	1	2
Female	10	11	21	11	10
No. of Cases	**11**	**13**	**24**	**12**	**12**
Marital Status					
Single	4	3	7	1	6
Married	7	9	16	10	6
Widow/er	–	1	1	1	–
No. of Cases	**11**	**13**	**24**	**12**	**12**
Religion					
Roman Catholic	11	9	20	9	11
Protestant	–	3	3	2	1
Seventh-Day Adventist (SDA)	–	1	1	1	–
No. of Cases	**11**	**13**	**24**	**12**	**12**
Educational Attainment					
College	8	5	13	6	7
Graduate	1	2	3	1	2
Postgraduate	2	6	8	5	3
Total	**11**	**13**	**24**	**12**	**12**
No. of Cases	**11**	**13**	**24**	**12**	**12**
Position					
CHO/MHO/Clinic Physician	4	6	10	6	4
PHN/Program Supervisor/FP Coordinator	3	7	10	3	7
Area/Program Manager	4	–	4	3	1
No. of Cases	**11**	**13**	**24**	**12**	**12**

FP and Health Service Utilization Pattern

FP and Health Service Utilization of Clients

The pattern of utilization of FP services is determined by the information collected about the clients' use of past and current methods, the service providers who conducted the counseling, the clients' visit to the health facility, and the clients' awareness of FP methods.

The clients generally use pills (40.61%), DMPA (21.84%), and intrauterine device (IUD) (15.32%). While there are more clients from private clinics who are currently using IUD than their counterparts from public facilities (19.08% vs. 11.54%), there are more DMPA users from public facilities than from private clinics (24.62% vs. 19.08%). A few (7.28%) have used the permanent method [bilateral tubal ligation (BTL)] and they are mostly from private facilities (9.16%) and low CPR areas (8.89%). The use of calendar/rhythm method (5.75%) is greater among clients from public facilities (6.92%) and low CPR areas (6.67%) than among those from private facilities (4.58%) and high CPR areas (4.76%). The proportions of condom users in private and public facilities are the same (7.69%), but between CPR areas, there are more condom users from high CPR areas (9.52%) than from low CPR areas (5.92%) [see Figure 4].

A greater number of clients from private clinics started using the method they are currently using only in 2002 (30.08%) and the previous two years, 1997-2001 (50.41%), while others started using it 1992-1996 (14.63%) and 1983-1991 (4.88%). Clients from public facilities who started using their current method in 2002 comprised 27.42% [see Table 8].

Figure 4
Percent Distribution of FP Methods Currently Used by Clients, by Type of Health Facility and CPR Performance

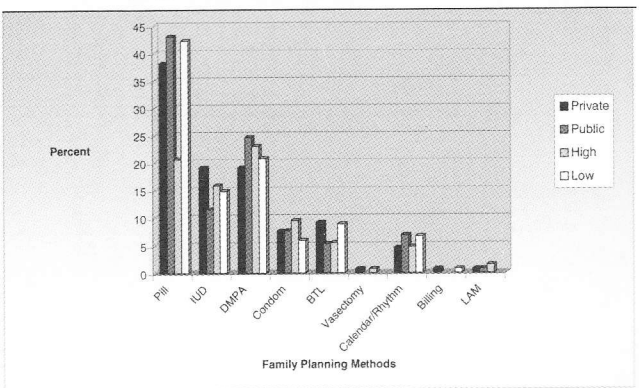


Table 8
Year of Start of Use of Clients' Current Method,
by Type of Health Facility and CPR Performance (In Percent)

Year	Facility		Total	CPR	
	Private	Public		High	Low
1983 - 1991	4.88	1.61	3.24	4.17	2.36
1992 - 1996	14.63	12.90	13.76	10.00	17.32
1997 - 2001	50.41	58.06	54.25	56.61	51.97
2002	30.08	27.42	28.74	29.17	28.35
Total	100.00	100.00	100.00	100.00	100.00
No. of Cases	131	130	261	126	135

Most clients (93.20%) have received FP counseling. Almost half of the client respondents have received counseling from a midwife (52.87%). The physicians and nurses ranked second (18.39% and 19.16%, respectively) in terms of FP counseling provision. There are more clients given with FP counseling by medical doctors in private clinics (24.43%) and low CPR areas (24.41%) than those in the public health centers (12.31%) and high CPR areas (14.58%). A few of the clients reported that they have received counseling from a BHW (9.58%). In general, FP counseling is integrated in the following services, namely, FP counseling (33.3%), prenatal care (29.20%), FP services (20.80%), and general consultation by respondents and postpartum care (20.80%) [see Figure 5].

Almost all of the client respondents have visited a health facility within the past six months (90.00%) [see Figure 6]. Most clients of public facilities have visited either the barangay health stations (48.09%) or city/rural health centers (46.57%), while those from the private facilities have visited NGO clinics (48.76%) and

Figure 5
Percent Distribution of FP Counseling Providers for Clients' Current Method, by Type of Health Facility and CPR Performance

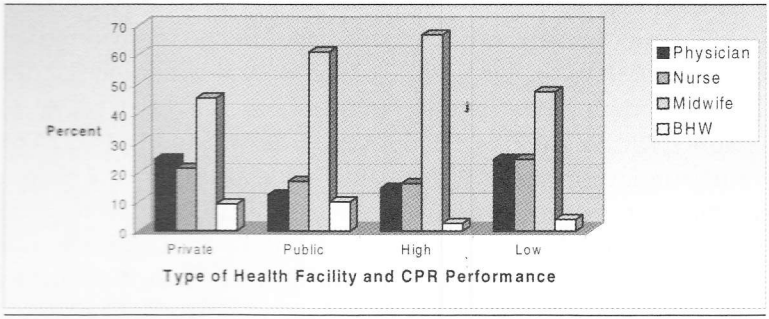
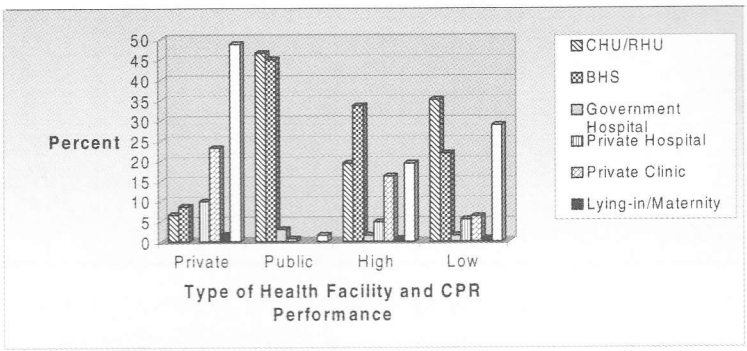


Figure 6
Percent Distribution of Type of Health Facility Visited by Clients within the Past Six Months, by Type of Health Facility and CPR Performance



private clinics (23.14%). Clients from high CPR areas have visited barangay health stations (37.90%), city/rural health centers (19.35%), NGO clinics (19.35%), and private clinics (16.13%), while those from low CPR areas have visited city/rural health centers (35.16%), NGO clinics (28.91%), and barangay health stations (21.87%). For the clients of both private and public facilities, encounters in the clinic were with the midwife (58.90%) or the physician (0.42%). The visit with the physician in private clinics is greater than those in public facilities (25.23% vs. 11.20%). Similarly, the proportion of those facilities/clinics that provided counseling by a nurse in low CPR areas is twice that in high CPR areas (23.73% vs. 11.86%).

More than one-fourth of the clients (26.46%) were visited by FP workers in their homes within the past six months. Table 9 shows that there are more clients from public than private facilities who were visited by an FP worker (33.33% vs. 14.53%). The visit to the client was mainly for FP follow-up (85.94%).

Most clients are aware of at least three FP methods [see Table 10]. Clients from private clinics have frequently mentioned pills (55.71%), DMPA (26.43%), IUD (24.29%), and condoms (24.29%). Similarly, clients from public facilities are mostly aware of pills (62.86%), DMPA (30.71%), condoms (27.86%), and IUD (22.86%). When comparing high CPR and low CPR areas, it can be noted that there is greater awareness about pills and condoms among clients from high CPR areas than among those from low CPR areas (pills = 62.14% vs. 56.43%; condoms = 32.86% vs. 19.29%). The least

Table 9
Reasons for Visits to Health Facilities by FP Providers, by Type of Health Facility and CPR Performance (In Percent)

Reason for Visit	Facility		Total	CPR	
	Private	Public		High	Low
FP follow-up	78.26	90.24	85.94	89.66	82.86
FP motivation	13.04	7.32	9.37	6.89	11.43
Give supply	8.70	2.44	4.69	3.45	5.71
Total	100.00	100.00	100.00	100.00	100.00
No. of Cases	23	41	64	29	35
Not applicable = 216					

Table 10
FP Methods Known by Clients, by Type of Health Facility and CPR Performance

FP Methods*	Facility		Total	CPR	
	Private	Public		High	Low
Pill	78 (55.71%)	88 (62.86%)	166 (59.28%)	87 (62.14%)	79 (56.43%)
DMPA	37 (26.43%)	43 (30.71%)	80 (28.57%)	40 (28.57%)	40 (28.57%)
Condom	34 (24.29%)	39 (27.86%)	73 (26.07%)	46 (32.86%)	27 (19.29%)
IUD	34 (24.29%)	32 (22.86%)	66 (23.57%)	31 (22.14%)	35 (25.00%)
Calendar/Rhythm	17 (12.14%)	17 (12.14%)	34 (12.14%)	16 (11.43%)	17 (12.14%)
BTL	19 (13.57%)	11 (7.86%)	30 (21.43%)	18 (12.86%)	12 (8.57%)
LAM	4 (2.86%)	6 (4.28%)	10 (3.57%)	8 (5.71%)	2 (1.43%)
Vasectomy	4 (2.86%)	1 (0.71%)	5 (1.79%)	5 (3.57%)	–
Billings	2 (1.43%)	1 (0.71%)	3 (1.07%)	1 (0.71%)	2 (1.43%)
BBT	1 (0.71%)	1 (0.71%)	2 (0.71%)	1 (0.71%)	1 (0.71%)
Sympto-thermal	1 (0.71%)	1 (0.71%)	2 (0.71%)	2 (1.43%)	–
Others	5 (3.57%)	7 (5.00%)	12 (4.29%)	9 (6.43%)	3 (2.14%)

*Above categories are mutually exclusive

known methods are vasectomy, basal body temperature (BBT), and sympto-thermal.

Past and current FP utilization data show that most client respondents have used at least three methods. The most common methods used by the clients are pills, IUD, and DMPA. The pill has been used by more than half of the clients from private and public facilities and from high and low CPR areas. Approximately, a fourth of the respondents each from private and public clinics as well as from high and low CPR areas have used the IUD. DMPA has been used by about 30.00% of the clients from public facilities and high and low CPR areas. On the other hand, less than 20.00% each of the clients from both private and public facilities and from high and low CPR areas have used the calendar or rhythm method, while LAM has been used by 5.70% of the clients from high CPR areas. In addition, the more permanent BTL has been adopted by 21.43% of the clients.

Regarding awareness of FP methods, most clients knew only of a few methods. However, when asked about the availability of FP methods, most of them are aware as to where to avail of at least seven methods (pills, IUD, DMPA, condoms, BTL, vasectomy, and calendar/rhythm). A smaller proportion of clients know where to avail of the services of Billings, sympto-thermal, BBT, and LAM (percentage of each is < 45% in all categories of client respondents).

Health Service Utilization of Nonclients

In this study, the health service utilization of nonclients is examined in terms of their recent visit to a health facility for any reason and the type of health service provider they encountered during the visit. A greater percentage of nonclient respondents (78.20%) visited a health facility within the past six months. The visits are mostly in city/rural health centers (34.40%), barangay health stations (34.40%), private clinics (10.09%), government hospitals (5.96%), and NGO clinics (5.50%). Most nonclients from low CPR areas visited the city/rural health centers (42.90%) while those from high CPR areas visited the barangay health stations (32.90%).

Half of the nonclients who have visited a health facility within the past six months (50.40%) claimed that they actually encountered a health service provider during their visit. The encounter was with the midwife (62.28%), nurse (22.81%), physician (19.30%), and/or BHW (19.30%) [see Table 11].

Figure 7
Percent Distribution of Type of Health Facility
Visited for Any Reason by Nonclients,
by Type of Health Facility and CPR Performance

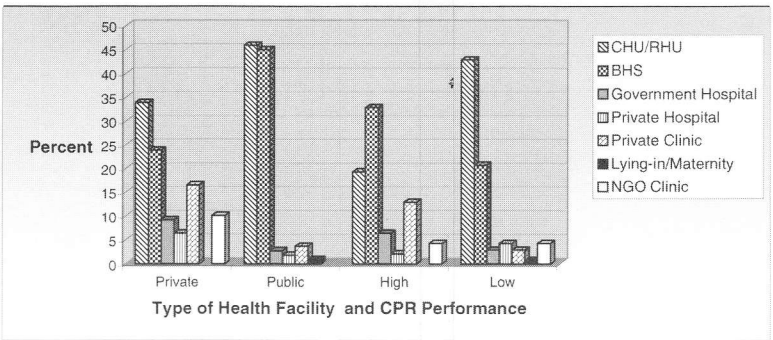


Table 11
Type of Health Service Provider Encountered
by Nonclients during Clinic Visit,
by Type of Health Facility and CPR Performance (In Percent)

Provider	Facility		Total	CPR	
	Private	Public		High	Low
Midwife	50.68	50.00	62.28	53.42	47.06
Nurse	15.07	22.06	22.81	20.55	16.18
Physician	17.81	13.24	19.30	19.18	11.76
BHW	16.94	14.70	19.30	6.85	25.00
Total	**100.00**	**100.00**	**100.00**	**100.00**	**100.00**
No. of Cases	**73**	**68**	**141**	**73**	**68**
Not applicable = 112					

CHAPTER 3

Counseling Process and Performance

One of the main concerns of this study is to describe the manner in which FP counseling is delivered. Several perspectives were considered in coming up with this description, and these include the clients, the nonclients, the providers themselves, and the clinic supervisors. The first part of this chapter discusses clients' experiences and expectations as they seek FP services from the health facility. This is followed by a description of the assessment of the FP counseling process and performance. In this section, the process flow of an actual "best practice" FP counseling is presented, followed by a typical session, and lastly by a non-ideal or undesirable one. The purpose of the description is to provide a glimpse of what has transpired during counseling and to ascertain the specific misconceptions and fears that clients have.

Clients' Evaluation of their FP Counseling Experience

In assessing how FP counseling is being delivered, it is very crucial that we give importance to the perceptions of the clients who have actually undergone counseling in the service delivery units included in this study. The following results were gathered from the interviews with FP counseling clients regarding their experience on FP counseling.

Results showed a somewhat positive picture of the manner in which FP counseling is being conducted in the various sites of the research. Clients provided mostly positive descriptions of the health providers giving FP counseling [see Table 12]. Clients perceived them to be good at providing information (57.33%), good at interpersonal communication (31.36%), and good at attending to clients' needs (6.94%). It can be inferred from this finding that clients give importance to the provision of information and that this aspect may even be given more attention or prominence than interpersonal skills. Majority of the client respondents indicated that their FP counseling providers encouraged them to ask questions during their sessions (86.79%), were good listeners (96.03%), were understanding (94.62%), were able to help them with their problems (93.55%), and were trustworthy (97.13%). Majority of the clients (91.34%) also felt that they were given ample time during the interaction to get all the information they needed. This pattern of responses was observed among clients from both private and public facilities, and from both low and high CPR areas. These findings would seem to imply that the respondents are quite satisfied with the experiences they had with the service providers who helped them with their FP-related concerns. However, such interpretations should be taken with caution in the light of findings and observations that had been gathered from previous researches about client satisfaction in the country (Lamberte &

Table 12
Description of Providers' Behavior during Actual Counseling, by Type of Health Facility and CPR Performance (In Percent)

Behavior*	Facility		Total	CPR	
	Private	Public		High	Low
Good at information-giving (teaching)	56.54	58.08	57.33	53.89	60.71
Good interpersonal communication skills	31.94	30.81	31.36	35.75	27.04
Good at attending to clients' needs (counseling)	8.38	5.56	6.94	5.18	8.67
Quality service provided yet affordable	1.57	0.51	1.03	0.52	1.53
Doesn't give enough time to clients	0.52	2.02	1.29	1.04	1.53
Provider doesn't explain the method well	0.52	2.02	1.29	2.59	–
Strict provider	0.52	0.51	0.51	0.52	0.51
Provider committed to work	–	0.51	0.26	0.52	–
No. of Responses	**191**	**198**	**389**	**193**	**196**

*Multiple responses were allowed.

Osteria, 1998; Lamberte, 2000, 2001). One concern that needs to be underscored is the tendency of clients to provide overly positive ratings of service providers, particularly when they were interviewed in the health facility immediately after receiving the services, and especially in a cultural setting like the Philippines where smooth interpersonal relationships are highly valued and where the desire to please others is positively construed.

Another important aspect considered in the clients' report involved the way clients actually behaved during their counseling session. Clients were asked if they posed questions during their counseling session. About 72.46% of the clients claimed to have asked questions during the session. Again, more or less the same pattern was observed among clients coming from public health centers and private clinics as well as those from high and low CPR areas. More than one-fourth (27.54%) of the clients mentioned that they did not ask any questions. For those who asked questions, the reasons forwarded included: clarifying methods and side-effects (61.50%), needing additional knowledge about FP methods (31.00%), and because their FP counseling provider encouraged them to talk (5.50%). For those who did not pose any questions, the most frequently cited reasons were: the methods had been explained fairly well (46.05%), they already know much or are already familiar with the method (17.10%), and they felt more comfortable to just listen (10.53%). It is quite important, although not surprising, to note that the main reason for asking questions is again focused on the need for more information or the need to have additional knowledge about FP. It can also be gleaned from the responses of the clients that they are really more comfortable not asking questions and contented just listening to the provider, and thus, the completeness of the information given to them is rather crucial. These findings seem to collaborate or support other findings regarding the desired traits of FP service providers. When clients express that they want providers to be good and thorough in the provision of information, it is probably because they want to avoid asking questions during the interaction. There are indications, however, that they would ask questions if they are encouraged to do so.

When clients were asked to indicate which provider behavior exhibited during the interactions they liked the most, the responses again centered on the following domains: appropriate provision of information (30.14%), good attitude towards clients

(33.91%), and good advice given to clients (7.83%). Similar to what was observed when clients were asked to cite the qualities of a good FP counseling provider, the responses reflect a combination of good knowledge and good interpersonal skills [see Table 13]. The bias for cognitive/didactic skills over interpersonal skills was, however, not as apparent.

Table 13
Providers' Behavior Liked Most by Clients, by Type of Health Facility and CPR Performance (In Percent)

Behavior*	Facility		Total	CPR	
	Private	Public		High	Low
Shows good attitudes towards clients	35.03	32.74	33.91	24.52	41.58
Provides appropriate information	29.38	30.95	30.14	36.77	24.74
Gives good advice on sexuality in FP	6.21	9.52	7.83	8.39	7.37
Listens attentively to clients	5.08	7.14	6.09	9.03	3.68
Gives IEC materials to take home	4.52	2.98	3.77	5.81	2.11
Anticipates clients' needs	2.26	3.57	2.90	2.58	3.16
Gives clients freedom to choose	2.26	1.79	2.03	1.29	2.63
Recommends other methods to clients	1.69	1.79	1.74	1.94	1.58
Is honest	1.69	1.19	1.45	2.58	0.53
Uses IEC materials during counseling	1.13	1.19	1.16	0.65	1.58
Is efficient	1.13	1.19	1.16	–	2.11
Is familiar with clients	1.13	–	0.58	1.29	–
No. of Responses	**137**	**133**	**270**	**134**	**136**

*Multiple responses were allowed.

A good way to assess whether a client was satisfied with the services provided by a clinic is if he/she would recommend it to significant members of his/her social network, i.e., relatives. Majority of the clients (96.77%) indicated that they would likely send their relatives to the FP facility. Reasons for making referrals included the presence of good service providers (36.67%), the desire to have their relatives informed about FP (21.85%), and the presence of a wide range of FP services in the facility (13.70%). The issue of response bias may again be implicated in these findings, but review of the data can still provide some useful information. One that is quite apparent is the value that is placed on the quality of service accorded to

Table 14
Reasons of Clients for Making Referrals of the Primary FP Facility to Others, by Type of Health Facility and CPR Performance (In Percent)

Reasons*	Facility		Total	CPR	
	Private	Public		High	Low
Good service providers	41.61	31.58	36.67	35.82	37.50
Family members and relatives have access to information and services	17.52	26.32	21.85	14.93	28.68
FP services are complete	19.71	7.52	13.70	16.42	11.03
Clinic is accessible	5.11	15.04	10.00	11.94	8.09
Free or cheap service fee	3.65	9.77	6.67	10.45	2.94
Trust the clinic service providers	4.38	5.26	4.81	6.72	2.94
Clinic is clean and orderly	5.84	2.26	4.07	2.24	5.88
Has proven the effectiveness of FP methods	0.73	1.50	1.11	0.75	1.47
Clinic member	0.70	0.75	0.74	0.75	0.74
Free snacks provided	0.73	–	0.37	–	0.74
No. of Responses	**137**	**133**	**270**	**134**	**136**
Not applicable = 12					

*Multiple responses were allowed.

the clients. This seems to be an important factor that is considered by clients in determining the utility of a clinic service delivery unit and whether they will access its services. It is interesting to note that physical facilities were not mentioned as a reason for a referral, which may indicate that these are not a strength in the clinics studied or it may also mean that these are not the most important consideration in figuring out which clinic to visit.

Nonclients' Perceptions of FP Counseling Services

Aside from eliciting feedback from people who actually underwent FP counseling, the study also looked into perceptions of people who either have not practiced FP or who may have used an FP method at one time but had stopped practicing at the time of the interview. From these respondents, one can draw information on the prospective clients' idea of the FP counseling services

provided by the centers and the things they may want to get or expect from the service providers. Results from the nonclient interviews showed that most of the respondents from both public and private clinics described the FP counseling provider as having good interpersonal communication skills (74.44%) and also being attentive to client's needs (17.98%). The most frequently mentioned responses included counselors being kind and good-natured, accommodating, and carrying a smile. In addition, providers are perceived by nonclient respondents to be good listeners (95.56%), understanding about client's concerns (94.49%), helpful in solving client's problems (91.85%), and trustworthy (95.88%). The pattern is common to both public and private nonclients and implies that nonclients actually have very positive images of FP counseling providers. However, one must note that this group does not recognize the information-giving role that is played by the FP counselors.

Majority of the nonclients also reported that they would likely ask questions and would also have sufficient time to receive information if they avail of services. As for why they would ask questions, the respondents mentioned the following: to clarify side-effects (51.01%), to gain additional knowledge about FP (26.77%), and to know what to do (8.08%). These findings are quite similar to what was learned from the interviews with clients. Again, we see that much of the reason for asking is to gather more information.

Table 15
Reported Reasons for Asking Questions among Nonclients, by Type of Health Facility and CPR Performance (In Percent)

Reasons	Facility		Total	CPR	
	Private	Public		High	Low
To clarify method/side-effects	50.00	52.00	51.01	59.81	40.66
For additional knowledge on other FP methods	26.53	27.00	26.77	28.97	24.18
So client will know what to do	10.20	6.00	8.08	4.67	12.09
Client is free to ask questions	5.10	8.00	6.57	2.80	10.99
To get all information needed	5.10	5.00	5.05	0.93	9.89
It concerns client's health	2.04	1.00	1.52	1.87	1.10
So client can convey information to others	1.02	1.00	1.01	0.93	1.10
Total	**100.00**	**100.00**	**100.00**	**100.00**	**100.00**
No. of Cases	**140**	**140**	**280**	**140**	**140**
Not applicable = 65					

The nonclients mentioned that if ever they do avail of FP counseling, they expect the counselor to exhibit these ideal behaviors: he/she should explain the different methods thoroughly (31.89%), should have a positive attitude towards clients (27.95%), and should give good advice regarding FP (11.02%). These were the top three answers of the respondents from public health centers and private clinics and those from high and low CPR areas [see Table 16]. As was found in the interviews with clients, the information-giving function is also highlighted in this group. It is probably safe to state that, indeed, this is an important aspect that needs to be addressed by FP counseling providers and also in the training of providers. Counseling can take several forms in various contexts and could have several foci. In the FP context, the current data suggests that this didactic component may be more salient.

Table 16
Providers' Behavior Liked Most by Nonclients, by Type of Health Facility and CPR Performance (In Percent)

Behavior*	Facility		Total	CPR	
	Private	Public		High	Low
Explains the method well	29.17	34.33	31.89	31.30	32.37
Shows good attitude towards clients	35.83	20.90	27.95	24.35	30.94
Gives good advice on sexuality and FP	9.17	12.69	11.02	6.09	15.11
Gives clients freedom to choose	5.00	7.46	6.30	8.70	4.32
Listens attentively to clients	4.17	5.97	5.12	9.57	1.44
Answers all questions well	3.33	5.97	4.72	6.09	3.60
Uses IEC materials during counseling	2.50	4.48	3.54	5.22	2.16
Is honest	2.50	1.49	1.97	–	3.60
Anticipates clients' needs	2.50	1.49	1.97	2.61	1.44
Uses simple terms when counseling	1.67	2.24	1.97	1.74	2.16
Gives IEC materials to take home	1.67	0.75	1.18	1.74	0.72
Explains side-effects	0.83	0.75	0.79	0.87	0.72
Is efficient	0.83	–	0.39	0.87	–
Is familiar with clients	0.83	–	0.39	–	0.72
Helps clients choose FP method	–	0.75	0.39	0.97	–
Is not boring	–	0.75	0.39	–	0.72
No. of Responses	**120**	**134**	**254**	**115**	**139**

*Multiple responses were allowed.

As a further indication of the positive image that they have about the service delivery units, the majority of the nonclients (93.88%) would likely recommend the FP facility to their relatives. Their desire to have their relatives properly informed about FP methods (30.43%), the presence of good service providers (28.46%), and the FP facility's accessibility (9.09%) are the main reasons given by the respondents for feeling positive about sending their relatives to these clinics [see Table 17].

Table 17
Reasons Why Nonclients Recommend the Primary FP Facility to Others, by Type of Health Facility and CPR Performance (In Percent)

Reasons	Facility		Total	CPR	
	Private	Public		High	Low
For relatives to be properly informed about FP methods	25.81	34.88	30.43	19.2	41.41
Good service providers	33.87	23.26	28.46	37.6	19.53
Clinic is accessible	6.45	11.63	9.09	8.8	9.38
Free or cheap service fee	7.26	8.53	7.91	7.2	8.59
Gives good services	8.87	6.98	7.91	12.8	3.13
FP services are complete	4.03	5.43	4.74	4.8	4.69
Client/family members are familiar with the clinic	4.84	3.10	3.95	4.0	3.91
Clinic is clean	3.23	2.33	2.77	0.8	4.69
Clinic service providers are trustworthy	2.42	1.55	1.98	2.4	1.56
Clinic member	1.61	1.55	1.58	2.4	0.78
Good building structure	0.81	0.78	0.79	–	1.56
Good location	0.10	–	0.40	–	0.78
Total	**100.00**	**100.00**	**100.00**	**100.00**	**100.00**
No. of Cases	**124**	**128**	**253**	**125**	**128**

Not applicable = 15

Service Providers' Perceptions of FP Counseling

When asked about their conceptualization of FP counseling, counselors emphasized the need to correct misconceptions about responsible parenthood. Ideally, FP counseling is done one-on-one with the client until a voluntary FP decision on adoption or method

choice is made based on accurate information. It must be noted that service providers themselves see that the major task in the process is the provision of information.

Most providers know that they are interacting well with clients when clients ask questions during an FP session. The most commonly identified nonverbal indicators are a positive facial expression, conduct of follow-through activity, and actual use of a method.

One important item in the interviews with the providers was asking them to make an assessment of the adequacy of the skills and knowledge they have in order to effectively counsel clients. Twenty out of 30 providers interviewed disclosed that they still do not have all the knowledge and skills needed to effectively counsel clients. This is reflective of a lack of confidence among the respondents regarding their competencies and preparedness to conduct FP counseling. This is quite interesting in the sense that clients seem to be rating the providers' work quite positively despite this feeling of inadequacy. This seeming lack of correspondence between clients' and providers' responses poses some questions about the clients' reports of satisfaction with the providers' services.

In the training of FP counseling providers, the GATHER Approach has been the most frequently utilized and prescribed procedure. It is thus important to inquire whether the respondents are familiar with this approach. Although 26 out of 30 provider-respondents have heard of the GATHER Approach [see Table 18], only three reported that it is consistently being used or followed when counseling FP clients. The rest either use the GATHER Approach with certain clients (e.g., first-time users) or do not follow it at all.

Perceived Expectations of Clients and Supervisors

This study also assessed whether FP counseling service providers are aware of the expectations of their clients and supervisors. Majority of the providers (28 out of 30) said that they are aware of these expectations. These expectations were content-analyzed and the four important domains under which the majority of the responses may be categorized are: provision of FP counseling (21 out of 30), possession of positive behavioral characteristics (26), provision of quality service (9), and competence in FP (8) [see Table 19].

Providers of FP counseling are expected to provide information about FP methods and to be able to explain these methods well. Of

Table 18
Providers' Awareness of the GATHER Approach and the Manner of Practice during FP Counseling, by Type of Health Facility and CPR Performance

Provider's Awareness of the GATHER Approach	Facility		Total	CPR	
	Public	Private		High	Low
Yes	14	12	26	15	11
No	2	2	4	2	2
No. of Cases	**16**	**14**	**30**	**17**	**13**
Manner of Incorporating the GATHER Approach during FP Counseling					
Usual routine/system practiced	1	2	3	3	–
Spontaneously	2	–	2	–	2
Doesn't follow GATHER	1	–	1	–	1
Can't remember	1	–	1	–	1
When patients need it	–	1	1	–	1
Only when patient is new acceptor	1	–	1	1	–
Not fully	1	–	1	1	–
No. of Cases	**16**	**14**	**30**	**17**	**13**
Not applicable = 7					

Table 19
Expectations of Supervisors and Clients in Terms of Providers' Interaction with Clients, by Type of Health Facility

Expectations	Private	Public	Total
Possess positive behavioral characteristics	16	10	26
Provision of FP counseling	7	14	21
Provision of quality service	5	4	9
Competency/Training	3	5	8
Good counselor-client relationship	1	2	3
Counsels on all matters	–	1	1
Use of GATHER	1	–	1
Promote other clinic services/programs	–	1	1
No. of Cases	**14**	**16**	**30**

the different behavioral characteristics mentioned, the most frequently cited trait was that of being approachable and friendly. As for the other two categories, there was an indication that providers perceive that their clients and supervisors expect them to provide quality service and to have some level of expertise in FP.

It is important to note that there is some congruence in the expectations perceived by the providers and the areas of satisfaction that were seen in the interviews with clients. Research reveals that the things clients liked most about their FP counseling experience are those aspects that involved the appropriate provision of information, a positive attitude towards clients, and giving of good advice. This finding suggests that the providers have a good reading of the needs and requirements of clients, which is necessary for effective FP counseling.

Conceptualizations of FP Counseling

The existence of definitions of FP counseling often leads some to assume that these definitions are also utilized by stakeholders as they participate in the FP counseling process. This is not always a safe assumption and it is quite interesting to assess exactly how the different stakeholders define or conceptualize FP counseling. There were two data-gathering tools used for this item: the interviews with service providers, and the stakeholders' meetings.

The conceptualizations of the providers as to what is involved in FP counseling have been mentioned earlier in this chapter. FP counseling among provider respondents is associated more with providing correct information about responsible parenthood. Ideally, it is done one-on-one with the client until a voluntary FP decision on adoption or method choice is made based on correct information.

Based on the responses given during the stakeholders' meetings, FP counseling is often delivered by medical professionals (e.g., doctors, nurses, midwives), trained volunteers (e.g., BHWs, BSPOs), social workers (specifically those engaged in premarriage counseling), and other members of the community (e.g., neighbors, pharmacy attendants).

The data from the stakeholders' meetings also showed that the stakeholders' concept of FP counseling is more frequently associated with information-giving or having to perform a didactic teaching function. Again, this is quite consistent with the findings in the client and nonclient interviews. Other responses included the facilitative function of FP counseling, especially in ensuring that a decision is made by clients about what method to use. There was no mention of the possible role that FP counseling may have on the emotional/affective concerns of clients. These findings are consistent with responses given during the stakeholders' meetings regarding what constitutes quality FP counseling. Across the different regions considered in the study, the teaching and/or information-giving functions were highlighted by the participants/respondents. Participants mentioned the need to provide complete and accurate information about the different methods, the necessity to correct misconceptions, and the need to deliver information in ways that could be easily understood by the target clients. Participants from the Visayas and Mindanao regions made specific mention of the GATHER Approach as the chosen approach to FP counseling.

Ideal Attributes of the Counseling Process

There were several ways in which this study assessed perceptions regarding the ideal attributes of the FP counseling process. These perceptions were assessed in the interviews and in the stakeholders' meetings.

When asked to describe their expectations of an ideal FP counseling session, client-respondents mentioned that they expect to be welcomed warmly by their providers. They expect that they would be greeted with a smile and asked about the reason for their visit. They also expect that service providers will treat them with respect, and be accommodating and kind [see Table 20].

Majority of the client-respondents also indicated that they expect to be given complete information during an ideal FP counseling session (91.34%). The most frequently mentioned reasons behind the need for complete information included the following: to ensure that clients are informed properly (56.30%), to prevent complications (16.30%), and to correct misconceptions (8.15%) [see Table 21]. The respondents also pointed out that they

Table 20
Clients' Expectations of an Ideal FP Counselor, by Type of Health Facility and CPR Performance (In Percent)

Expectations*	Facility		Total	CPR	
	Private	Public		High	Low
Smiles	28.91	26.09	27.51	31.68	23.61
Greets client and offers a seat	13.74	21.26	17.46	14.85	19.91
Is accommodating	18.96	11.59	15.31	15.35	15.28
Treats client with respect	17.06	13.53	15.31	15.35	15.28
Asks about client's reason	10.90	12.08	11.48	11.88	11.11
Attends to client's needs	8.53	6.76	7.66	7.43	7.87
Is kind and good-natured	0.95	6.76	3.83	2.97	4.63
Not strict	0.47	1.45	0.96	0.50	1.39
Has a sense of humor	0.47	0.48	0.48	–	0.93
No. of Responses	**211**	**207**	**418**	**202**	**216**

*Multiple responses were allowed.

Table 21
Clients' Reasons Behind the Need for Complete Information, by Type of Health Facility and CPR Performance (In Percent)

Reasons	Facility		Total	CPR	
	Private	Public		High	Low
Client will be informed properly	55.15	57.46	56.30	57.89	54.74
Prevent complications	14.71	17.91	16.30	12.78	19.71
Correct misconceptions and misinformation	10.29	5.97	8.15	14.29	2.19
Provider is responsible	8.09	4.48	6.30	4.51	8.03
Client will make informed choice	5.88	3.73	4.81	2.26	7.30
Makes client capable of conveying information to others	2.21	5.97	4.07	4.51	3.65
Client will trust provider	2.21	2.99	2.59	2.26	2.92
Provider is concerned about client's health	0.74	0.75	0.74	0.75	0.73
Client will be encouraged to use FP	0.74	0.75	0.74	0.75	0.73
Total	**100.00**	**100.00**	**100.00**	**100.00**	**100.00**
No. of Cases	**136**	**134**	**270**	**133**	**137**

would feel more comfortable in asking questions during a session if their service provider is friendly (33.82%), sensitive to their needs, and knowledgeable.

The client-respondents were also asked to list some attributes of ideal client behaviors in an FP counseling session. The top three responses for both private and public clients were: clients should show respect to the providers (31.16%), clients should be cooperative (15.58%), and clients should ask questions (13.41%) [see Table 22]. It should be noted in this set of findings that although asking questions was mentioned, it does not really surface as the predominant response. The characteristics of being respectful and cooperative both reflect that clients are more comfortable taking on a somewhat passive and compliant role in the interaction. These behaviors, however, are likely to be exhibited if they are with someone whom they perceived to be competent in providing them the information they need.

The top three ideal FP counseling provider characteristics that were cited by nonclients included being easily understood by clients (25.87%), knowledgeable (21.62%), and helping clients solve their FP problem (13.13%). In the ideal counseling session,

Table 22
Attributes of an Ideal Client Behavior in an FP Counseling Session, by Type of Health Facility and CPR Performance (In Percent)

Ideal Client Behavior	Facility		Total	CPR	
	Private	Public		High	Low
Is respectful	32.12	30.22	31.16	32.37	29.93
Is cooperative	13.87	17.27	15.58	15.11	16.06
Asks questions	16.79	10.07	13.41	17.99	8.76
Is attentive/a good listener	13.14	10.79	11.96	12.95	10.95
Treats provider as a friend	5.11	12.23	8.70	2.88	14.60
Is sincere	6.57	4.32	5.43	7.19	3.65
Is well-mannered	2.19	5.04	3.62	2.16	5.11
Is open-minded	3.65	2.16	2.90	3.60	2.19
Is patient	2.92	2.88	2.90	1.44	4.38
Seeks help from provider	2.90	2.88	2.54	3.60	1.46
Speaks freely	1.46	2.16	1.81	0.72	2.92
Total	100.00	100.00	100.00	100.00	100.00
No. of Cases	137	139	276	139	137

the respondents expect that they be greeted with a smile by the provider (27.51%), that they be greeted as well as offered a seat (17.46%), and that they be accommodated (15.31%) and treated with respect (15.31%). These responses are quite consistent with the findings derived from the client interviews. Again, we see an emphasis on the information-giving focus of counseling.

Table 23
Nonclients' Expectations of an Ideal FP Counselor, by Type of Health Facility and CPR Performance (In Percent)

Expectations*	Facility		Total	CPR	
	Private	Public		High	Low
Smiles	28.91	26.09	27.51	31.68	23.61
Greets client and offers a seat	13.74	21.26	17.46	14.85	19.91
Treats client with respect	17.06	13.53	15.31	15.35	15.28
Is accommodating	18.96	11.59	15.31	15.35	15.28
Asks about client's reason	10.90	12.08	11.48	11.88	11.11
Attends to client's needs	8.53	6.76	7.66	7.43	7.87
Is kind and good-natured	0.95	6.76	3.83	2.97	4.63
Is not strict	0.47	1.45	0.96	0.50	1.39
Has a sense of humor	0.47	0.48	0.48	–	0.93
No. of Responses	**211**	**207**	**418**	**202**	**216**

*Multiple responses were allowed.

When asked about their perceptions of the ideal client behavior, the nonclient respondents mentioned that clients need to be respectful (27.03%), should be cooperative (18.47%), and should be good listeners (17.12%) [see Table 24]. This trend of responses was consistent in both private clinics and public health centers and also in low and high CPR areas. This was also evident in the client interviews. Again, we see that the ideal client behavior reflects a more passive and compliant stance.

From the point of view of the providers from private clinics, an ideal FP client is one who has expressed a desire to practice FP, follows provider's instructions properly, and comes back regularly for a follow-up examination. During the FP counseling session, the ideal client asks questions, shows interest, and behaves well. To make most providers' jobs easier, clients should listen, ask questions, and not be shy during FP counseling.

had to do with clients' commitment to undergo FP and the need for them to be more active in the counseling process. Participants specified that clients should listen attentively to what their FP providers are explaining and should feel comfortable to ask questions when there are matters that are not clear to them.

Gaps between Ideal and Actual FP Counseling

Beyond just looking into the perceptions of what constitutes the ideal FP counseling process, this study also explored the gaps between the ideal and the actual practice of counseling. Several ways were employed in this study to assess the gaps between the perceptions of the ideal FP counseling and the actual practice of FP counseling.

In the interviews conducted with clients, the respondents who indicated that there were gaps between the ideal service facility and the actual service facility identified mostly factors related to physical facilities (53.71%) and problems of space (17.71%) [see Table 25]. The same trend was observed in the interviews with nonclients. Majority of nonclients also identified factors related to physical facilities (50.00%) and the problem of space (25.30%). There were only a few responses that pertained to FP

Table 25
Gaps between the Ideal and Actual Service Facilities, by Type of Health Facility and CPR Performance (In Percent)

Gaps between the Actual and Ideal Service Facilities (Clients)*	Facility		Total	CPR	
	Private	Public		High	Low
Physical facilities	45.78	60.87	53.71	63.83	41.98
Operational concerns	22.89	17.39	20.00	10.64	30.86
Space	21.69	14.13	17.71	15.96	19.75
Supplies	9.64	7.61	8.57	9.57	7.41
No. of Cases	**83**	**92**	**175**	**94**	**81**
Gaps between the Actual and Ideal Service Facilities (Nonclients)*					
Physical facilities	48.19	51.81	50.00	59.09	44.00
Space	20.48	30.12	25.30	21.21	28.00
Operational concerns	26.51	13.25	19.88	16.67	22.00
Supplies	4.82	4.82	4.82	3.03	6.00
No. of Cases	**83**	**83**	**166**	**66**	**100**

*Multiple responses were allowed.

counseling services: clients (12.70%) and nonclients (10.10%). This finding is not surprising as respondents from these groups seem to have very positive evaluations of the services of FP counseling providers although, as was already pointed out, these may also be brought about by some response styles.

Perceptions regarding the gaps between the ideal and actual practices of FP counseling were also addressed in the stakeholders' meetings. Participants were asked to give their opinions regarding the ideal or desirable behavior that can be expected of FP counseling providers and clients. As mentioned in the previous section, the descriptions of the ideal FP provider behavior resulting from qualitative analysis were divided into three major categories: good interpersonal communication skills, sufficient knowledge about FP, and the display of positive traits that can draw people to them. The participants in the stakeholders' meetings stated that these ideal behaviors are not always manifested. Several reasons were cited to explain why these gaps exist. One of the most frequently cited root causes of the gaps is the large amount of work usually assigned to an FP service provider (e.g., providers have too many responsibilities, heavy volume of clients). The other frequently mentioned root cause is the lack of training on the part of the providers, especially in interpersonal communication skills. The problem of inadequate facilities also surfaced as a cause of the observed gap.

As mentioned earlier, the stakeholders' meetings also addressed ideal client behavior in the counseling process. Participants in the stakeholders' meetings also noted that clients do not always behave according to the ideal behavior identified. Participants reported that clients are sometimes not very committed to their decision to pursue FP. This is manifested in the tendency of clients to forget their appointments, their lack of interest while listening to the explanations given by providers, and their tendency to be very quiet and passive (i.e., not asking questions) during the counseling process. The identified causes for these behaviors included the lack of motivation to undergo FP and the lack of information on FP.

The other important data source used to determine whether counseling is being conducted in accordance with the standards of appropriate practice is the observation of actual counseling sessions done in the clinics included in this study.

Results of the FP counseling sessions disclose that most of the FP counseling providers from both public and private clinics used

the local language when interacting with their clients [see Table 26]. This is a good indication that providers are trying to make their explanations as simple as possible for their clients to understand. In addition, most of the counseling sessions observed (86% of 42 sessions) did not go beyond 45 minutes. This may be the typical length of an FP counseling session. Data from the observation's checklist of topics discussed in the taped sessions revealed that most of the required topics (as specified by the GATHER Approach) were appropriately addressed except those pertaining to HIV/AIDS/STI-related matters.

Table 26
Language Spoken during the Counseling Session, by Type of Health Facility and CPR Performance

Language	Facility		Total	CPR	
	Public	Private		High	Low
Cebuano	8	7	15	7	8
Tagalog/Filipino	9	5	14	7	7
Ilonggo	3	2	5	4	1
Waray	2	1	3	–	3
English + Tagalog	1	2	3	–	3
Kapampangan	1	–	1	1	–
Tagalog + Cebuano	–	1	1	1	–
No. of Cases	**24**	**18**	**42**	**20**	**22**

The observations of the counseling sessions also showed that most of the behaviors required from an FP counselor (as specified in the GATHER Approach) were exhibited by majority of the providers except for the following two areas: a) assurance of confidentiality; and b) utilization of IEC materials.

Supervisors and their Involvement in the FP Counseling Process

Results from the interviews of clinic supervisors/heads revealed that majority of their health facilities have included FP

counseling agenda in their unit and this is stated specifically in their goals/mission. FP counseling is addressed in the performance objectives. The clinic supervisors also mentioned that FP counseling is frequently integrated in the maternal health care program, specifically in the provision of FP services, prenatal checkups, and postpartum checkups. It is worth noting that this component of FP is recognized as salient and has been given emphasis in relation to the service facilities considered in this study.

Suggestions and Recommendations

One innovative approach employed in this study was to let clients/nonclients describe an ideal health facility and compare it with the actual health facility that is serving their community (for nonclients) or that they have been going to (for clients). The respondents were then asked to give suggestions on how to bring the actual conditions closer to the ideal. This approach allowed the researchers to solicit ideas and recommendations from the clients and nonclients on what areas of FP counseling need improvement and on how to facilitate such improvement. The approach is also based on the performance improvement framework that has been considered in this study.

Among the clients, 72.73% indicated that the clinic they were visiting was different from their concept of an ideal FP counseling facility. To improve their clinic and get it closer to their perceived ideal clinic, they suggested mostly physical changes/improvement of facilities (67.92%). The other most frequently given suggestion was to ensure the availability of supplies (12.97%). Suggestions that pertained to the manner in which counseling is delivered was very minimal (e.g., efficient service: 4.10%).

This pattern was more or less similar to that found among nonclients [see Table 27], as around 75.74% of this group assessed that the clinic serving their community is different from their perceived ideal clinic. Suggestions made by this group also centered on improvement of physical facilities (77.32%). The need to ensure availability of FP supplies was also mentioned by some respondents (11.75%).

The other important source of data regarding suggestions/recommendations on how to further improve FP counseling

Table 27
Suggestions of Clients and Nonclients on the Primary Facility to Become More Ideal, by Type of Health Facility and CPR Performance (In Percent)

Suggestions of Clients	Facility		Total	CPR	
	Private	Public		High	Low
Improve physical structure	69.47	66.67	67.92	73.20	62.14
Ensure availability of FP supplies and commodities	6.11	18.52	12.97	10.46	15.71
Hire additional personnel/staff	3.82	6.17	5.12	3.27	7.14
Provide affordable/free services	7.63	1.85	4.44	3.27	5.71
Provide efficient service	5.34	3.09	4.10	5.23	2.86
Eradicate discrimination	3.05	1.85	2.39	0.65	4.29
Computerize records	1.53	1.23	1.37	1.31	1.43
Hire friendly staff	2.29	0.62	1.37	1.96	0.71
Provide community outreach	0.76	–	0.34	0.65	–
No. of Responses	**131**	**162**	**293**	**153**	**140**
Suggestions of Nonclients					
Improve physical structure	73.71	80.63	77.32	81.82	73.63
Ensure availability of FP supplies and commodities	12.57	10.99	11.75	9.09	13.93
Provide efficient service	8.00	1.05	4.37	4.85	3.98
Hire additional personnel/staff	2.86	3.14	3.01	2.42	3.48
Eradicate discrimination	0.57	2.62	1.64	1.21	1.99
Provide affordable/free services	2.29	1.05	1.64	0.61	2.49
Provide community outreach	–	0.52	0.27	–	0.50
No. of Responses	**175**	**191**	**366**	**165**	**201**

services is the stakeholders' meeting. A very interesting part of the meeting was the strategies suggested by the participants on how to properly address the root causes of the identified performance gaps.

For concerns related to the huge amount of work assigned to an FP service provider, suggestions were focused on implementing operational changes as well as advocacy efforts to acquire additional work force. Specific suggestions included proper scheduling of health services delivery so that client flow is appropriately managed. Another suggestion was to identify one person in the office who will serve as the FP counseling provider and whose job function will primarily be to conduct

FP counseling. The provision of an incentive was another suggestion made to address this problem.

The other frequently mentioned root cause is the lack of training on the part of the providers especially in interpersonal communication skills. The suggested strategy to deal with this problem was to further train service providers and to conduct refresher courses on FP.

The problem on inadequate facilities, which also surfaced as a cause of the observed gap, was likewise considered. For this concern, it was suggested that the local government should be urged to assist in the improvement of facilities. There were also suggestions for a simple rearrangement of office facilities to bring forth a clinic environment more conducive to counseling.

State of FP Counseling Sessions: An Analysis of the 42 Audiotaped Sessions

Researchers' Evaluation Rating on the Level by which Specific Aspects of the GATHER Approach Were Exhibited in the Audiotaped Counseling Sessions

The most in-depth and thorough evaluation of actual counseling that may also be an excellent source of information in identifying performance gaps is the review and evaluation of the audiotaped sessions. Using the GATHER Approach as a framework for the analysis and evaluation, a rating system was established by the researchers. An audiotaped counseling process was subjected to a rating ranging from 4, indicating fully exhibited GATHER steps, to 0, demonstrating that steps in GATHER have not been exhibited at all.

Results indicate that providers exhibited most of the steps/instructions under the elements/acronym "Tell" (mean rating = 2.24) and "Ask" (mean = 1.92) which yielded the highest rating; meanwhile, "Return" (mean = 1.29) had the lowest evaluation. The provision of useful and accurate information (mean = 3.25) and helping clients understand this information (mean = 2.85) were the overall most exhibited skills. With regard to individual items, the GATHER indicators that were least exhibited in the counseling sessions have been: a) invited clients to bring others (0.13) **R**; b) explored need for sexually transmitted

disease (STD)/HIV prevention (0.25) **A**; c) discussed STD prevention and gave condoms, if needed (0.25) **E**; d) explained any printed instructions and gave them to the client (0.18) **E** ; e) asked about feelings (0.63) **A**; f) assured client of confidentiality (0.70) **G**; and g) explained what to expect from the counseling session (0.73) **G**. It was also observed from the actual transcriptions and observation analysis that the sequence of the GATHER Approach was not properly followed by the service providers during the counseling sessions.

Content and Process Analysis of FP Counseling Sessions

The 42 audiotaped FP counseling sessions were analyzed by the researchers using the following parameters:

1. The relative ratios of the frequencies of open-ended versus close-ended questions asked by the provider as they occurred during the session;
2. Comparisons of open-ended and close-ended questions in initial (first time) and follow-up sessions;
3. The frequency of the questions coming from clients;
4. The misconceptions verbalized by clients and addressed by counseling providers;
5. Common side-effects discussed by providers; and
6. The accuracy of the medical information given during counseling.

Questions refer to those asked by the provider to the client. Open-ended questions are those that were stated in such a way that allow clients to give more than just single-word answers and encourage elaboration (e.g., "Why did you choose pills as your FP method?"). Close-ended questions are single-answer or categorical questions or those that are answerable by yes or no (e.g., "Is pills your chosen FP method?"). Ideally, there should be more open-ended questions coming from the provider during counseling to facilitate a better exploration of the client's concerns. If this is not possible, ideally, there should be an attempt from the provider to balance the type of questions asked.

An analysis of the audiotaped counseling sessions shows that there were a total of 1,238 questions in the 42 taped sessions [see Table 28]. Overall, there was an average of 2.78 open-ended questions

Table 28
Analysis of Questions Asked in the Sessions

Participants/Activities	Number/Ratios
Total number of questions asked	1,238
Number of taped sessions	42
Average number of questions per session	29.48
Overall average of close-ended questions per session	28.64
Overall average of open-ended questions per session	2.78
Overall ratio of close- and open-ended questions	1:10.30
Number of initial (intake) sessions	21
Average number of close-ended questions per session	39.76
Average number of open-ended questions per session	2.67
Ratio of close- and open-ended questions	1:14.86
Number of follow-up/resupply sessions	21
Average number of close-ended questions per session	17.53
Average number of open-ended questions per session	2.90
Ratio of close- and open-ended questions	1:6.04

and 28.64 close-ended questions that occurred in each counseling session (ratio of 1:10.30). The range was zero (none) to 12 open-ended questions and two to 96 close-ended questions for each session. There were consistently more questions asked during initial sessions compared to follow-up sessions.

Since there was an equal number of session types (21 initial and 21 follow-up/resupply sessions), further assessment was done comparing the ratios of the two question types found in each category. The rationale for this was to compare the nature of questions in initial sessions with that of follow-up/resupply sessions since it is expected that there are more questions to be asked during initial counseling. This is due to the provider's need to establish demographic and other baseline data for each client.

For the 21 initial or intake FP counseling sessions, there was an average of 2.67 open-ended questions and 39.76 close-ended questions. This is translated into a ratio of 1:14.86. On the other hand, in the 21 follow-up/resupply sessions, the average number of open-ended questions for each session was 2.90. There was an average of 17.53 close-ended questions, resulting in a ratio of 1:6.04.

Again, as expected, there were more questions asked during initial FP counseling sessions as compared to follow-up sessions. However, the average number of open-ended questions was almost the same for both session types (2.67 and 2.90, respectively). This data shows that open-ended questions were generally not utilized in FP counseling. The predominance of close-ended questions reflects more direct information-gathering or queries from the provider and does not allow a deeper discussion of an issue from the clients' point of view. Providers who use more open-ended questions during counseling allow clients to speak more and facilitate a freer exchange of ideas. The predominance of close-ended questions supports the analysis of the counseling interviews using the GATHER Approach as framework, where the "Tell" and "Explain" segments gained the highest scores based on how often they were exhibited. There were many questions asked by the provider during counseling but these were geared towards information-gathering and -giving and not towards further exploration of clients' concerns and fears. This finding is consistent with previous researches on FP counseling.

Clients also asked questions during FP counseling. Overall, they made queries approximately three (2.995) times during each counseling session. Dividing these into the session types, more questions were asked during initial counseling sessions (average of 3.28 questions per session) as compared to follow-up sessions (average of 2.71 questions per session). Although the difference is not very large, the data shows that clients are more encouraged to talk during initial sessions. This could be attributed to their need to clarify concerns about the methods that the providers present to them for the first time [see also Tables 29-31, Appendix D].

FP counseling sessions are affected by many factors. There are many probable reasons why clients are encouraged or not encouraged to ask questions. The finding that there is a consistently low number of questions asked on the average could explain why clients have an apparent lack of involvement in the counseling process that could ultimately affect the overall quality of FP counseling.

In follow-up sessions, clients were encouraged to ask questions because of their familiarity with the provider and their experience with their chosen FP method based on their initial encounter with their providers. Also, the focus on information-giving and the barrage of questions coming from the provider (directed towards

establishing demographic and baseline health data) during the initial visit may not have created opportunities for the client to talk. An ideal provider must be aware of this possibility and make adjustments to provide ample time for the clients to verbalize misconceptions and other concerns.

Within the counseling sessions, there were transcript-based observations showing factors that might have hindered clients from asking questions, thus affecting the quality of counseling. To illustrate, some providers were noted to:

1. Shout (noted as raised tone of voice in the transcript),
2. Laugh at clients (as opposed to laugh with),
3. Directly or indirectly make fun of a clients' response,
4. Bombard clients with questions,
5. Have not allowed opportunities for clients to talk,
6. Cut clients off in the middle of their statements,
7. Avoid answering clients' questions, and
8. Give very vague answers to questions raised by clients.

These incidences drawn from the transcripts do not necessarily reflect what happens in all of the FP counseling sessions all over the country. Needless to say, the fact that these situations exist, indeed, confirms their occurrence at the health facilities.

An analysis of the 42 audiotaped counseling sessions also yielded a list of clients' misconceptions emerging during the counseling process. The providers' management of the misconceptions, however, varied. While some attempted to address them, others merely took note of them. There were also those who failed to address the misconceptions directly. Among the misconceptions that were identified in actual FP counseling sessions were the following:

1. The use of oral contraceptive pills (OCPs) causes swelling of the uterus.
2. The use of OCPs directly causes hypertension.
3. OCPs should not be taken during menstruation.
4. OCPs directly cause headaches.
5. OCPs leave sediments inside the body, specifically in the uterus, which could cause myomas and other tumors to form. These sediments could also cause obstructions in the women's "passageways" in the body.

6. The use of OCPs makes women more irritable.
7. Lifting a heavy load automatically causes the expulsion of an IUD, even when the woman is not menstruating.
8. The IUD can be removed very easily.
9. IUD causes pagbibinat or body malaise.
10. IUD causes obstructions in the body.
11. IUD causes abdominal tenderness.
12. IUD causes ectopic pregnancy.
13. IUD causes hemorrhage.
14. The string of the IUD goes inside the body.
15. The string of the IUD can strangle a man's penis during intercourse.
16. One will constantly be aware of the presence of an IUD inside one's body.
17. Tubal ligation causes stomachache.
18. Tubal ligation causes women to be more sexually aggressive and promotes infidelity.
19. Condoms are not reliable or safe. They often break and cause unwanted pregnancies.
20. Depo-Provera injections provide protection against STIs.
21. While on Depo-Provera, an enlarged abdomen immediately implies that the woman has developed a tumor.
22. Injections provide protection against STIs.
23. Menstruation causes numbness of the body.
24. A Pap smear can detect myomas in the uterus.

The misconceptions often come from anecdotal evidence of others' experience with a method, hearsay, or ill-informed advice from significant others. These misconceptions are actually misinterpretations or exaggerations of well-founded medical information. For example, some women are expected to feel bloated or would actually gain weight while on OCPs. The providers seem to tell this misinformation to clients when they choose OCPs as their FP method. However, this does not necessarily imply that the uterus is swelling. To put this in proper perspective, OCPs are also not advised for those with hypertension since they may have some unwanted haematologic effects, although they do not directly cause hypertension. Most hypertensive cases are idiopathic in nature and are managed through lifestyle changes (e.g., diet regulation and nonsmoking). The use of OCPs may cause headache for some clients but this could also be caused by other factors, such

as emotional and environmental problems. Headache may also be caused by internal and environmental stressors that are common among females, regardless of whether they are current users or nonusers of OCPs. Some clients seemed to be worrying too much about the use of a contraceptive method.

The rest of the misconceptions reflect an exaggeration of the possible side-effects of certain contraceptive methods. Some, such as "tubal ligation causes women to be more sexually aggressive and promotes infidelity," are completely untrue. This could just be an unfounded expression of the fears or insecurities of female clients or their male partners.

However, not all misconceptions come from outside sources. Clients often attempt to come up with their own explanations for what they feel based on their own understanding. These self-generated attempts to find reasons usually aim to come up with explanations for what one feels or notices in his/her body. The misconceptions may also be due to internal misinterpretations or inadequate knowledge about the human anatomy. For example, there was a misconception stated by a client, notably because of unfamiliarity with her own body. She mistook her cervix (which she was able to feel inside her) as a foreign object or a tumor. These misconceptions crystallized through time due to lack of medical consultation as well as advice, and aggravated due to reinforcements from others.

Generally, when clients verbalized misconceptions, quite a number of providers attempted to correct them. Some of the providers seemed successful in doing so. There were some providers who actually shared their own experiences with the method to allay clients' fears. However, some providers gave responses that do not adequately remove clients' fears, or that skirt around the issue, probably due to lack of competence or understanding of the issues being raised by clients. Knowledge of the misconceptions and how to effectively address them would be beneficial in providing better FP counseling.

Side-effects were often covered during FP counseling sessions. The discussion of the side-effects could either be triggered by a query from the client ("I heard that...", "My sister said that...") or presented as part of information-giving when discussing a method. The type of side-effects discussed depends on the method covered. Most of the providers adequately discussed the side-effects. Some of them even used techniques such as asking the clients for restatements, asking questions, or providing cases. The following are the common side-effects covered in relation to a specific FP method:

Pills

1. Irritability or mood changes
2. Increased appetite
3. Increased weight
4. Feeling of being bloated
5. Breast changes (lumps, tenderness)
6. Headaches
7. Menstrual changes

IUD

1. May fall out (e.g., when lifting heavy objects), especially during menstruation
2. Abdominal pain
3. Menstrual changes
4. Dysmenorrhea

DMPA (Injectables)

1. Fattening/bloating
2. Increased appetite
3. Menstrual changes (spotting and amenorrhea)
4. Increased pimple formation

The providers also often tell clients about the warning signs of OCP use, such as chest pains, blurring of vision, extreme leg pain, breast masses, prolonged menses, or difficulty in breathing. The indications and contraindications were often relayed to the clients as the baseline data and demographic information are gathered during the intake session.

Generally, the providers seem to manifest a certain level of knowledge when it comes to the medical information given during counseling. However, there were some observed instances wherein clients' concerns were not adequately addressed. Some providers also fumbled when confronted with the request to provide more detailed information about FP or to further clarify a concern raised by a client.

The findings suggest that there are still some FP counseling providers who need further training on FP methods to develop their expertise. For those who have had previous FP training, this

may be an expression of the providers "forgetting" what they have learned, which implies the need for updates or continuing FP education. Forgetting previous learning was also reported by providers as a common reason why they feel that they still do not have adequate knowledge and skills in conducting FP counseling. It is imperative, therefore, to identify providers that need technical input. Trainings and seminars to enhance the quality of their performance at work are therefore necessary. This may also signal the need to review the preemployment educational requirements for new or aspiring FP service providers.

Providers' Manner of Addressing Misconceptions during FP Counseling

Various misconceptions expressed by the FP clients were relayed to the provider as direct questions that seek explanations or clarifications. How did the FP provider address these? Although there were attempts by the provider to clear these misconceptions, they were inadequately handled so as to effectively dispel the myths and create desirable behavioral changes among clients. It seems that the providers are also in a dilemma as to whether to discuss misconceptions lengthily, or to focus more on probing new FP information to encourage clients to use a certain method.

Here are examples of how providers addressed clients' misconceptions in a less than ideal way. Although these were reported using a local language, they were translated here in English:

1. Directly ignoring or moving on to another topic
2. Restating the client's concern but not really addressing the misconception
3. Deflecting the misconception by advising the client to seek medical consultation or read IEC materials:

Client: I heard that pills cause varicose veins.
Provider: You need to go to the clinic for checkup first. Check varicose veins. Examine your legs before we give the pills.
Client: Could I get pregnant again?

Provider: That's why you need to see the doktora.
Client: If I carried a case of soft drinks (when using IUD)...?
Provider: That is not a problem as long as you do not have menstruation. You can do anything you want. I will give you reading materials on this later.

4. Using technical terms without adequate explanation:

Client: I heard that DMPA causes pimples or zits to be formed.
Provider: Actually, those with pimples have hormonal imbalance, but here (DMPA), the only thing you will experience would be weight gain.

5. Skirting the issue or not adequately confronting it:

Client: Some said that when your period is there, you don't have to take pills... only after menstruation.
Provider: I will explain that to you. One of the advantages of taking pills is it does not interrupt your sexual enjoyment in lovemaking... unlike condoms.

6. Telling the client that it is something she has to accept at face value, without adequately explaining why this is so:

Client: You think it's OK, there's no danger of cancer? Because I've noticed when I stopped taking my...
Provider: Your menses become irregular. It's really like that... you get withdrawal symptoms.

Client: Sister, will it (IUD) not go inside my body?
Provider: No. That's really how it is. It's not going out. Think about it. Even if it enters your body, it's not dangerous.

The aforementioned management and technique of addressing misconceptions are rather inadequate and problematic, as they did not seem to form knowledge and insight among the clients. This observation reinforces the low score given by raters on the

sessions using the GATHER Approach (e.g., "made sure that the knowledge is based on accurate understanding").

On the other hand, some providers also adequately and effectively addressed clients' misconceptions. For example, one provider actually gave a demonstration to dispel the client's fears on the effect of IUD on sexual intercourse. Another technique used to dispel misconceptions is through the use of other clients' experiences as examples. Some providers have developed their own style or strategy to promote an accurate understanding of use of FP methods among their clients.

Description of the Illustrative Cases of the FP Counseling Session: Best Practice, Non-ideal, and Typical

Illustrative cases were also noted for the researchers to have an idea of the actual FP counseling process followed in each health facility. The researchers also attempted to identify the "best practices" among the 42 FP sessions. A typical FP counseling session that makes use of the best practices is presented in Flowchart 1.

History of Hyaditiform mole
Ectopic pregnancy

Blood pressure
Weight

→ Explanation of the next step (examination)

Conduct of physical examination

Restatement of what the client wants in terms of number of children
Introduction of available FP options to client

Ask client what she wants to be explained to her
Client states method of choice (OCP)
Clarify whether client is knowledgeable about reproductive anatomy

→ Use analogies to make it easier for the client to understand

Explain female reproductive anatomy and process of fertilization

Explain effect of the pill on the lining of the uterus
Clarify client's concern on the harmful effects of pills
State advantages and disadvantages of pills
Explain how pill is used

→ Provider inquires whether client wants to know about another method (IUD)
→ Client consents

Explain how the IUD works
Address client's questions about IUD
Clarify what happens to the thread of the IUD

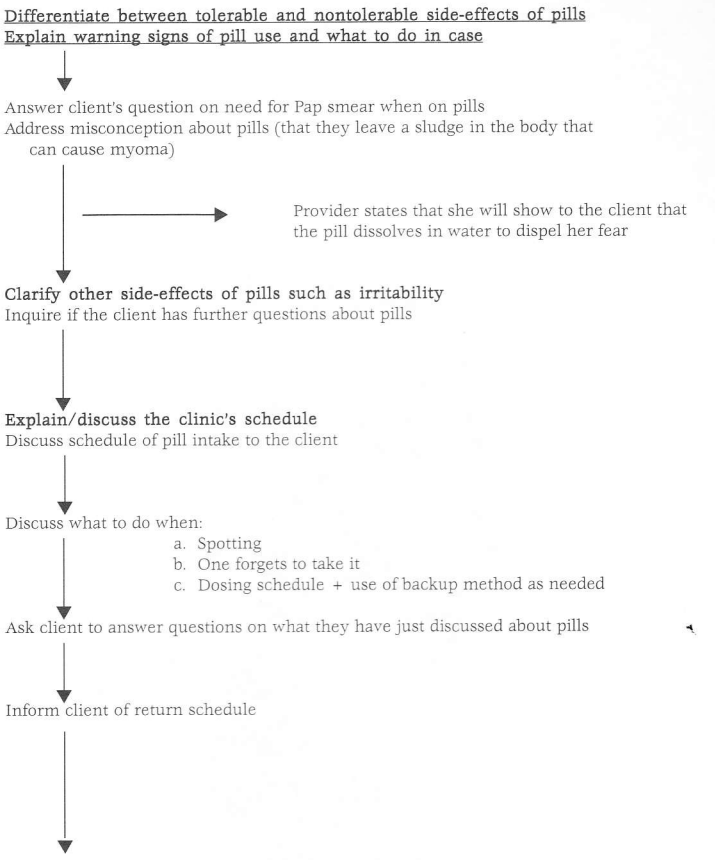
→ Ask client to restate what was told to her earlier

Clarify client's concern on the harmful effects of pills
State advantages and disadvantages of pills

→ Provider inquires if client wants to know about another method (condom)
Client informs provider she'd rather know more about injectables
Provider gets a sample of injectables

Explain how the DMPA works
Address client's questions about DMPA
Ask client which of the three temporary methods she would choose based on the discussion

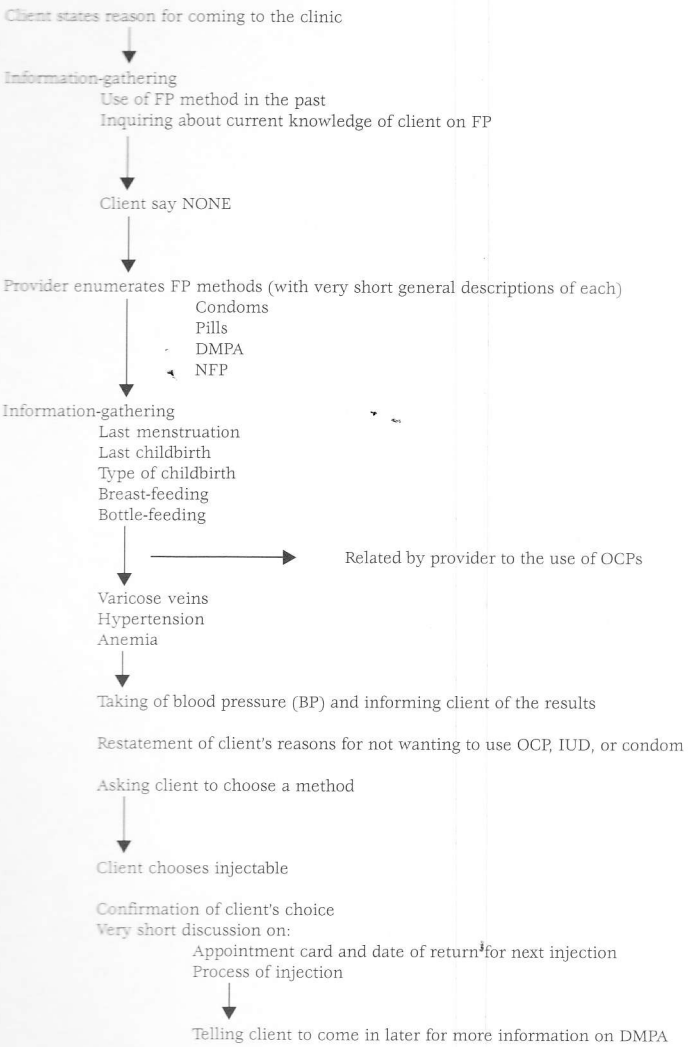
→ Client chooses pills
Provider asks client to restate what she learned about the pills from the discussion (including side-effects)



For the non-ideal practice, the observations are shown in the process flow on page 69. This particular FP counseling session was identified as non-ideal for the following reasons: a) there was inadequate discussion of the various FP methods available; b) provider hastily injected DMPA without giving enough information regarding its indications, contraindications, and side-effects; c) the session was conducted hastly; d) baseline client information was inadequately taken; e) there were no statements made regarding confidentiality and warning signs; and f) the basis of client's choice of method was not adequately explored.

Flowchart 2

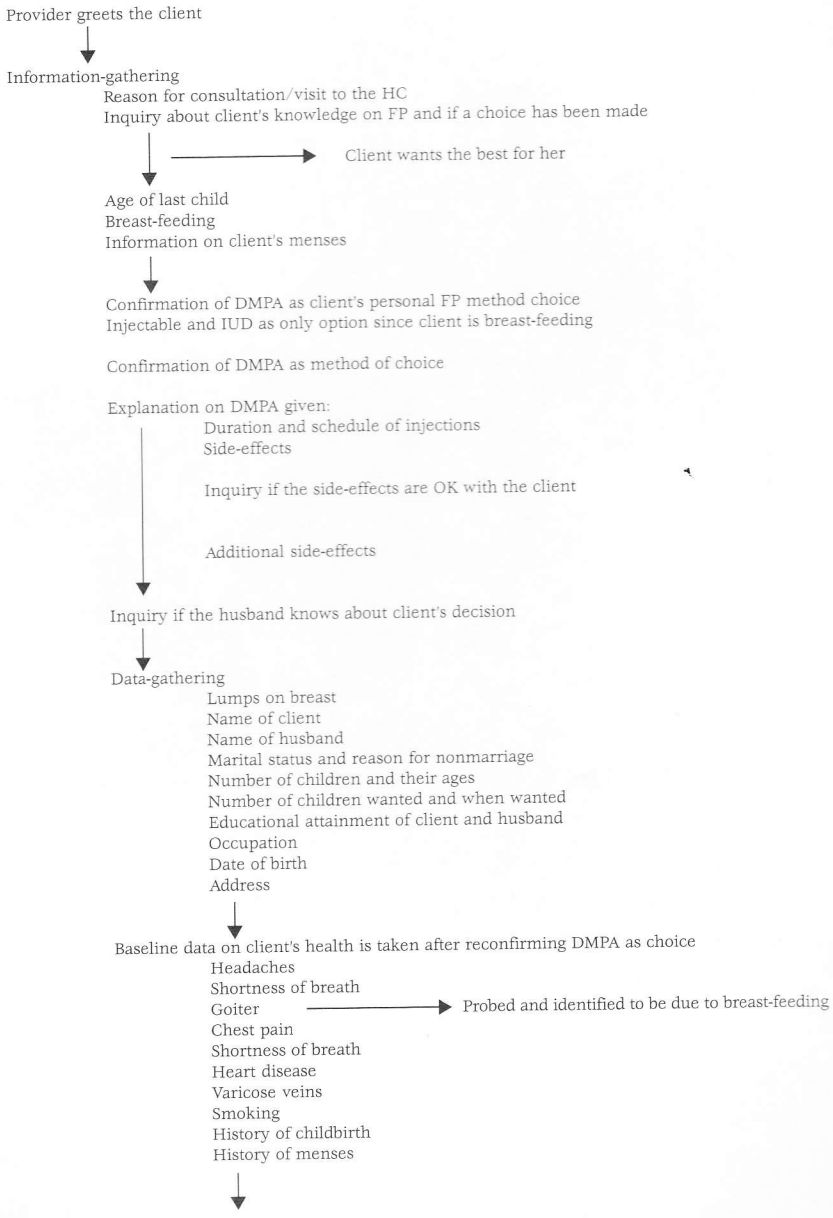
Process Flow of an Actual Non-Ideal FP Counseling Session

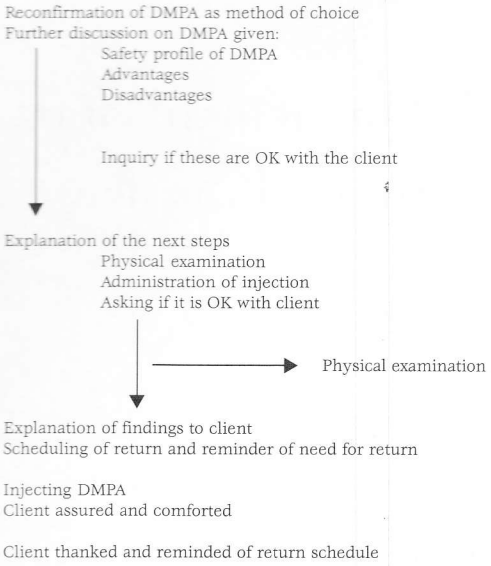


A typical FP counseling process is also illustrated here.

Flowchart 3

Process Flow of a Typical FP Counseling Session





It must be noted that the researchers found it difficult to identify a common pattern of "typical FP counseling session" since the modes of client-provider interaction vary. Most intake sessions though were noted to have the following characteristics:

1. Baseline data-gathering for new clients
2. Inquiry whether client has already chosen an FP method
3. The chosen method, if found fit for the client, is discussed and further explained.
4. Inquiry about what the client knows about the chosen method and other FP methods
5. Discussion of indications, contraindications, and side-effects in various degrees of adequacy
6. Inadequate exploration of client's views, fears, and feelings about the methods

CHAPTER 4

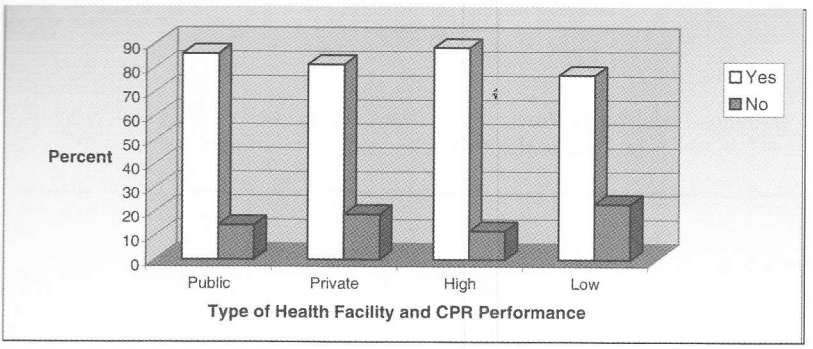
Management and Support System

FP counseling does not occur in isolation. It is an end product of many factors working together to promote better reproductive health in the community. Providers, supervisors, and clients interact at several levels and with various considerations. It is in this light that the management and support system, factors that directly or indirectly promote effective FP counseling, were assessed in the study. The findings on the various management and support system for FP counseling follow.

Training

Ideally, providers should be adequately trained to provide quality FP counseling. Data shows that majority of providers from public health centers and private clinics have undergone training (81.20% and 85.70%, respectively) within the last seven years. This equates to one untrained provider for every seven trained providers in public clinics [see Figure 8]. In private clinics, on the other hand, there is one untrained provider for every four providers who received training in recent years. Therefore, there is a larger percentage of government-based providers in the sample who have undergone training as compared to their private counterparts. Also, data from providers from both high and low CPR areas also showed that majority have undergone trainings related to FP (88.20% and 76.90%, respectively).

Figure 8
Percent Distribution of Providers Who Received Training within the Last Seven Years, by Type of Health Facility and CPR Performance



Most providers in public clinics have received the following trainings: FP Counseling Training (40.00%), Training on FP Methods (45.70%), Reproductive Health (RH)/Safe Motherhood Training (5.70%), and Gender-Sensitivity Training (5.70%). This trend was also reflected among providers in private clinics [see Table 32], where the most common training received was Training on FP Methods (40.50%), followed by FP Counseling Training (24.32%), RH/Safe Motherhood Training (10.80%), and FP Quality Care Training (8.10%). While there were no providers from the public sector who reported having gone through FP Quality Care Training, there is a parallelism in the trainings received by providers from the two clinic types: these were basic trainings which are minimum requirements before a counselor can effectively counsel clients on FP. The fact that many providers have gone through FP Counseling Training highlights the need for providers to know not only what to say but also how to say it to clients.

A comparison of the trainings received by providers from high and low CPR areas yielded similar results. Providers from high CPR areas reported to have received the following trainings: Training on FP Methods (36.80%), FP Counseling Training (31.60%), and RH/Safe Motherhood Training (10.50%). Meanwhile, providers from low CPR areas have mostly gone through FP Counseling Training (32.40%) and Training on FP Methods (50.00%). The data also shows that some providers have gone through several trainings on FP provided by various agencies. Again, the most commonly attended FP trainings were those

described to be basic seminars on FP, which are necessary in order for providers to effectively render the service. The popularity of the basic seminars among providers is consistent across public/private clinics and high/low CPR areas.

Table 32
Trainings Received by Providers and the Entities that Provided the Trainings, by Type of Health Facility and CPR Performance

Types of Training	Facility		Total	CPR	
	Public	Private		High	Low
Training on FP Methods (Basic/Comprehensive DMPA, NFP, etc.)	16	14	30	17	13
FP Counseling Training	14	9	23	12	11
RH/Safe Motherhood Training	2	4	6	4	2
Gender-Sensitivity Training	2	2	4	3	1
FP Quality Care Training	–	3	3	2	1
Training on Obstetrical Emergencies	–	2	2	1	1
Revised Midwifery Law-Postgraduate Skills Training	–	1	1	–	1
Refresher Course on FP Methods	1	1	2	2	–
No. of Responses	**35**	**36**	**71**	**41**	**30**
No. of Cases	**16**	**14**	**30**	**17**	**13**
Groups that Provided Training					
DOH/CHO/RHO/PHO	16	10	26	17	9
John Snow Research and Training Institute	–	6	6	2	4
Friendly Care Clinic, Inc.	–	5	5	1	4
EngenderHealth	2	2	4	1	3
Family Planning Organization of the Philippines (FPOP)	–	4	4	3	1
Private hospital	–	2	2	–	2
University of the Philippines-Manila	–	2	2	2	–
Institute of Maternal and Child Care	–	1	1	1	–
UNFPA	–	1	1	–	1
Government hospital	1	–	1	–	1
No. of Responses	**19**	**33**	**52**	**27**	**25**
No. of Cases	**16**	**14**	**30**	**17**	**13**

Most of the trainings received by FP providers were conducted by the DOH central or regional offices, city health offices (CHO), rural health units (RHU), and provincial health offices (PHO). This is also true across public/private clinics and high/low CPR areas. A significant number of providers from the private sector (37.5%) and high CPR areas (11.8%) have received training from the John Snow Research and Training Institute. Training from the Friendly Care Clinic, Inc. was participated in by 31.3% of private sector providers [see Table 32].

Most providers seem to satisfy what their clinical supervisors expect of them in terms of trainings completed. A survey of supervisors' expectations show that majority of those from public clinics (76.2%) and 58.8% of those from high CPR areas want their providers to undergo Training on FP Methods. This requirement was fulfilled in most cases. On the other hand, supervisors from private clinics (76.9%) preferred their providers to receive FP Counseling Training (52.6%). This is also echoed by most of the supervisors from low CPR areas (39.3%) and 35.3% of those supervisors from high CPR areas. Most supervisors already have a specific idea of what training they would like their providers to have. This translates as the minimum level of knowledge and skills required of providers from the point of view of their supervisors. Some supervisors, however, provided more general or less specific answers as to what they require from their FP counselors. This finding has implications on the standards that clinics generally follow and the expectations of supervisors from their workers [see Table 33].

Trainings that were observed to provide more knowledge and skills tend to be viewed favorably by those who took them. Data showed that the Basic/Comprehensive Training Course on FP was

Table 33
Types of Training Desired by Supervisors for FP Counselors, by Type of Health Facility and CPR Performance

Types of Training	Facility		Total	CPR	
	Public	Private		High	Low
Training on FP Methods	11	8	19	7	12
FP Counseling Training	5	10	15	6	9
RH Training	–	1	1	1	–
No. of Responses	16	19	35	14	21
No. of Cases	11	13	24	12	12

the training most liked by 56% of providers from public and private clinics; 7.7% of private sector providers reported that they liked all the trainings that they underwent. Similarly, the Basic/Comprehensive Training Course on FP is the most popular among providers from high CPR areas (57.1%) and even from low CPR areas (54.4%). The second most-favored training across clinic types is the FP Counseling Training [see Table 34]. The preference was reported by providers to be primarily the result of the conduct of these trainings which are primarily geared toward skill acquisition. Aside from this, the usefulness and applicability of the acquired learning to actual settings were the reasons stated by many providers from both public (12.5%) and private (15.8%) clinics. It is interesting to note that the technique used in the training such as role-playing was favored by 37.5% of public providers. These findings support the notion that a training is well-liked and found effective by FP providers if it is skill-based and applicable to actual settings [see Table 34].

Comparing the responses across CPR areas, a particular training was reported as being liked by the majority of providers from high and low CPR areas because they provide the needed skills (23.8% and 14.3%, respectively). Similar to findings based on public vs. private comparisons, the usefulness and applicability of a training to actual counseling settings were common reasons why trainings are viewed favorably by providers. This is especially true among those from low CPR areas (28.6%). The kinds of methodology used during training, particularly the field trips, were also mentioned by those from high CPR areas (33.3%). Therefore, data shows that aside from applicability of the knowledge and skills acquired from the training, a specific training is liked by providers because of the methodology.

As regards least-liked trainings, about 57.1% of those from private clinics affiliated with Well-Family Midwife Clinics (WFMC) favored least the NFP Training and the Ambulatory Health Facility Management Training. Meanwhile, providers from public clinics liked least the FP Counseling Training (33.3%) and Interpersonal Communication Skills Training (16.7%) [see Table 35]. Similarly, Interpersonal Communication Skills Training, RH Training/Advocacy Program, and Basic/Comprehensive Training Course on FP were also identified as least liked by the majority of providers from high CPR areas (14.3% for all three). For those coming from low CPR areas, 60% identified FP Counseling Training as least liked.

Table 34
Trainings Most-liked by Providers and Their Reasons, by Type of Health Facility and CPR Performance

Types of Training	Facility		Total	CPR	
	Public	Private		High	Low
Basic/Comprehensive Training Course on FP	6	8	14	8	6
FP Counseling Training	2	2	4	2	2
NSV Training	3	1	4	2	2
AVSC Training	–	1	1	1	–
Echo seminar given by supervisor	1	–	1	–	1
Liked all trainings	–	1	1	1	–
No. of Cases	**12**	**13**	**25**	**14**	**11**
Reasons					
Methodology used in training (e.g., role-playing, actual demonstration, field trips)	6	6	12	7	5
Skill-based/increases skills	3	4	7	5	2
Useful/applicable in actual practice	2	3	5	1	4
FP updates	2	2	4	2	2
Logistic support	2	1	3	3	–
Challenging/interesting	–	2	2	2	–
Only training received	1	–	1	1	–
Good trainer	–	1	1	–	1
No. of Responses	**16**	**19**	**35**	**21**	**14**
No. of Cases	**16**	**14**	**30**	**17**	**13**
Not applicable = 3					

An analysis of the least-liked vs. most-liked trainings shows that the FP Counseling Training was viewed differently by providers. There were some who liked it and some who did not. Since this training is considered a basic training on FP, the finding that it is not quite popular among some providers, especially those coming from public clinics, warrants a review of its content and methodology. For the providers, the most commonly reported reason why the training was least-liked was that the FP counseling-related concepts/methods were tedious and difficult to learn. This data shows that the providers generally found complex the topics discussed. The

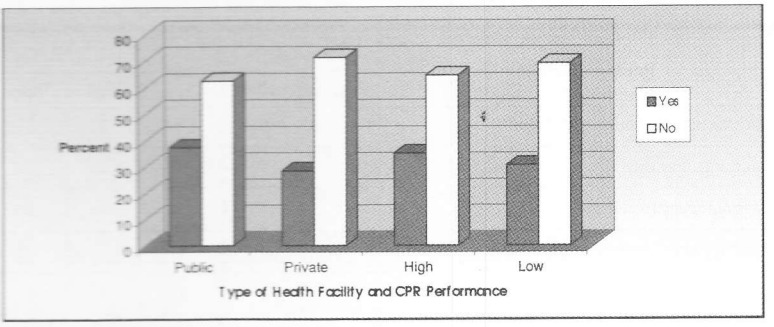
methodologies used in the trainings seemed to have an impact on the providers' evaluation of such a training [see Table 35]. This implies that training module developers and FP trainers should take these into account when conducting training.

Quality FP counseling provision is partly maintained through the continuous training of service providers, aside from regular assessment and evaluation. Regardless of clinic type, most of the providers felt that they have all the skills needed for communication (with clients). The proportion of providers who felt that they are confident about their counseling skills came from public clinics (37.5%) and high CPR areas (35.3%). This data could be interpreted in many ways. One interpretation would be that majority of the providers already feel that they are doing their job well or are receiving good feedback from their clients. This could also imply that they are not that motivated anymore to seek further

Table 35
Trainings Least-liked by Providers and Their Reasons, by Type of Health Facility and CPR Performance

Types of Training	Facility		Total	CPR	
	Public	Private		High	Low
FP Counseling Training	2	1	3	–	3
NFP Training	1	2	3	1	2
Interpersonal Communication Skills Training	1	1	2	2	–
RH Training/Advocacy Program	1	1	2	2	–
Basic/Comprehensive Training Course on FP	1	1	2	2	–
Ambulatory Health Facility Management Training for WFMC Midwives	–	1	1	1	–
No. of Cases	**6**	**7**	**13**	**8**	**5**
Reasons					
Taxing/tedious	1	1	2	1	1
Hard to teach others	–	1	1	1	–
Many responsibilities	1	–	1	–	1
Lack of self-confidence	1	–	1	1	–
Not realistic	–	1	1	1	–
Too general in scope	–	1	1	1	–
No. of Responses	**3**	**4**	**7**	**5**	**2**

Figure 9
Percent Distribution of Providers Having All the Knowledge and Skills Necessary to Effectively Counsel Clients, by Type of Health Facility and CPR Performance



development of their skills as FP counseling providers [see Figure 9].

The majority of providers who felt that they have all the skills needed for communication (with clients) reported that they can already tell that their patients were able to understand better. It seemed that many providers used client responses as a subjective system of self-assessment, although this may not be accurate in all cases [see Table 36]. There were, however, some providers who felt the need to further develop their skills as FP counselors. For those who felt that their existing knowledge and skills are inadequate, the reason commonly given was that they have already forgotten what they have learned (ranging from 40% to 60% across clinic types). Another reason given was the need for regular updates and opportunities to acquire new skills. This response was most prevalent among public sector providers (33.3%). The inadequate number of trainings attended was identified as another reason by 25% of public sector providers and 27.3% of providers from high CPR areas.

Communication skills are important provider requirements that advance quality FP counseling. What were the identified skills needed by providers to encourage better client communication? The findings show that having good interpersonal skills was one of them. It was identified as a need by a majority of providers from public clinics (46.2%) and high CPR areas (35.3%) to strengthen communication with clients. Also, a relatively high percentage of providers from the private sector (41.2%) and high CPR areas (23.5%) added that patience and ingenuity with clients

Table 36
Providers' Reasons for Having and Not Having All the Knowledge and Skills Necessary to Effectively Counsel Clients, by Type of Health Facility and CPR Performance

Positive Reasons	Facility		Total	CPR	
	Private	Public		High	Low
Can make clients understand better	1	2	3	2	1
Can clarify questions	1	1	2	1	1
Sufficient training attended	1	1	2	–	2
Capability to do community counseling	–	1	1	1	–
Can motivate clients to practice FP	–	1	1	1	–
Adequate knowledge and skills in FP counseling	1	–	1	1	–
Had years of experience on FP practice	1	–	1	–	1
No. of Responses	**5**	**6**	**11**	**6**	**5**
No. of Cases	**16**	**14**	**30**	**17**	**13**
Negative Reasons					
Forgetting what is learned	2	3	5	3	2
Needs updates/new skills	4	1	5	3	2
Inadequate training attended	3	1	4	3	1
Lack of specific training	1	1	2	1	1
Need for more facilities, equipment and/or materials	1	1	2	1	1
Lack of time to apply skill in clinics	1	–	1	–	1
No. of Responses	**12**	**7**	**19**	**11**	**8**
No. of Cases	**16**	**14**	**30**	**17**	**13**

are vital. In the public sector, on the other hand, 23.1% of providers suggested undergoing training courses on FP counseling. This data reflects the current need among providers to hone their communication skills through training and to practice better client relations by adopting a more agreeable and appropriate attitude towards clients [see Table 37].

Related to this, most respondents suggested further training and updates on FP knowledge so that other FP counseling providers can improve communication with client. A high percentage of public clinic providers (35.7%) specifically suggested that they undergo the Interpersonal Communication Skills Training to improve their skills when working with clients. The finding is noteworthy since

Table 37
Skills Needed by Provider and Other Providers to Effectively Communicate with Clients, by Type of Health Facility and CPR Performance

Skills Needed by Provider	Facility		Total	CPR	
	Public	Private		High	Low
Good interpersonal communication skills	6	2	8	6	2
Patience and ingenuity with clients	1	5	6	4	2
Training/refresher course on FP counseling	3	2	5	3	2
More time for clients	1	2	3	2	1
Good public relations	1	1	2	2	–
Visual aids	1	–	1	–	1
No. of Responses	**13**	**12**	**25**	**17**	**8**
No. of Cases	**16**	**14**	**30**	**17**	**13**
Skills Needed by Other Providers					
Training/updates on FP knowledge	9	7	16	10	6
Interpersonal Communication Skills Training	5	2	7	4	3
Good public relations	–	1	1	1	–
Proper work attitude	–	1	1	1	–
No. of Reponses	**14**	**11**	**25**	**16**	**9**
No. of Cases	**16**	**14**	**30**	**17**	**13**

16.7% of public clinic providers have also previously identified this particular training as among those they least liked. There is also data which cited a small percentage of providers feeling that other providers do not need to have additional skills or to develop present skills. Not having other providers in the clinic and trusting the capabilities of a colleague could be the reasons for this observation.

To increase knowledge on FP counseling, majority of the providers across all clinic types reiterated the need for further training and skills development. A total of 42.8% of private clinic providers and 46.2% of providers from low CPR areas specifically identified refresher courses and practice on FP counseling as immediate needs. This finding is consistent with the data presented earlier on providers forgetting what they have learned as a common reason for their lack of skill, hence they require refresher courses. On the other hand, a similar response was given by most public clinic providers (37.50%) and providers from high CPR areas

Table 38
Ways to Increase Knowledge and Skills on FP Counseling and Interaction with Clients, by Type of Health Facility and CPR Performance

Ways to Increase Knowledge and Skills	Facility		Total	CPR	
	Public	Private		High	Low
Trainings or seminars on FP	6	5	11	7	4
Refresher courses/Practice on FP counseling	4	6	10	4	6
Logistic support	3	–	3	2	1
By reading	1	1	2	1	1
Increase in IEC activities	–	1	1	1	–
House-to-house motivation/lectures	1	–	1	1	–
Training other staff as reliever	–	1	1	1	–
Regular meetings and consultations with staff	1	–	1		1
No. of Cases	**16**	**14**	**30**	**17**	**13**

(41.2%) who also emphasized the need for more trainings and seminars on FP [see Table 38].

Since providers need to be trained before they can give quality services, it follows that supervisors should be one step ahead. Supervisors need to be trained as providers as well. However, there are other specialized trainings that ideally they should have undergone to prepare for their role as clinic managers. Unfortunately, data from this study shows that a majority or 16.7% of supervisors from the public sector and 16.1% of those from low CPR areas have not received any form of training related to their job. Most providers from the private sector (23.1%) and high CPR areas (20%) received FP Counseling Training (identified earlier as a least-liked training). A smaller percentage of supervisors received Basic/Comprehensive Training Course on FP. There were only 15.4% from private facilities who actually received training on FP supervision. However, not a single supervisor from public clinics reported having received this training [see Table 39]. Clearly, there is a need for supervisors to undergo further training to become better role models to their providers.

Standards

Standards are needed because they serve as the gauge for good performance. In this study, all providers from public clinics were

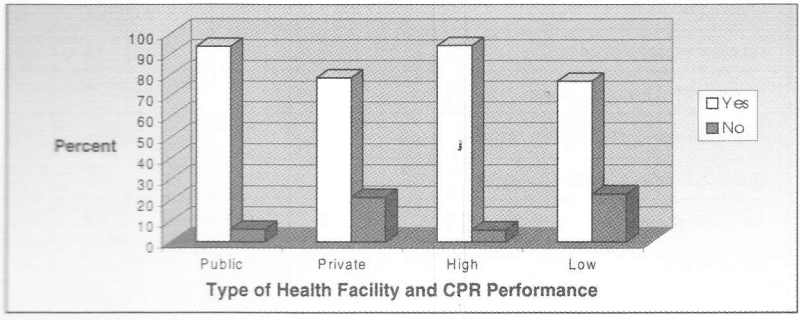
Table 39
Trainings Received by Supervisors, by Type of Health Facility and CPR Performance

Types of Training	Facility		Total	CPR	
	Public	Private		High	Low
FP Methods	11	9	20	8	12
Training on Management	8	5	13	7	6
FP Counseling	4	6	10	5	5
FP Supervision	–	4	4	2	2
Clinic Data Analysis on FP	1	1	2	2	–
OB-GYN Training	1	–	1	1	–
Gender-Sensitivity Training	–	1	1	1	–
No. of Responses	**25**	**26**	**51**	**26**	**25**
No. of Cases	**11**	**13**	**24**	**12**	**12**
Not applicable = 7					

aware of the standards on FP counseling. This was reflected by most of the providers from private clinics (78.6%) and high (94.1%) and low (76.9%) CPR areas. However, there were still some who claimed not having any knowledge on FP counseling [see Figure 10].

Across variables (public vs. private/high vs. low CPR areas), almost all providers have identified a specific standard for FP counseling. A majority of providers from private clinics (54.4%) and high CPR areas (37.5%) identified the GATHER Approach as

Figure 10
Percent Distribution of Providers' Awareness of Standards on FP Counseling, by Type of Health Facility and CPR Performance



their standard for FP counseling. However, for most public clinic providers (37.5%) and those coming from low CPR areas (36.36%), the gauge of performance used is the one based on the FP Counseling Standards of the DOH. There are plausible explanations for this observation. One is that providers might have made a distinction between the DOH FP Counseling Standards and the GATHER Approach making the former as their standard. The finding may also indicate that the GATHER Approach is still not widely accepted or used by all FP providers as "the standard," in spite of their knowledge and awareness of it. This particular data is ironic, especially since many providers actually claimed awareness of GATHER as a method or standard in counseling. This finding was consistent across all clinic types. The GATHER Approach is also made as a tool/guide in FP counseling, particularly in the training

Table 40
Distribution of Providers Who Claimed that Their Supervisors Discussed FP Counseling Standards with Them and the Nature of Standards for FP Counseling Discussed, by Type of Health Facility and CPR Performance

Supervisors Discussed Standards	Facility		Total	CPR	
	Public	Private		High	Low
Yes	11	7	18	11	7
No	5	3	8	5	3
No. of Cases	**16**	**10**	**26**	**16**	**10**
Not applicable = 4					
Standards					
GATHER Approach	4	6	10	6	4
Standards on FP Counseling (DOH Manual)	6	1	7	3	4
Privacy and confidentiality	–	2	2	2	–
Checkup before recommendation	1	1	2	1	1
Let client choose method	2	–	2	2	–
Assessment of the client's needs	1	–	1	1	–
3 C's (counseling, contraceptive, checkup)	–	1	1	–	1
Give quality service to attain quality life	1	–	1	1	–
No. of Responses	**16**	**11**	**27**	**16**	**11**
No. of Cases	**16**	**14**	**30**	**17**	**13**
Not applicable = 4					

provided to DOH and local public health service providers, thus engendering health.

Also, a high percentage of providers across clinic types claimed that their supervisors discussed FP counseling standards with them. A smaller percentage, however, stated that this is not applicable. This response could be attributed to the absence of specially designated clinic supervisors or the presence of inadequate supervisor-provider interaction [see Table 40].

Do the providers actually know what GATHER is? The providers in this study gave several descriptions when asked about what GATHER is. Majority of providers from public, private, and high CPR clinics gave specific meanings and examples for each letter of the GATHER Approach [see Table 41]. Many providers were also aware that the letters stand for something, even if they were not able to elaborate on this. They might have heard about it before but could no longer remember the details anymore. The popularity of using the GATHER Approach among providers is supported by these findings. For those who did not elaborate on the GATHER Approach, there was a claim that this was so because the materials on the topic were not yet made available to local health providers.

Table 41
Providers' Awareness and Knowledge of the GATHER Approach, by Type of Health Facility and CPR Performance

Providers' Awareness of GATHER	Facility		Total	CPR	
	Public	Private		High	Low
Yes	14	12	26	15	11
No	2	2	4	2	2
No. of Cases	**16**	**14**	**30**	**17**	**13**
Knowledge of GATHER					
Letters have meaning and examples	6	6	12	6	6
Step-by-step process/guide in counseling	3	–	3	2	1
Technique in counseling	1	1	2	1	1
Routine in FP service provision	1	–	1	–	1
Part of FP counseling standards	–	1	1	1	–
No. of Responses	**11**	**8**	**19**	**10**	**9**
No. of Cases	**16**	**14**	**30**	**17**	**13**
Not applicable = 4					

Feedback Mechanisms

Feedback is an important aspect of the evaluation system. It is constantly needed to maintain quality of service provision. Majority of providers across clinic types [for both public (93.8%) and private (92.9%) sectors, in both high (88.2%) and low (100%) CPR areas] reported that they want feedback from their supervisors. Exceptions were found only in cases when immediate supervisors were not available in their clinic's setup. It is interesting to note that the highest need to receive feedback from supervisors came from the low CPR areas where all providers claimed to have this need. Clearly, the data supports the urgency to establish a system of giving regular feedback and evaluation to make FP counseling provision more fine-tuned and improved [see Table 42].

The most commonly identified reason for wanting this feedback from supervisors was the providers' need to have a basis for self-improvement. This was observed across all clinic types. The supervisor was the chosen source of feedback by 27.9% of providers from high CPR areas because of the former's higher position, which could translate into a perceived higher level of

Table 42
Providers' Reasons for Wanting Feedback from Supervisors, by Type of Health Facility and CPR Performance

Reasons	Facility		Total	CPR	
	Public	Private		High	Low
Basis for self-improvement	7	3	10	5	5
Manner of giving feedback	2	4	6	2	4
Direct/immediate supervisor	4	2	6	5	1
More knowledgeable and experienced	2	2	4	2	2
Closeness with the person	3	1	4	3	1
Actually observed respondent	2	–	2	–	2
Concerned with the clinic	–	1	1	1	–
Confidentiality	1	–	1	1	–
Knowledgeable about the organization/system	–	1	1	1	–
Competent in solving specific problems	–	1	1	–	1
No. of Responses	**21**	**15**	**36**	**20**	**16**
No. of Cases	**16**	**14**	**30**	**17**	**13**

knowledge on or expertise in FP. Hence, the supervisors are potential sources of input. This is similar to the reason given by 19% of those coming from public clinics. They want their supervisors to give them feedback because they are their direct or immediate bosses/superiors. The provider's personal relationship with the supervisor and the supervisor's approach were less commonly identified as reasons for this preference [see Table 42].

Providers should have a means of finding out whether they are doing their jobs adequately or not through feedback. Data from this study illustrates that across clinic types, majority of providers have received feedback on their performance. All providers from the public sector claim to have received feedback. The response is similar across types of facilities and level of CPR.

For all providers (regardless of clinic type), the clients were their most commonly identified source of feedback. The supervisors were the next common source of feedback, also across all variables. Also mentioned by a few as sources of feedback were the community members, staff nurse, staff doctor, DOH representative, co-staff, and fellow providers [see Table 43].

Almost all supervisors across categories/variables claim to give feedback to their staff. This is given through verbal forms or opinions. The next most common type of feedback are announcements during group or staff meetings. One-on-one talks were also popular among providers from private clinics (11.1%) and high CPR areas (15.8%). Nonverbal forms of feedback were not commonly reported, except by some providers who received them through annual performance ratings.

Regarding the type of feedback used, verbal feedback was identified as the most helpful by a majority of providers across clinic types. This is the opinion of public clinic providers and also of those coming from high CPR areas. One-on-one talks (a specific form or variant of verbal feedback) is the second most popular form of feedback from the providers' point of view. Notes or written feedback were not as popular as verbal forms but these were still reported as helpful by a percentage of providers from private clinics and high CPR areas. Most providers commonly practice the use of suggestion boxes and feedback cards [see Table 44].

As to what type of feedback was not helpful, indirect verbal feedback (gossip or hearsay) was pointed out by a majority of providers across clinic types, with the highest percentages coming from the providers in public clinics and high CPR areas. Reprimanding

Table 43
Persons Who Provide Feedback to Providers and Their Manner of Giving Feedback, by Type of Health Facility and CPR Performance

Persons Who Provide Feedback to Providers	Facility		Total	CPR	
	Public	Private		High	Low
Clients	9	10	19	13	6
Supervisor/clinic manager	5	7	12	8	4
Coworkers/colleagues	2	2	4	3	1
Staff doctor	2	1	3	2	1
Staff nurse	2	1	3	1	2
DOH representative	1	–	1	–	1
Community members	–	1	1	–	1
No. of Responses	**21**	**22**	**43**	**27**	**16**
No. of Cases	**16**	**14**	**30**	**17**	**13**
Not applicable = 4					
Manner of Giving Feedback					
Verbal feedback or opinions	9	9	18	11	7
Group or staff meetings	5	4	9	4	5
One-on-one talks	1	2	3	3	–
Supervisor asks clients	–	1	1	1	–
Annual performance rating	–	1	1	–	1
Quarterly program performance reviews	1	–	1	–	1
Give gifts as token	–	1	1	–	1
No. of Responses	**16**	**18**	**34**	**19**	**15**
No. of Cases	**16**	**14**	**30**	**17**	**13**

in public, comments on personal (nonwork related) affairs, accusations and criticisms, and wrongly stated feedback were also reported by a small percentage of providers. These reports support the idea that FP counseling providers generally prefer to receive direct verbal feedback in private, probably in order to avoid embarrassment.

Most supervisors reported that they give feedback to their FP counselors. This is done mostly through regular staff meetings. As mentioned earlier, direct verbal feedback was the most common means of feedback-giving. The most commonly cited way of doing this is through one-on-one talks and direct evaluations/observations.

Most public and private clinic supervisors expect their FP counselors to have a mastery of knowledge on FP. They also expect

Table 44
Helpful and Unhelpful Feedback Given to Providers, by Type of Health Facility and CPR Performance

Helpful Feedback	Facility		Total	CPR	
	Public	Private		High	Low
Verbal feedback	9	5	14	8	6
One-on-one talks	5	3	8	4	4
Meetings/group talks	3	3	6	3	3
Notes/written feedback	1	3	4	4	–
Client feedback	2	2	4	3	1
Feedback cards	–	1	1	–	1
Suggestion box	–	1	1	–	1
No. of Responses	**20**	**18**	**38**	**22**	**16**
No. of Cases	**16**	**14**	**30**	**17**	**13**
Not applicable = 5					
Unhelpful Feedback					
Gossip and other feedback not directed to the person	7	6	13	7	6
Accusations or criticisms	1	3	4	3	1
Feedback on personal affairs	2	1	3	1	2
Use of reprimanding tone while giving feedback	1	–	1	1	–
Reprimanding in public	1	–	1	–	1
No. of Responses	**12**	**10**	**22**	**12**	**10**
No. of Cases	**16**	**14**	**30**	**17**	**13**
Not applicable = 8					

providers to have the ability to explain FP information to clients adequately. Behaviorally, they expect providers to handle clients well and exhibit skills in listening to clients' concerns. A few supervisors also expect their counselors to participate in the promotion (marketing) of the clinic, observe proper documentation procedures, give feedback to their superiors, and achieve the clinic's target goals. A supervisor from a private clinic, interestingly, expected her providers to motivate clients to use an FP method [see Table 46]. This highlights a possible mind-set among supervisors that a provider is good if he/she can convince clients to adopt an FP method.

Table 45
Manner and Frequency of Giving Feedback to Providers, by Type of Health Facility

Manner of Giving Feedback	Facility		Total
	Public	Private	
Direct verbal feedback	8	14	22
Direct sharing/reporting of experiences of assigned persons	1	2	3
Through in-house training	1	0	1
Through outside-provided training	1	0	1
No specific protocol	0	1	1
No. of Responses	**11**	**17**	**28**
No. of Cases	**13**	**11**	**24**
Frequency of Giving Feedback			
Regular weekly/monthly staff meetings	5	3	8
Immediate feedback	1	1	2
Unscheduled meetings	1	0	1
Daily feedback from supervisor	0	1	1
No. of Responses	**7**	**5**	**12**
No. of Cases	**13**	**11**	**24**

Table 46
Supervisors' Expectations from FP Counselors, by Type of Health Facility

Expectations	Facility		Total
	Public	Private	
Knowledgeable and give good explanations	6	5	11
Achieve clinic target goals	3	2	5
Know how to deal with clients/listen attentively	2	–	2
Able to motivate clients to use an FP method	–	1	1
Promote/market clinic services	–	1	1
Give feedback to supervisor	1	–	1
Meet set standards	–	1	1
Have adequate FP methods supply	1	–	1
Practice proper documentation	1	–	1
No. of Responses	**16**	**10**	**26**
No. of Cases	**13**	**11**	**24**

Transportation

Most of the providers from public clinics use public transportation (e.g., bus, jeep, tricycle, pedicab). Walking to work was also practiced by some of the providers, especially those coming from the public sector. Meanwhile, a good number of private providers and only a few of the public providers have access to a service vehicle or actually use their own vehicle. Only one provider from a public clinic and low CPR area reported having access to a service vehicle [see Table 47].

Table 47
Information Related to Transportation

Means of Transportation	Facility		Total	CPR	
	Public	Private		High	Low
Public transportation	9	4	13	8	5
Service vehicle	1	5	6	5	1
Walking	4	1	5	2	3
Private vehicle	1	–	1	1	–
No. of Responses	**16**	**12**	**28**	**18**	**10**
No. of Cases	**16**	**14**	**30**	**17**	**13**
Not applicable = 7					
Convenience of Trips					
Yes	10	7	17	9	8
No	5	5	10	6	4
No. of Cases	**15**	**12**	**27**	**15**	**12**
Geographical Areas Served					
Several barangays in the city	11	1	12	7	5
Whole province	1	4	5	4	1
Whole city plus other nearby cities	–	2	2	–	2
Whole city	–	2	2	–	2
Several parts of the province	–	1	1	–	1
All barangays in the city	1	–	1	–	1
Province-wide and other provinces	–	1	1	1	–
No. of Cases	**13**	**11**	**24**	**12**	**12**

Generally, FP counseling providers have to go to the communities that they serve for outreach and follow-up. Majority of them, across clinic types, report that travel to communities is convenient enough. However, there were also providers (across categories) who reported that these trips were not convenient.

Most providers from high and low CPR areas reported that their clinics serve several barangays in the city. This is truer for those in the public sector. Most private clinics and clinics in high CPR areas serve the whole province. Since the number of constituents (size of population served) is also an indication of the area covered and reflects the clinic's level of utilization, this data implies that clinics in the public sector are the most utilized. It is also interesting to note that a large percentage of clinics described as being high-performing serve the whole province. This could indirectly mean that the quality and efficiency of service (in terms of number of clients reached) could still be maintained despite a clinic's large catchment area.

Resupply System

For FP job aids, four out of six providers from low CPR areas reported that there was no previous incident of job aids running out. In high CPR areas, when job aids ran out, majority of providers request for supplies from the main health office/agency/organization. This was the most common coping mechanism they used to identify the problem [see Table 48]. The majority of providers from both low and high CPR areas claimed that they had no incident of FP supplies running out in the past six months. To maintain stocks, they have a system of inventory with some clinics having an inventory officer. Keeping buffer stocks and advanced orders also help in ensuring adequate supplies. In cases when clients need to be resupplied and the clinic cannot provide what is needed, providers from both high and low CPR areas ask their clients to buy supplies from outside sources.

Maintenance System of the Facility

A high percentage of providers from low CPR areas has access to janitorial services and utility workers to maintain clinic cleanliness.

Table 48
Resupply System of Job Aids and FP Methods,
by Type of Health Facility and CPR Performance

Resupply System of Job Aids	Facility		Total	CPR	
	Public	Private		High	Low
Ask supply from main health office/NGO	4	5	9	6	3
No incident of job aids running out	3	3	6	2	4
Get supply from main health office/central head office of NGO	2	1	3	–	3
Reproduce copies	2	1	3	2	1
Do nothing/go on counseling	1	1	2	2	–
Request for resupply via text or in person	–	2	2	2	–
Keep own copy of job aids	2	–	2	2	–
Use alternatives/actual models	–	1	1	–	1
Ask patient to buy	1	–	1	1	–
No one resupplies	1	–	1	–	1
No. of Responses	**16**	**14**	**30**	**17**	**13**
No. of Cases	**16**	**14**	**30**	**17**	**13**
Resupply System of FP Methods					
No incident of FP supply running out	9	3	12	6	6
Ask clients to buy	2	4	6	4	2
Request/ask main health center or NGO office	2	3	5	4	1
Make emergency request/purchase	2	–	2	1	1
Get supply from main health office	1	–	1	–	1
DOH provides logistic support	–	1	1	–	1
Refer to supervisor	–	1	1	1	–
Buy from NGO	–	1	1	1	–
No. of Responses	**16**	**13**	**29**	**17**	**12**
No. of Cases	**16**	**14**	**30**	**17**	**13**
Not applicable = 1					

Only a few private providers and providers from high CPR areas reported having this service. In most cases and settings, the staff cleans the clinic [see Table 50]. Less commonly, BHWs were also reported to help in clinic maintenance. In some settings, family members of the staff help out in cleaning the clinic. These reflect a high level of cooperation not only within the ranks of the

clinic staff but also in other circles to maintain cleanliness and orderliness in the clinics.

Table 50
Maintenance System, by Type of Health Facility and CPR Performance

Maintenance System	Facility		Total	CPR	
	Public	Private		High	Low
Staff cleans	4	7	11	8	3
Janitorial services/utility workers	3	5	8	4	4
Janitors and staff clean	4	–	4	1	3
BHWs clean by rotation	3	1	4	1	3
Staff and BHWs clean	2	–	2	2	–
Family members clean	–	1	1	1	–
No. of Cases	**16**	**14**	**30**	**17**	**13**

In terms of improving client-provider interaction (CPI) provision, logistic support in the form of supplies and services was the most commonly identified way to improve CPI by providers from the public sector and high CPR areas [see Table 51]. For the majority of providers from high CPR areas and the private sector, additional or more comprehensive training on FP was most commonly identified. Aside from these, other important environmental factors to improve CPI that were given by the providers were the existence of job/supervisor support, an environment conducive to FP provision, and increased exposure to FP environment.

IEC materials, such as leaflets and brochures, were the tools identified most often by providers from public clinics and high CPR areas to improve CPI. The provision of FP commodities and methods was needed most in low CPR areas. In the private sector, the most commonly identified tools needed are IEC materials and job aids. Generally, IEC materials (which include brochures and leaflets) and methods and job aids (physical models) were acknowledged as useful by most providers across sectors. FP counseling provision, therefore, does not depend on verbal exchange between the provider and client alone. Tools and aids are used as examples during counseling. They are also employed to clarify the explanations given by most providers regardless of their grouping.

Table 51
Social Environmental Factors and Tools to Help Improve CPI, by Type of Health Facility and CPR Performance

Social Environmental Factors	Facility		Total	CPR	
	Public	Private		High	Low
Job/supervisor support	8	8	16	9	7
Logistic support (supplies and services)	8	3	11	7	4
Community support (barangay and religious organizations)	5	1	6	4	2
Increased exposure to FP environment	2	4	6	5	1
FP counseling room	3	2	5	2	3
Local government support	1	–	1	1	–
Support from peers/family	1	–	1	–	1
Media support (information dissemination)	–	1	1	1	–
Presentable/complete facilities	1	–	1	–	1
No. of Responses	**29**	**19**	**48**	**29**	**19**
No. of Cases	**16**	**14**	**30**	**17**	**13**
Tools					
IEC materials/job aids	16	14	30	17	13
FP commodities/methods	4	5	9	4	5
Audiovisual aids/video	7	1	8	5	3
Physical models	3	3	6	4	2
Books/manuals on FP	1	1	2	–	2
Instruments for examination	–	2	2	2	–
Patient assessment form/charts	1	1	2	1	1
Client feedback	1	–	1	–	1
Overhead projector	–	1	1	–	1
Generator	–	1	1	1	–
No. of Responses	**33**	**29**	**62**	**34**	**28**
No. of Cases	**16**	**14**	**30**	**17**	**13**

Motivation and Incentives

Providers are constantly faced with many challenges in their work. Since they are in the front lines of service provision, they should be properly motivated and reinforced. What are the

motivators and reinforcers currently in place? A majority of providers remarked that there is no mechanism in place to acknowledge their commendable performance. Across facilities, majority of public and private clinic providers said that there is no mechanism in place. This is also true for providers from high and low CPR areas. However, there were also a few providers who said that a mechanism is in place. Bonuses, cash incentives, gifts, and trophies were given and received in recognition of their work. It is worthy to note that there were some providers who claimed that recognition of their good performance increased their client loads. This, however, may not directly be viewed as reinforcing by most people [see Table 52].

Most public clinic providers do not receive recognition for their effective FP counseling services. This is also true for high and low CPR areas. For those who were recognized, verbal praise was the most frequently reported form of recognition. Receiving praise was the most prominent response given by private providers. Awards, plaques and certificates, increased number of clients, travel allowances, and good feedback from their supervisors were also identified as recognition mechanisms to a lesser degree [see Table 52].

Again, like most people, FP counseling providers need to be motivated to make them perform better. What motivates them? Data shows that recognition or gratitude was most needed in public clinics and health centers located in low CPR areas. About one-fifth of providers from private clinics and high CPR areas were motivated by their good relationship or interaction with their clients. Monetary incentives and other gifts, to a lesser extent, were also viewed by providers as sources of motivation to improve client interaction [see Table 53].

As a form of feedback and assessment to encourage better performance, performance reviews of providers are mostly done by clinic supervisors. The evaluations are held periodically (as contrasted to regularly) using a performance evaluation form and indicators such as client feedback and personal observations. The supervisors in many clinics covered also perform clinical assessments. The supervisors and/or CHOs are most often the ones who are tasked to impose disciplinary action on providers and other clinic staff if needed. Reprimands are mostly given verbally; written memos are less commonly employed.

Table 52
Distribution of Mechanisms to Recognize Good Performance of Providers, by Type of Health Facility and CPR Performance

Existence of Mechanisms to Recognize Good Performance	Facility		Total	CPR	
	Public	Private		High	Low
Yes	4	5	9	6	3
No	12	9	21	11	10
No. of Cases	**16**	**14**	**30**	**17**	**13**
Mechanisms to Recognize Good Performance					
Gifts or goods	3	–	3	2	1
Bonuses	–	2	2	–	2
Trophies	–	2	2	2	–
Cash incentives	1	–	1	1	–
Increase in client load	–	1	1	1	–
No. of Responses	**4**	**5**	**9**	**6**	**3**
No. of Cases	**16**	**14**	**30**	**17**	**13**
Provider Received Recognition					
Yes	9	12	21	12	9
No	7	2	9	5	4
No. of Cases	**16**	**14**	**30**	**17**	**13**
Manner of Recognition					
Good feedback from clients and supervisors	5	6	11	5	6
Award/plaque/certificate of recognition	3	1	4	3	1
Increased number of clients	1	2	3	1	2
Supervisor gives incentives or treats staff	–	2	2	2	–
Travel allowance	–	1	1	1	–
No. of Cases	**9**	**12**	**21**	**12**	**9**
Not applicable = 9					

Provider Expectations

A majority of providers agree that they have knowledge in terms of what clients and supervisors expect of them. They know that it is their job to provide quality FP counseling to the clients. Most of these providers are also aware that they should exhibit positive behavioral characteristics

Table 53
Types of Motivation Needed by Providers to Perform Better in Their Interaction with Clients, by Type of Health Facility and CPR Performance

Types of Motivation	Facility		Total	CPR	
	Public	Private		High	Low
Recognition or gratitude	4	1	5	2	3
Reimbursable travel expenses or travel allowance	4	1	5	3	2
Commitment to job	2	3	5	3	2
Good relationship or interaction with clients	1	3	4	4	–
Increased number of clients	1	1	2	1	1
Incentives	1	1	2	–	2
Logistic support	2	–	2	1	1
Tokens	–	1	1	–	1
Moral support from supervisor	–	1	1	1	–
No. of Responses	**15**	**12**	**27**	**15**	**12**
No. of Cases	**16**	**14**	**30**	**17**	**13**

such as developing trust, communicating well, and being approachable and confident. Aside from these, some providers are aware that they need to develop greater expertise on FP through training. In terms of client expectations, it was specifically mentioned that providers were expected to use the GATHER Approach during counseling [see Table 54].

Most providers also know that they are expected to provide quality FP counseling to their clients. Moreover, they stressed that positive behavioral characteristics were also emphasized by many as being necessary during counseling. As employees, they were aware of the need to develop their knowledge and skills on counseling, and to follow standard procedures. One of these procedures is employing the GATHER Approach in counseling [see Table 54]. The providers learned about the expectations primarily through talks with their supervisors (meetings, assessments, and verbal, one-on-one feedback). Other commonly cited sources of knowledge about the expectations were seminars, trainings, and classes which they attended. Informal staff meetings were also identified as a source of expectations [see Table 55].

Table 54
Expectations of Supervisors and Clients in Terms of Delivery of FP Counseling and Providers' Expectations on Interaction with Clients, by Type of Health Facility

Expectations on FP Counseling	Facility		Total
	Private	Public	
Provider of FP counseling	12	14	26
Possess positive behavioral characteristics	9	10	19
Competence/training	4	7	11
Follow protocols	2	3	5
Use of the GATHER Approach	2	–	2
Create good counselor-client relationship	–	2	2
Provision of quality service	–	1	1
No. of Responses	**29**	**37**	**66**
No. of Cases	**14**	**16**	**30**
Expectations on Interaction with Clients			
Provider of FP counseling	7	14	21
Positive behavioral characteristics	14	10	24
Provision of quality service	5	4	9
Competency/training	3	5	8
Good counselor-client relationship	1	2	3
Counsel on all matters	–	1	1
Use of the GATHER Approach	1	–	1
Promote other clinic services/programs	–	1	1
No. of Responses	**33**	**37**	**70**
No. of Cases	**14**	**16**	**30**

Work Force

Most FP providers in public clinics were midwives, PHMs, or RHMs. These job positions were also the most commonly reported across areas. The second most commonly occurring job position in clinics was that of the nurse. Clinic manager was identified as a key position in private facilities. There was a broad range of job titles or descriptions found across clinic types [see Table 56, Appendix D].

Table 55
Distribution of Manner of Relaying Expectations to Provider by Supervisors and Clients, by Type of Health Facility

Manner of Relaying Expectations by Supervisors	Facility		Total
	Private	Public	
During trainings	4	4	8
During seminars	–	2	2
Regular checking of accomplishments	–	2	2
Informal meetings	–	2	2
One-on-one with the supervisor	–	1	1
Verbal feedback from the supervisor	1	–	1
Following guidelines by EngenderHealth	1	–	1
During FP updates	–	1	1
During FP classes	–	1	1
No. of Responses	**6**	**13**	**19**
No. of Cases	**14**	**16**	**30**
Manner of Relaying Expectations by Clients			
Directly	5	10	15
Indirectly	5	6	11
No. of Responses	**10**	**16**	**26**
No. of Cases	**14**	**16**	**30**

Related to their positions, most providers across clinic categories have a degree in midwifery. B.S. Nursing was the second most common or prevalent degree in the clinics. The data implies that most FP clinics in the country are being run and even managed by midwives and nurses.

In terms of adequacy of clinic personnel, majority of public clinic supervisors reported that it was not enough, compared to only a few of private clinic supervisors who said manpower was not enough. Therefore, from the point of view of clinic supervisors, a majority of private clinics have enough personnel. This trend is true for all areas [see Figure 11].

Related to this, the majority of supervisors, across clinic types, reported having no vacancy in their clinics during the time of the research. Not a single supervisor from the private sector reported a vacancy. A smaller percentage reported that personnel are still

being processed for vacancies or are waiting for job items to be available. More than one-third of public clinic supervisors, and those from the other categories, gave no information on this matter. It seems that they are really unaware of the existence of vacancies in their respective clinics, primarily because they are not directly involved in or are not privy to information regarding the hiring of clinic personnel.

Most staff members of clinics from both high and low CPR areas were tasked to serve as FP providers and FP counselors. For the low CPR areas, majority reported that the staff is involved in dispensing FP commodities and FP methods. Other most

Figure 11
Percent Distribution of Adequacy of Personnel, by Type of Health Facility and CPR Performance

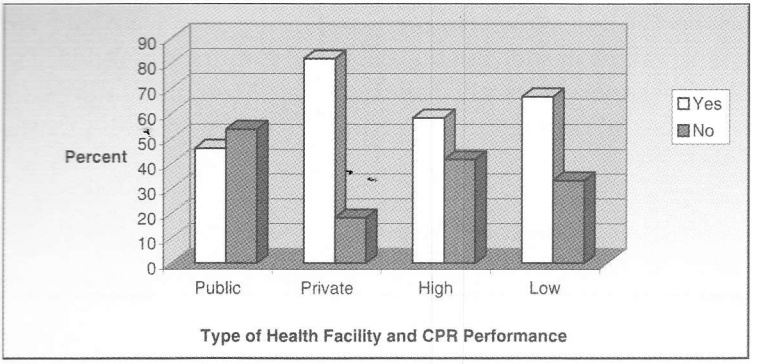
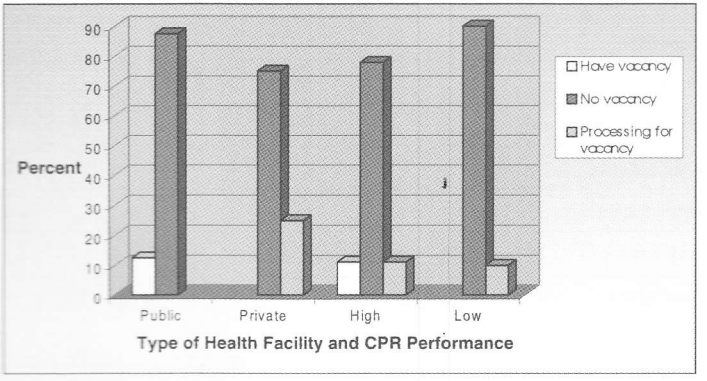


Figure 12
Percent Distribution of Vacancy for FP Provider, by Type of Health Facility and CPR Performance



commonly cited tasks carried out by the staff were (in order): clinic supervision, patient reception and treatment, and FP operation coordination. Table 57 shows that the clinic staff is generally involved in many responsibilities. The large volume of work could have an effect on the quality of FP counseling that these personnel provide their clients. Similarly, most supervisors in the private and public clinics reported that their clinic staff is tasked to provide FP counseling. Community lectures were carried out by 15.4% of private clinic providers. This was not reported in the public sector. Also, all the providers coming from the public sector were involved in dispensing FP commodities and FP methods, among other things.

The hiring or assignment of personnel was mostly based on training, experience, and/or decision of a higher agency (e.g., CHO, municipal hall, mother organization). Supervisors often have no personal involvement in the recruitment process [see Table 58]. Some specific bases of recruitment and hiring cited were interviews and personal merit such as education and trainings attended. There were a few supervisors who reported that recommendations made by officials and through the "padrino system" were still practiced.

Table 57
Tasks and Responsibilities of Staff, by Type of Health Facility and CPR Performance

Tasks and Responsibilities	Facility		Total	CPR	
	Public	Private		High	Low
As an FP provider	13	3	21	4	12
Patient reception and treatment	9	7	16	4	12
FP counseling	10	4	14	7	7
FP operation coordination	6	2	8	3	5
Clinic supervision	5	2	7	4	3
FP acceptor screening	2	3	5	2	3
Recording/reporting	4	1	5	1	4
Community lectures	–	4	4	2	2
Administrative tasks	2	–	2	–	2
Laboratory screening	2	–	2	2	–
No. of Responses	**53**	**26**	**79**	**29**	**50**
No. of Cases	**13**	**11**	**24**	**12**	**12**

Table 58
Information Related to Work Force

Requirements/Skills Needed to Become an FP Counselor	Facility		Total
	Public	Private	
Personal attributes/attitudes	16	14	30
Adequate FP training	9	5	14
Mastery of information/skills about FP methods	5	8	13
Counseling skills	–	3	3
Can motivate clients	–	2	2
Minimum educational background	2	–	2
No. of Responses	**32**	**32**	**64**
Person Doing the Recruitment			
City health office/city or municipal hall	9	–	9
No personal involvement in recruitment	2	2	4
Head/central office	–	3	3
Human resource department	–	2	2
Owner of clinic	–	1	1
No. of Responses	**11**	**8**	**19**
Manner of Recruitment			
Personal attributes	5	2	7
Feedback/recommendations helpful for hiring	2	1	3
Conduct of interviews	–	2	2
Padrino system	1	–	1
Criteria are followed	1	–	1
No. of Responses	**9**	**5**	**14**
Manner of Assigning Personnel to be FP Counselors			
Training-based	6	4	10
Another person/agency assigned the provider to the clinic	3	2	5
Unspecified qualifications	1	2	3
Based on equal division of tasks	2	–	2
All are assigned as FP counselors	1	1	2
Job rotation	–	2	2
Experienced with FP	–	2	2
Interest in the job	1	–	1
Communication skills	1	–	1
Performance evaluation	–	1	1
No. of Responses	**15**	**14**	**29**

Since the assignment of clinic personnel to specific tasks has been identified as a strategy to achieve the clinic's goals, supervisors reported that they do this based mostly on the training completed by their personnel. Other qualifications, such as experience, skills in handling clients, and performance evaluations, were also used. A high percentage of supervisors claimed that the assignment of clinic personnel was not in their job description; another person or agency was tasked to do this. Other techniques used in personnel assignment were those based on equal division of clinic tasks and job rotation. There were a few supervisors who assigned all clinic personnel as point persons for FP counseling provision.

Vision, Mission, and Goals

Majority of all providers across public and private settings and high and low CPR areas reported that FP counseling is included in the goals and mission of their clinics [see Table 59]. A smaller percentage also claimed that FP counseling is specifically contained in their clinics' goals and mission. A majority of providers across categories also reported that FP counseling is pursued in their clinics' performance objectives and site strategies. Similarly, FP counseling is addressed in the action plans of most clinics across types of facility. This data implies that FP counseling is acknowledged as an important aspect of clinic services, and that achieving FP targets is a priority for majority of the clinic providers.

In terms of performance objectives, although both sectors include FP concerns, private clinics focus more on clinic marketing and operations. Public clinics pattern their objectives more on prescribed quotas and strategies of agencies (e.g., DOH) and less on sustainability or profitability. Thus, taken in the light of government/DOH/NGO objectives, the overall goal/mission of the public clinic is to provide communities with accessible, sustainable, quality, and competent basic health and FP services at an affordable price.

Supervisors reported that, generally, their clinics aim to provide quality FP service that is affordable and accessible, aside from providing other (usual) clinic services, in the broader context of establishing happier and healthier communities. The sustainability of the clinic was identified as a goal by the supervisors of private clinics.

Table 59
Information Related to Strategic Decisions vis-à-vis FP Counseling

FP Counseling Included in Goals/Mission	Facility		Total	CPR	
	Public	Private		High	Low
Included in clinic's goals/mission	9	5	14	8	6
Addressed specifically	4	4	8	3	5
No. of Cases	**13**	**9**	**22**	**11**	**11**
Not applicable = 2					
FP Counseling Addressed in Performance Objectives					
Yes	11	9	20	9	11
No	1	1	2	1	1
No. of Cases	**12**	**10**	**22**	**10**	**12**
Not applicable = 2					
FP Counseling Addressed in Site Strategies					
Yes	11	9	20	11	9
No	2	–	2	–	2
No. of Cases	**13**	**9**	**22**	**11**	**11**
Not applicable = 2					
FP Counseling Addressed in Action Plans					
Yes	9	8	17	9	8
No	1	–	1	–	1
No. of Cases	**10**	**8**	**18**	**9**	**9**
Not applicable = 6					

To achieve their established goals and objectives, most supervisors have undertaken outside activities (such as outreach) aside from the usual clinic-based activities (personnel development and actual FP provision/counseling). Also, specific personnel have been identified as responsible for providing certain services (clinic work/tasking assignments).

The supervisors of private clinics in relation to their clinic sustainability goals employed advertising and marketing strategies. Public clinic providers who have a guaranteed flow of clients because of the free services that they provide did not prioritize this need. Other strategies, such as following-up of clients and establishing linkages, were also identified.

Table 60
Performance Objectives, by Type of Health Facility and CPR Performance

Performance Objectives	Facility		Total	CPR	
	Public	Private		High	Low
Integrated in the statement of General Health Program Goals	13	5	18	6	12
Specific program objective to increase CPR	4	6	10	6	4
Establishing linkages with other institutions	3	1	4	3	1
Operational sustainability	–	3	3	3	–
Affordable fees	–	2	2	–	2
Clinic structure and facilities	1	–	1	1	–
Advertising/popularizing clinic services	–	1	1	–	1
Specific objectives to increase FP counseling coverage	–	1	1	–	1
Community health education/outreach	–	1	1	1	–
No. of Responses	**21**	**20**	**41**	**20**	**21**
No. of Cases	**13**	**11**	**24**	**12**	**12**

Revenues

One public clinic reported very low revenue for the previous month (₱400). Private clinics tend to earn more, ranging from a low ₱1,260 to a high ₱400,000. Meanwhile, there were clinics from low CPR areas that reported incomes of ₱105,000 and ₱400,000. This finding implies that clinics that provide FP services have a wide range of income from the very low to the very high. Very high incomes may be due to the other services, aside from FP counseling provided by private clinics, and the fact that some clinics have set monthly revenues as organizational targets/goals [see Table 62].

Similarly, various private clinics that provide FP services have a wide range of budgets, from a low annual budget of ₱700,000 to as high as ₱4,726,000. Public clinic supervisors, however, gave no specific data on their budget. Generally, FP needs are included as items in the budget of the clinic. This could be in the form of funds for the FP counselor, commodities, and training expenses. Some clinics also have a matching grant program.

Table 61
Overall Goals, Mission, and Site Strategies Employed by Clinic, by Type of Health Facility

Overall Goals and Mission	Facility		Total
	Public	Private	
Provide quality health services (preventive, curative, and promotive)	10	4	14
Provide quality FP service	2	6	8
Sustainability of services for FP clients (goals)	–	5	5
Affordability	1	2	3
Implement the health program of DOH	2	–	2
Personnel development	–	2	2
Make FP services available to all (accessibility)	–	1	1
Establish linkages	–	1	1
No. of Responses	15	21	36
No. of Cases	13	11	24
Overall Site Strategies Employed			
Outside clinic FP service provision/activities	9	5	14
Advertising/marketing strategies	3	8	11
Within clinic FP service provision/activities	6	1	7
Personnel-in-charge identified	3	3	6
Establishment of linkages and advocacy	3	1	4
Client follow-up strategies	1	2	3
Improved feedback and evaluation strategies	3	–	3
Supply and logistics adequacy strategies	2	–	2
Staff development	–	1	1
Clinic system innovations	1	–	1
No. of Responses	31	21	52
No. of Cases	13	11	24

Initiatives to Improve Quality of Service Delivery

Public clinic supervisors suggested that to improve the quality of health services, the following must be accomplished: conduct outreach programs, form linkages with communities, devise better patient monitoring, and follow up on dropouts. Supervisors from private clinics, however, focused more on areas such as operations, supervision, and marketing [see Table 63].

Table 62
Information Related to Revenues

Previous Month's Revenue	Facility		Total	CPR	
	Public	Private		High	Low
₱400	1	–	1	–	1
₱1,260	–	1	1	–	1
₱5,024	–	1	1	1	–
₱9,494	–	1	1	1	–
₱105,000	–	1	1	–	1
₱400,000	–	1	1	–	1
No. of Cases	**1**	**5**	**6**	**2**	**4**
Annual Site Budget					
₱700,000	–	1	1	–	1
₱1,000,000	–	1	1	1	–
₱1,200,000	–	1	1	–	1
₱1,266,847	–	1	1	1	–
₱4,726,000	–	1	1	1	–
No. of Cases	–	**5**	**5**	**3**	**2**
Budget Item Including FP					
FP counselor, commodities, training	–	1	1	–	1
Matching grant program	1	–	1	–	1
No. of Cases	**1**	**1**	**2**	–	**1**

Table 63
Distribution of Initiatives Undertaken by Supervisors to Improve the Quality of Health Services, by Type of Health Facility and CPR Performance

Initiatives	Facility		Total	CPR	
	Public	Private		High	Low
Improvement of basic facilities and logistic support	3	4	7	4	3
Linkages with other health institutions	4	2	6	5	1
Marketing and advertisement	–	4	4	–	4
Patient monitoring/program review	4	–	4	1	3
Staff development program	–	4	4	1	3
Conduct of outreach programs	3	–	3	1	2
Staff supervision and evaluation	2	–	2	1	1
Recording and reporting system	1	–	1	–	1
No. of Responses	**17**	**14**	**31**	**13**	**18**
No. of Cases	**13**	**11**	**24**	**12**	**12**

For IEC/counseling materials, both public and private providers have affirmed the usefulness of the following (from most to least useful): sample methods, brochures, flip charts, cue cards, other FP posters, service delivery guides, physical models, Thiart posters, and audiovisual equipment. These materials were reported to be available in most clinics. In terms of nonavailability, the most sought-after in the public sector (32.6%) was audiovisual equipment. Physical models and cue cards were not available in either sector.

To ensure the delivery of quality service, most public and private clinic supervisors employed direct observation and supervision of the FP counselor. Client monitoring and evaluation was also used. The presence of adequate FP supplies would also ensure quality service. Quality was also associated with the amount of time spent with the client. A number of supervisors encouraged counselors to have an efficient work load, particularly in spending more time with their clients, as a gauge of quality FP service provision [see Table 64].

To guarantee a steady supply of FP needs, most supervisors claimed to have a system of inventory in place. For the public clinics, buffer stocks are kept aside from prescheduled supply deliveries based on projected needs to prevent lack of supply. This practice is often based on government policies. Other strategies employed

Table 64
Distribution of Ways of Ensuring Delivery of Quality Service, by Type of Health Facility

Ways of Ensuring Delivery of Quality Service	Facility		Total
	Public	Private	
Program performance monitoring and supervision	7	7	14
Staff development program	7	2	9
Feedback mechanisms	4	3	7
Provision of basic equipment and logistics	3	4	7
Observation of program protocol	1	4	5
Efficient work loading	2	1	3
Recording/reporting system	–	1	1
No. of Responses	**24**	**22**	**46**
No. of Cases	**13**	**11**	**24**

were the adoption of a first-in, first-out system (prevents expiration of stocks) and emergency procurement based on need. In cases where FP supplies were unavailable due to increased demand, clients were advised to buy their own supplies. This practice may have an effect on clients' relationship with the clinic and may discourage follow-up, especially in the public sector where free services and supplies are expected.

Most supervisors claimed not having experienced running out of supplies in recent times. However, when supplies do run out, the effectiveness of counseling and quality of services are affected (e.g., client may not be able to observe birth spacing). This observation is especially true for the public sector in which the major clientele generally cannot afford to buy their own supplies. Hence, there is a need to constantly maintain available stocks. In the last six months, majority of supervisors both from the public and private sectors reported running out of stocks only in the case of pills and condoms. Again, running out of stocks was observed to affect client satisfaction by decreasing clients' FP options, affecting continuity of treatment, and creating the problem of asking clients to buy their own supplies.

In general, the study's findings for management and support system reflect many areas for improvement towards quality FP counseling. Nevertheless, there were many identified effective system and practices that are already present. These should be further developed and maximized if quality FP counseling is to be achieved.

Information System

Information system refers mainly to the process of data collection and recordkeeping in the health facilities. The health service providers and supervisors who were interviewed provided the necessary information as to how their records have been kept and managed, and how the data or pieces of information collected in their respective health facilities have been used.

The providers in both public (9) and private (9) health facilities commonly do individual charting of clients through the Individual Treatment Records (ITR) which are alphabetically arranged and kept in filing cabinets. This recordkeeping system is widely used in high (9) and low (9) CPR areas. The

public providers (12) also use the Field Health Service Information System (FHSIS) and Target Client List (TCL) forms. The data in these forms are usually provided by BHWs. A small number of health facilities also use the Contraceptive Distribution and Logistics Management Information System (CDLMIS) to monitor FP supply and distribution (public = 3, private = 2; high CPR areas = 3, low CPR areas = 2) [see Table 65].

Recordkeeping is done manually in most facilities (28). Only private providers reported access to computer-based recordkeeping (3) [see Table 66].

Various tools/systems are used by health providers in recording and reporting FP services. The most commonly used tools are the FHSIS (16) and FP Form 1 (16). Both public and private providers use these forms to monitor their clients. FP supply and activities are recorded in CDLMIS forms. This tool is used by a few public (5) and private (3) facilities [see Table 67].

The pieces of information collected and recorded by the health providers are mainly used for monitoring FP service delivery (21) and inventory (22). The public facilities also use the information to monitor their FP program (4) [see Table 68].

Table 65
Recording Systems of Health Facilities, by Type of Health Facility and CPR Performance

Recording Systems*	Facility		Total	CPR	
	Public	Private		High	Low
Individual Treatment Records	9	9	18	9	9
FHSIS/Target Client List	12	3	15	8	7
CDLMIS (Logistic Mgt.)	3	2	5	3	2
Dispensary Logbook	2	1	3	1	2
Computer-generated Form	–	3	3	2	1
Community-based Distribution Record	–	1	1	1	–
Non-FP Record	–	1	1	–	1
No. of Responses	**26**	**20**	**46**	**24**	**22**
No. of Cases	**16**	**14**	**30**	**17**	**13**

*Multiple responses were allowed.

Table 66
Recordkeeping Systems of Health Facilities, by Type of Health Facility and CPR Performance

Recordkeeping Systems*	Facility		Total	CPR	
	Public	Private		High	Low
Manual filing	15	13	28	16	12
Computerized database	–	3	3	2	1
No. of Responses	**15**	**16**	**31**	**18**	**13**
No. of Cases	**16**	**14**	**30**	**17**	**13**

*Multiple responses were allowed.

Table 67
Tools Used for FP Service Recording and Reporting, by Type of Health Facility and CPR Performance

Tools*	Facility		Total	CPR	
	Public	Private		High	Low
FP Form 1	7	9	16	10	6
FHSIS	9	7	16	9	7
CDLMIS	5	3	8	4	4
Daily/Weekly/Monthly/Quarterly/Annual Reports	4	3	7	4	3
Saving System Report	–	1	1	1	–
Non-FP Record	–	1	1	1	–
No. of Responses	**25**	**24**	**49**	**29**	**20**
No. of Cases	**16**	**14**	**30**	**17**	**13**

*Multiple responses were allowed.

Table 68
Purpose of FP Data Collected by Tools, by Type of Health Facility and CPR Performance

Purposes*	Facility		Total	CPR	
	Public	Private		High	Low
For logistic inventory	10	12	22	13	9
For FP service delivery	11	10	21	10	11
For program monitoring	4	1	5	5	–
Required by central/head office	–	1	1	–	1
No. of Responses	**25**	**24**	**49**	**28**	**21**
No. of Cases	**13**	**11**	**24**	**12**	**12**

*Multiple responses were allowed.

CHAPTER 5

Physical Environment

The physical environment of the health facility was assessed by examining the respondents' description and expectation of the facility. Their suggestions for improvement were also elicited to determine the gap between the existing and the ideal physical environment. Information was collected from the results of the stakeholders' meeting and from interviews with clients, nonclients, and supervisors.

Clients

The environment of the facilities was positively recognized by the clients, particularly with respect to the physical structure of the clinic. Clients from both private and public facilities (26.70% and 24.40%, respectively) as well as those from high and low CPR areas (25.10% and 26.40%, respectively) highlighted the physical condition of the clinics and the materials the buildings are made of. The buildings are reported to be made of concrete, are well-painted or colorful, and have a good, stable structure. Clients also mentioned other positive attributes of the facilities, such as their having a quiet environment, being surrounded by plants and trees, and having ample space.

Most of the descriptions given by clients are related to the environmental attributes of the clinic or health center (50.00%). They mentioned cleanliness (private = 29.00%, public = 28.70%; high

CPR areas = 28.50%, low CPR areas = 29.20%), orderliness (private = 14.80%, public = 14.80%; high CPR areas = 15.00%, low CPR areas = 14.6%), and absence of foul smell (private = 2.40%, public = 1.60%; high CPR areas = 1.60%, low CPR areas = 2.50%). Private facilities were also commended for having complete facilities and other features such as a playing area for kids and clean comfort rooms with running water supply (10.20%) [see Table 69].

The various features of the health facility that clients liked or disliked include physical structure, facilities, furnishing, equipment, lighting, ventilation, and general environmental attributes. The location and accessibility of the clinic and the availability of the FP methods and IEC materials have also been mentioned by a few clients.

In general, cleanliness and other environmental attributes (43.9%) are the features of the clinics that the clients liked. They also mentioned the comfort that the physical structure provides such as quiet and spacious environment, and air conditioning (private = 27.00%, public = 16.90%; high CPR areas = 19.10%, low CPR areas = 25.10%). There are more clients from the private facilities and high CPR areas who claimed that they liked the facilities because they are complete and there are rooms designated for FP service provision (private = 12.50%, high CPR areas = 13.80%). In contract, more clients from the public facilities and low CPR areas liked the facilities because they are well-ventilated and water supply and electricity are available (public = 13.10%, low CPR areas = 10.40%) [see Table 70].

Most of the respondents in all client categories (80.50%) disliked the facilities' structure as they are poorly maintained. Many clients, particularly those from private facilities and low CPR areas, expressed dislike for the warm atmosphere inside the building (77.20% and 70.40%, respectively), while a few clients from high CPR areas and public facilities expressed dislike for the lack of space. The inadequacies of the public facilities mentioned by the clients are due to insufficient furnishing (6.70%), lack of water supply (2.80%), dirty comfort room (5.00%), poor ventilation (1.10%), disorganized clinic (3.90%), and lack of privacy (2.80%). In comparison, clients from private facilities mentioned insufficient furnishing (4.90%), poor ventilation (1.60%), disorganized clinic (2.40%), and dirty comfort room (1.60%) [see Table 71].

Clients expected and wanted the clinic environment to be more spacious (14.40%). They also wanted the clinic to have a good building structure (public = 3.90%, private = 5.00%; high CPR

Table 69
Clients' Description of the Clinic Environment, by Type of Health Facility and CPR Performance (In Percent)

Clients' Description	Facility		Total	CPR	
	Private	Public		High	Low
I. Physical Structure					
Spacious	5.10	5.90	5.50	6.00	5.10
Good building structure	5.40	4.60	5.10	4.40	5.70
Cool environment	5.40	4.30	4.90	4.40	5.40
Not spacious	4.20	5.30	4.70	5.60	3.80
Painted	4.20	2.00	3.20	4.40	1.90
Surrounded by trees	1.80	4.00	2.80	1.60	4.10
Quiet environment	2.40	1.60	2.10	1.20	2.90
Uncomfortable environment	0.90	1.30	1.10	1.60	0.60
Concrete	0.90	1.00	1.00	1.60	0.30
Pleasant to the eyes	0.90	0.70	0.80	0.60	1.00
Colorful	0.60	0.30	0.50	0.90	–
Noisy environment	–	0.70	0.30	–	0.60
Subtotal Responses	**32.00**	**31.70**	**31.90**	**32.30**	**31.40**
II. Location and Accessibility					
Strategic location	1.20	0.30	0.80	0.60	1.00
Convenient trips	0.60	0.70	0.60	1.20	–
Accessible	0.60	0.70	0.60	0.90	0.30
Near business center	–	0.30	0.20	–	0.30
Subtotal Responses	**2.40**	**2.00**	**2.20**	**2.80**	**1.60**
III. Facilities					
With complete facilities	7.20	4.60	6.00	6.60	5.40
With clean comfort room (CR) and with water	1.20	1.60	1.40	0.60	2.20
With designated play area	1.80	–	1.00	1.60	0.30
No designated FP room	0.30	0.70	0.50	0.60	0.30
Subtotal Responses	**10.60**	**6.90**	**8.80**	**9.40**	**8.20**
IV. Furnishing and Equipment /IEC Materials					
Provides clients with IEC materials	3.30	4.00	3.60	4.10	3.20
Not enough furnishing	0.90	2.30	1.60	1.60	1.60
With furnishing	0.60	2.30	1.40	0.90	1.90
With audiovisual facilities	0.30	0.70	0.50	0.60	0.30
Subtotal Responses	**5.10**	**9.30**	**7.10**	**7.20**	**7.00**
V. Environment Attributes					
Clean	29.00	28.70	28.90	28.50	29.20
Orderly	14.80	14.80	14.80	15.00	14.60
No foul smell	2.40	1.60	2.10	1.60	2.50
Crowded	1.50	2.00	1.70	1.90	1.60
Disorganized	0.60	1.30	1.00	0.90	1.00
No privacy	0.90	0.70	0.80	–	1.60
Organized flow of activities	0.30	0.70	0.50	–	1.00
Untidy	0.30	0.30	0.30	0.30	0.30
Subtotal Responses	**49.80**	**50.20**	**50.00**	**48.30**	**51.80**
No. of Responses	**331**	**303**	**634**	**319**	**315**

Table 70
Aspects Liked by Clients in the Clinic Environment, by Type of Health Facility and CPR Performance (In Percent)

Aspects Liked by Clients	Facility		Total	CPR	
	Private	Public		High	Low
I. Physical Structure					
Air-conditioned	8.00	2.70	5.60	4.40	6.60
Comfortable clinic environment	5.70	4.10	5.00	5.30	4.60
Spacious	4.20	4.50	4.30	4.40	4.20
With trees and plants around	1.50	3.20	2.30	1.30	3.10
Quiet environment	2.70	1.40	2.10	0.90	3.10
Pleasant to the eyes	3.40	0.50	2.10	1.80	2.30
Rooms painted in different colors	1.50	0.50	1.00	0.90	1.20
Subtotal Responses	**27.00**	**16.90**	**22.30**	**19.10**	**25.10**
II. Facilities					
With complete facilities	6.10	6.80	6.40	7.60	5.40
With designated room for FP	3.40	2.30	2.90	3.10	2.70
With play area	2.70	1.80	2.30	3.10	1.50
With parking area	0.40	–	0.20	–	0.40
Subtotal Responses	**12.50**	**10.90**	**11.80**	**13.80**	**10.00**
III. Furnishing and Equipment/IEC Materials					
With enough furnishing	2.30	3.60	2.90	3.60	2.30
IEC materials available	3.40	2.30	2.90	3.10	2.70
With audiovisual facilities	0.80	–	0.40	–	0.80
Subtotal Responses	**6.50**	**5.90**	**6.20**	**6.70**	**5.80**
IV. Lighting, Ventilation, and Utilities					
With water	4.50	5.50	5.00	2.20	7.30
Well-ventilated	1.50	5.80	3.50	4.90	2.30
With electricity	0.40	1.80	1.00	1.30	0.80
Subtotal Responses	**6.40**	**13.10**	**9.50**	**8.40**	**10.40**
V. Environment Attributes					
Clean	28.00	31.80	29.80	31.60	28.20
Orderly	14.40	15.00	14.70	14.70	14.70
No foul smell	1.50	1.80	1.60	1.30	1.90
Subtotal Responses	**43.90**	**48.60**	**46.10**	**47.60**	**44.80**
VI. Location and Accessibility					
Accessible	3.00	3.60	3.30	4.00	2.70
VII. Availability and Affordability of FP Methods					
Affordable service fees	0.40	0.50	0.40	–	0.80
FP methods available	–	0.50	0.20	–	0.40
Subtotal Responses	**0.40**	**1.00**	**0.60**	**–**	**1.20**
No. of Responses	**264**	**220**	**484**	**225**	**259**

Table 71
Aspects Disliked by Clients in the Clinic Environment, by Type of Health Facility and CPR Performance (In Percent)

Aspects Disliked by Clients	Facility		Total	CPR	
	Private	Public		High	Low
I. Physical Structure					
Warm/high room temperature	77.20	58.70	66.20	62.90	70.40
Lack of space	8.90	10.60	9.90	12.00	7.40
Poorly maintained building	–	5.00	3.00	4.80	0.70
Occupationally hazardous building	1.60	1.10	1.30	0.60	2.20
Subtotal Responses	**87.80**	**75.40**	**80.50**	**80.20**	**80.70**
II. Furnishing and Equipment/Facilities					
Insufficient furnishing	4.90	6.70	6.00	6.00	5.90
Dirty comfort room (CR)	1.60	5.00	3.60	3.00	4.40
Old equipment	0.80	0.60	0.70	0.60	0.70
Subtotal Responses	**7.30**	**12.30**	**9.80**	**9.60**	**11.10**
III. Lighting, Ventilation, and Utilities					
No water	–	2.80	1.70	1.80	1.50
Poor ventilation	1.60	1.10	1.30	1.80	0.70
Subtotal Responses	**1.60**	**3.90**	**3.00**	**3.60**	**2.20**
IV. Environment Attributes					
Disorganized clinic	2.40	3.90	3.30	3.00	3.70
No privacy	0.80	2.80	2.00	2.40	1.50
Noisy	–	1.70	1.00	1.20	0.70
Subtotal Responses	**3.20**	**8.40**	**6.30**	**6.60**	**5.90**
No. of Responses	**132**	**207**	**339**	**186**	**153**

areas = 4.3%, low CPR areas = 4.6%), air conditioning (public = 2.8%, private = 6.6%; high CPR areas = 5.9%, low CPR areas = 3.4%), complete facilities and equipment (public = 14.0%, private = 11.3%; high CPR areas = 11.8%, low CPR areas = 13.5%), good ventilation (public = 5.0%, private = 6.3%; high CPR areas = 4.8%, low CPR areas = 6.6%), and furnishing (public = 5.3%, private = 2.8%; high CPR areas = 4.3%, low CPR areas = 3.7%). More than one out of four clients wanted a clean, orderly, and spacious clinic (public = 26.6%, private = 30.0%; high CPR areas = 25.8%, low CPR areas = 31.1%) [see Table 72].

The most frequently cited suggestion for improvement by the clients involved the physical structure of the building (36.7%) and the facilities within the clinic/health center (22.25%). Most of the clients suggested the improvement/expansion of the building in

Table 72
Clients' Expectations of the Clinic Environment, by Type of Health Facility and CPR Performance (In Percent)

Clients' Expectations	Facility		Total	CPR	
	Private	Public		High	Low
I. Physical Structure					
Spacious	14.00	14.80	14.40	17.20	11.50
Air-conditioned	6.60	2.80	4.70	5.90	3.40
Good building structure	5.00	3.90	4.40	4.30	4.60
With plants around the clinic	1.90	4.20	3.10	2.40	3.70
Rooms should be painted	3.30	2.20	2.80	2.70	2.90
Quiet environment	1.90	1.10	1.50	1.10	2.00
Concrete structure	–	0.80	0.40	–	0.90
With parking space	0.30	0.30	0.30	0.30	0.30
One floor only	0.30	0.30	0.30	0.50	–
With curtain	–	0.30	0.10	–	0.30
No big trees	–	0.30	0.10	0.30	–
Subtotal Responses	**33.30**	**31.00**	**32.10**	**34.70**	**29.60**
II. Location and Accessibility					
Accessible	2.20	1.70	1.90	1.60	2.30
Good location	1.10	0.60	0.80	0.80	0.90
Far from PUV terminal	0.30	0.60	0.40	–	0.90
Subtotal Responses	**3.60**	**2.80**	**3.20**	**2.40**	**4.00**
III. Facilities					
With designated room for counseling	1.10	5.00	3.10	3.20	2.90
With audiovisual facilities	1.70	0.60	1.10	1.60	0.60
With clean comfort room (CR)	0.80	1.10	1.00	1.30	0.60
With play area	1.90	–	1.00	1.30	0.60
With ancillary services	1.10	0.30	0.70	0.50	0.90
Subtotal Responses	**6.60**	**7.00**	**6.90**	**7.90**	**5.60**
IV. Furnishing, Equipment, and Supplies/IEC Materials					
Complete facilities and equipment	11.30	14.00	12.60	11.80	13.50
With furnishing	2.80	5.30	4.00	4.30	3.70
With IEC materials	1.70	2.20	1.90	1.90	2.00
With available supplies	0.60	2.20	1.40	1.30	1.40
With new equipment	0.80	0.60	0.70	1.10	0.30
With computer	0.60	0.30	0.40	0.50	0.30
Subtotal Responses	**17.80**	**24.60**	**21.00**	**20.90**	**21.20**
V. Lighting, Ventilation, and Utilities					
Good ventilation	6.30	5.00	5.70	4.80	6.60
With water and electricity	0.80	2.20	1.50	1.90	1.10
Well-lighted rooms	1.70	0.30	1.00	1.30	0.60
Subtotal Responses	**8.80**	**7.50**	**8.20**	**8.00**	**8.30**
VI. Other Attributes					
Clean	21.80	19.60	20.70	18.00	23.60
Orderly	6.30	6.40	6.40	6.40	6.30
Not crowded	1.90	0.30	1.10	1.10	1.20
High volume of clients	–	0.30	0.10	0.30	–
Subtotal Responses	**30.00**	**26.60**	**28.30**	**25.80**	**31.10**
No. of Responses	**363**	**358**	**721**	**373**	**348**

order to come up with a room to ensure privacy in the clinic (public = 33.0%, private = 36.5%; high CPR areas = 39.4%, low CPR areas = 33.9%) and upgrading the facilities (public = 19.4%, private = 16.0%; high CPR areas = 17.0%, low CPR areas = 19.0%). A few also suggested assigning a room for counseling (public = 3.9%, private = 2.6%; high CPR areas = 3.2%, low CPR areas = 3.4%) and installing air conditioner in the clinic (public = 3.9%, private = 3.8%; high CPR areas = 4.8%, low CPR areas = 2.9%) [see Table 73].

Nonclients

The nonclient respondents also provided a more positive image of the health facilities. They described the physical structure as good, spacious, painted, and surrounded by trees (public = 24.0%, private = 27.6%; high CPR areas = 27.3%, low CPR areas = 24.3%). The facilities have clean toilets, complete with water, and also have audiovisual facilities (public = 7.4%, private = 5.5%; high CPR areas = 9.1%, low CPR areas = 3.8%). Another significant attribute mentioned by the nonclients was cleanliness (public = 28.9%, private = 28.0%; high CPR areas = 27.7%, low CPR areas = 29.1%) [see Table 74].

What nonclients favored most about the facilities were the cleanliness (public = 42.53%, private = 33.64%; high CPR areas = 36.68%, low CPR areas = 38.62%) and orderliness (public = 13.22%, private = 14.95%; high CPR areas = 17.09%, low CPR areas = 11.11%) of the clinic. The nonclients also liked the spaciousness of the clinic (public = 4.02%, private = 4.21%; high CPR areas = 4.52%, low CPR areas = 3.7%) and the comfortable clinic environment (public = 3.45%, private = 6.54%; high CPR areas = 3.02%, low CPR areas = 7.41%). They also liked the completeness of the facilities (public = 5.75%, private = 4.21%; high CPR areas = 4.02%, low CPR areas = 5.82%). A few were also happy with the location of the clinic (public = 6.9%, private = 5.14%; high CPR areas = 4.52%, low CPR areas = 7.41%) [see Table 75].

The nonclients reported the lack of space was something they disliked about the clinic environment (public = 16.43%, private = 10.71%; high CPR areas = 13.57%, low CPR areas = 13.57%). They also mentioned other attributes of the clinic environment such as its being disorganized, dirty, foul-smelling, and noisy

Table 73
Clients' Suggestions for Improvement of the Clinic Environment, by Type of Health Facility and CPR Performance (In Percent)

Clients' Suggestions	Facility		Total	CPR	
	Private	Public		High	Low
I. Physical Structure and Environment					
Widening or improvement of building	36.50	33.00	34.50	36.20	32.80
Plant trees around clinic	1.90	0.50	1.10	1.10	1.10
Separate or own building	1.30	0.50	0.80	1.60	–
One floor only	–	0.50	0.30	0.50	–
Subtotal Responses	**39.70**	**34.50**	**36.70**	**39.40**	**33.90**
II. Location and Accessibility					
Change clinic location	5.10	1.00	2.80	3.70	1.70
III. Facilities					
Upgrade facilities	16.00	19.40	18.00	17.00	19.00
Assign room for counseling	2.60	3.90	3.30	3.20	3.40
Assign play area	0.60	0.50	0.65	1.10	–
With operating room for surgical methods	0.60	–	0.30	0.60	–
Subtotal Responses	**19.80**	**23.80**	**22.25**	**21.90**	**22.40**
IV. Furnishing, Equipment, and Supplies/IEC Materials					
Install air conditioner	3.80	3.90	3.90	4.80	2.90
Provide audiovisual equipment	1.90	1.00	1.40	2.10	0.60
Make IEC materials available	1.90	–	0.80	–	1.70
Install telephone	0.60	0.50	0.60	1.10	–
Subtotal Responses	**8.20**	**5.40**	**6.70**	**8.00**	**5.20**
V. Lighting, Ventilation, and Utilities					
Install water supply and electricity	1.30	3.40	2.50	1.6	3.4
Improve room ventilation	0.60	1.90	1.40	1.6	1.1
Improve lighting	0.60	–	0.30	–	0.6
Subtotal Responses	**2.50**	**5.30**	**4.20**	**3.2**	**5.1**
VI. Maintenance					
Hire janitorial services	–	1.00	0.60	–	1.10
No. of Responses	**156**	**206**	**362**	**188**	**174**

(public = 8.57%, private = 5.71%; high CPR areas = 7.15%, low CPR areas = 7.13%) [see Table 76].

The expectations of nonclient respondents focused on the cleanliness and orderliness of the clinic (public = 28.58%, private = 27.75%; high CPR areas = 27.25%, low CPR areas = 28.92%), completeness of facilities and amenities/equipment (public = 12.10%, private = 14.00%; high CPR areas = 15.50%, low

Table 74
Nonclients' Description of the Clinic Environment, by Type of Health Facility and CPR Performance (In Percent)

Nonclients' Description	Facility		Total	CPR	
	Private	Public		High	Low
I. Physical Structure					
Spacious	6.91	7.50	7.19	8.56	5.82
Not spacious	7.24	7.14	7.19	4.11	10.27
Good building structure	7.24	6.79	7.02	4.45	9.59
Cool environment	4.28	2.50	3.42	3.77	3.08
Concrete	4.28	1.43	2.91	5.14	0.68
Painted	2.30	1.79	2.05	3.42	0.68
Surrounded by trees	0.99	3.21	2.05	1.03	3.08
Colorful	0.99	0.36	0.68	0.68	0.68
Quiet environment	0.33	0.36	0.34	0.34	0.34
Pleasant to the eyes	0.33	–	0.17	–	0.34
Subtotal Responses	**34.89**	**31.08**	**33.02**	**31.50**	**34.56**
II. Location and Accessibility					
Accessible	0.66	1.43	1.03	1.03	1.03
Convenient trips	0.99	0.36	0.68	0.34	1.03
Strategic location	0.66	0.71	0.68	0.34	1.03
Subtotal Responses	**2.31**	**2.50**	**2.39**	**1.71**	**3.09**
III. Facilities					
With complete facilities	4.61	4.64	4.62	6.85	2.40
With clean comfort room (CR) and with water	0.33	2.14	1.20	1.03	1.37
No designated FP room	1.32	0.71	1.03	1.03	1.03
With audiovisual facility	0.33	0.71	0.51	1.03	–
With designated play area	0.33	–	0.17	0.34	–
Subtotal Responses	**6.92**	**8.20**	**7.53**	**10.28**	**4.80**
IV. Furnishing and Equipment/IEC Materials					
Provides clients with IEC materials	3.95	4.64	4.28	5.14	3.42
With furnishing	1.97	4.64	3.25	2.05	4.45
Not enough furnishing	1.97	0.71	1.37	1.03	1.71
Subtotal Responses	**7.89**	**9.99**	**8.90**	**8.22**	**9.58**
V. Service Attributes					
Clean	27.96	28.93	28.42	27.74	29.11
Orderly	12.50	12.14	12.33	13.36	11.30
Crowded	3.95	2.86	3.42	3.08	3.77
Uncomfortable environment	0.99	2.14	1.54	1.71	1.37
Privacy	0.33	0.71	0.51	0.68	0.34
Untidy	0.66	0.36	0.51	0.68	0.34
Disorganized clinic	0.33	0.71	0.51	–	1.03
No foul smell	0.66	0.36	0.51	0.68	0.34
Noisy environment	0.66	–	0.34	0.34	0.34
Subtotal Responses	**48.04**	**48.21**	**48.09**	**48.27**	**47.94**
No. of Responses	**304**	**280**	**584**	**292**	**292**

Table 75
Aspects Liked by Nonclients in the Clinic Environment, by Type of Health Facility and CPR Performance (In Percent)

Aspects Liked by Nonclients	Facility		Total	CPR	
	Private	Public		High	Low
I. Physical Structure					
Comfortable clinic environment	6.54	3.45	5.15	3.02	7.41
Air-conditioned	2.80	1.15	2.06	3.52	0.53
Spacious	4.21	4.02	4.12	4.52	3.70
Quiet environment	–	1.72	0.77	0.50	1.06
Rooms painted in different colors	1.87	1.15	1.55	2.01	1.06
Pleasant to the eyes	1.40	1.15	1.29	1.51	1.06
With trees and plants around	1.87	5.17	3.35	3.02	3.70
With parking area	–	0.57	0.26	0.50	–
Subtotal Responses	**18.69**	**18.38**	**18.55**	**18.60**	**18.52**
II. Facilities					
With complete facilities	4.21	5.75	4.90	4.02	5.82
With designated room for FP	5.14	1.72	3.61	4.52	2.65
With comfort room (CR) and water	0.93	1.15	1.03	1.51	0.53
With audiovisual facilities	1.40	0.57	1.03	1.01	1.06
With play area	0.47	0.57	0.52	1.01	–
Subtotal Responses	**12.15**	**9.76**	**11.09**	**12.07**	**10.06**
III. Furnishing and Equipment					
With enough furnishing	2.80	2.30	2.58	1.51	3.70
IV. Lighting, Ventilation, and Utilities					
Well-ventilated	0.93	3.45	2.06	0.50	3.70
With electricity	–	0.57	0.26	0.50	–
Subtotal Responses	**0.93**	**4.02**	**2.32**	**1.00**	**3.70**
V. Other Attributes					
Clean	33.64	42.53	37.63	36.68	38.62
Orderly	14.95	13.22	14.18	17.09	11.11
No foul smell	1.87	0.57	1.29	1.51	1.06
Subtotal Responses	**50.46**	**56.32**	**53.10**	**55.28**	**50.79**
VI. Location and Accessibility					
Accessible	5.14	6.90	5.93	4.52	7.41
No. of Responses	**214**	**174**	**388**	**199**	**189**

CPR areas = 11.00%), and the availability of furnishing (public = 5.90%, private = 3.60%; high CPR areas = 2.50%, low CPR areas = 6.60%). Other nonclients from public facilities and high CPR areas want a designated room for counseling in the clinic (3.40% and 4.60%, respectively), while a few from private facilities

Table 76
Aspects Disliked by Nonclients in the Clinic Environment, by Type of Health Facility and CPR Performance (In Percent)

Aspects Disliked by Nonclients	Facility		Total	CPR	
	Private	Public		High	Low
I. Physical Structure					
Lack of space	10.71	16.43	13.57	13.57	13.57
Uncomfortable environment	2.86	4.29	3.57	3.57	3.57
Poorly maintained building	0.71	4.29	2.50	2.86	2.14
Occupationally hazardous building	0.71	2.86	1.79	1.43	2.14
No plants	–	0.71	0.36	–	0.71
Subtotal Responses	**14.99**	**28.58**	**21.79**	**21.43**	**22.13**
II. Furnishing and Equipment					
Old equipment	1.43	2.14	1.79	2.86	0.71
Insufficient furnishing	1.43	1.43	1.43	0.71	2.14
Subtotal Responses	**2.86**	**3.57**	**3.22**	**3.57**	**2.85**
III. Facilities					
Partially complete comfort room (CR)	–	0.71	0.36	–	0.71
No waiting area	0.71	–	0.36	–	0.71
Subtotal Responses	**0.71**	**0.71**	**0.72**	**–**	**1.42**
IV. Ventilation					
Poor ventilation	–	2.14	1.07	–	2.14
V. Location and Accessibility					
Inaccessible	–	1.43	0.71	–	1.43
Poor location	–	0.71	0.36	–	0.71
Near PUV terminal	–	0.71	0.36	–	0.71
Subtotal Responses	**–**	**2.85**	**1.43**	**–**	**2.85**
VI. Other Attributes					
Dirty	3.57	4.29	3.93	4.29	3.57
Noisy	2.14	1.43	1.79	1.43	2.14
Disorganized	–	2.14	1.07	1.43	0.71
With foul smell	–	0.71	0.36	–	0.71
Subtotal Responses	**5.71**	**8.57**	**7.15**	**7.15**	**7.13**
No. of Responses	**140**	**140**	**280**	**140**	**140**

and low CPR areas expect good ventilation in the clinic (5.00% and 6.10%, respectively) [see Table 77].

To improve the facilities, most nonclients suggested widening or improving the physical structure of the building (public = 36.65%, private = 32.95%; high CPR areas = 35.15%, low CPR areas = 34.65%) and upgrading the facilities (public = 20.94%, private = 21.02%; high CPR areas = 23.64%, low CPR areas = 18.81%). The nonclients also

Table 77
Nonclients' Expectations of the Clinic Environment, by Type of Health Facility and CPR Performance (In Percent)

Nonclients' Expectations	Facility		Total	CPR	
	Private	Public		High	Low
I. Physical Structure					
Spacious	16.76	18.32	17.49	17.96	17.08
Air-conditioned	4.95	4.35	4.66	6.50	3.03
Good building structure	3.30	4.66	3.94	2.79	4.96
With plants around the clinic	2.47	3.73	3.06	2.17	3.86
Rooms should be painted	1.92	1.86	1.90	3.10	0.83
Quiet environment	1.10	0.93	1.02	0.93	1.10
With curtain	0.27	0.62	0.44	0.93	–
One floor only	0.27	0.31	0.29	–	0.55
Concrete structure	0.27	0.31	0.29	0.62	–
Subtotal Responses	**31.31**	**35.09**	**33.09**	**35.00**	**31.41**
II. Location and Accessibility					
Accessible	1.65	0.93	1.31	1.55	1.10
Good location	1.65	0.93	1.31	0.31	2.20
Subtotal Responses	**3.30**	**1.86**	**2.62**	**1.86**	**3.30**
III. Facilities					
With designated room for counseling	2.75	3.42	3.06	4.64	1.65
With clean comfort room (CR)	1.92	2.17	2.04	2.17	1.93
With audiovisual facilities	1.10	0.62	0.87	0.93	0.83
With play area	0.82	0.62	0.73	1.24	0.28
Subtotal Responses	**6.59**	**6.83**	**6.70**	**8.98**	**4.69**
IV. Furnishing, Equipment, and Supplies/IEC Materials					
Complete facilities and equipment	14.01	12.11	13.12	15.48	11.02
With furnishing	3.57	5.90	4.66	2.48	6.61
With available supplies	2.47	2.80	2.62	1.55	3.58
With IEC materials	1.37	1.55	1.46	2.17	0.83
With new equipment	–	0.31	0.15	0.31	–
With computer	0.27	–	0.15	0.31	–
Subtotal Responses	**21.69**	**22.67**	**22.16**	**22.30**	**22.04**
V. Lighting, Ventilation, and Utilities					
Good ventilation	4.95	4.35	4.66	3.10	6.06
With water and electricity	1.37	0.31	0.87	0.31	1.38
Well-lighted rooms	1.10	–	0.58	0.93	0.28
Subtotal Responses	**7.42**	**4.66**	**6.11**	**4.34**	**7.72**
VI. Other Attributes					
Clean	19.78	20.19	19.97	18.58	21.21
Orderly	7.97	8.39	8.16	8.67	7.71
Not crowded	0.82	–	0.44	–	0.83
High volume of clients	0.27	–	0.15	0.31	–
Subtotal Responses	**28.84**	**28.58**	**28.72**	**27.56**	**29.75**
No. of Responses	**364**	**322**	**686**	**323**	**363**

suggested installing water and lighting facilities as well as improving ventilation (public = 4.18%, private = 4.54%; high CPR areas = 3.63%, low CPR areas = 4.96%) which are essential in improving service provision [see Table 78].

Table 78
Nonclients' Suggestions for Improvement of the Clinic Environment, by Type of Health Facility and CPR Performance (In Percent)

Nonclients' Suggestions	Facility		Total	CPR	
	Private	Public		High	Low
I. Physical Structure and Environment					
Widening or improvement of building	32.95	36.65	34.88	35.15	34.65
One floor only	0.57	2.09	1.36	0.61	1.98
Plant trees around the clinic	0.57	1.05	0.82	0.61	0.99
Subtotal Responses	**34.09**	**39.79**	**37.06**	**36.37**	**37.62**
II. Location and Accessibility					
Change clinic location	2.84	3.14	3.00	3.03	2.97
III. Facilities					
Upgrade facilities	21.02	20.94	20.98	23.64	18.81
Assign room for counseling	1.70	2.09	1.91	1.82	1.98
Assign play area	–	1.05	0.54	1.21	–
With operating room for surgical methods	0.57	–	0.27	–	0.50
Subtotal Responses	**23.29**	**24.08**	**23.70**	**26.67**	**21.29**
IV. Furnishing, Equipment, and Supplies/IEC Materials					
Install air conditioner	5.68	6.28	5.99	7.88	4.46
Provide audiovisual equipment	0.57	1.57	1.09	1.21	0.99
Make IEC materials available	–	1.05	0.54	1.21	–
Install telephone	–	0.52	0.27	–	0.50
Subtotal Responses	**6.25**	**9.42**	**7.89**	**10.30**	**5.95**
V. Lighting, Ventilation, and Utilities					
Install water supply and electricity	1.70	2.09	1.91	1.21	2.48
Improve room ventilation	2.27	1.57	1.91	1.21	2.48
Improve lighting	0.57	0.52	0.54	1.21	–
Subtotal Responses	**4.54**	**4.18**	**4.36**	**3.63**	**4.96**
VI. Maintenance					
Hire janitorial services	–	0.52	0.27	0.61	–
No. of Responses	**176**	**191**	**367**	**165**	**202**

Supervisors

From the point of view of the supervisors, the waiting room is favorable since it has the basic furniture (16 out of 22) needed to make clients comfortable while waiting for their turn. Specifically, supervisors from private clinics reported the availability of other amenities like TV (two out of 10), brochure racks, and colorful chairs (seven out of 10). All of the private facilities and most of those from high CPR areas also have adequate supply of IEC materials displayed in the waiting area while only six out of 13 public health centers and five out of 10 of the facilities in low CPR areas have enough IEC materials. Some supervisors gave negative comments about the waiting room such as the limited waiting area (public = two out of 13 and low CPR areas = three out of 12), not being well-maintained (public = two out of 12), and dirty (public = two out of 12 and high CPR areas = two out of 12) [see Table 79].

The supervisors from private facilities and high CPR areas made a more positive description of their counseling room: the room greatly provided auditory and visual privacy during CPI (six out of 10 and six out of 12, respectively). In some private facilities, audiovisual equipment are available for use during counseling sessions (three out of 10). In contrast, supervisors from public facilities reported that their clinics have no counseling room (five out of 12); meanwhile, a curtain provides a semblance of privacy in three others [see Table 80].

According to some of the providers, they have more than one examining room (public = two out of 13, private = two out of 11; high CPR areas = three out of 12, low CPR areas = one out of 12), with complete facilities/equipment (public = three out of 13, private = one out of 11; high CPR areas = two out of 12, low CPR areas = two out of 12) and provided privacy (public = four out of 13, private = four out of 11; high CPR areas = three out of 12, low CPR areas = five out of 12). Supervisors from private facilities and high CPR areas described their clinics as clean (seven out of 11 and seven out of 12, respectively) and orderly (five out of 11 and six out of 12, respectively). In two out of 13 public facilities, the examining room also served other purposes such as being a kitchen and storage place as well as a counseling room for clients. The examining room in some public facilities is described as lacking privacy (two out of 13), dirty (three out of 13), and small (three out of 13) [see Table 81].

Table 79
Supervisors' Description of Waiting Room,
by Type of Health Facility and CPR Performance

Supervisors' Description	Facility		Total	CPR	
	Public	Private		High	Low
I. Furnishing, Equipment, and Instruments					
Have basic furniture	9	7	16	8	8
With audiovisual facilities	–	2	2	1	1
Not enough furnishings	3	1	4	1	3
II. IEC Materials					
Have available IEC materials	6	11	17	12	5
Lack IEC materials	7	–	7	5	2
III. Lighting and Ventilation					
Poor ventilation	2	–	2	–	2
Not well-lighted	–	1	1	1	–
IV. Space					
Limited space	2	2	4	1	3
Spacious	1	1	2	2	0
V. Physical Facilities					
Well-equipped/complete facilities	1	2	3	2	1
Comfort room (CR) not functioning well	1	–	1	1	–
VI. Attributes					
Clean	8	7	15	7	8
Orderly	2	3	5	2	3
Comfortable	1	1	2	1	1
Not well-maintained/old building structure	2	–	2	1	1
Dirty	2	–	2	2	–
Attractive surroundings	–	1	1	–	1
Disorganized	1	–	1	1	–
No. of Responses	**49**	**42**	**91**	**40**	**51**

Outcome of the Stakeholders' Meeting

Findings from the stakeholders' meeting revealed that the physical environment is critical in providing quality FP counseling. In the three areas of Luzon, Visayas, and Mindanao, the performance gap in FP counseling is the absence of auditory and visual privacy during counseling sessions, basically attributed to the lack of a counseling room in many centers/clinics. In Visayas and Mindanao, the participants suggested looking for available funds to add another room for counseling use only; while in Luzon, the

Table 80
Supervisors' Description of Counseling Room, by Type of Health Facility and CPR Performance

Supervisors' Description	Facility		Total	CPR	
	Public	Private		High	Low
I. Existing Counseling Room					
No counseling room	5	–	5	2	3
Doctor's office doubles as counseling room	1	2	3	2	1
Makeshift room	2	1	3	2	1
Uses living room as counseling room	–	1	1	1	–
II. Privacy					
With privacy	3	6	9	6	3
No/less privacy	3	–	3	2	1
III. Furnishing and Equipment					
Has audiovisual equipment	–	3	3	2	1
Has couch	–	1	1	–	1
Has an overhead projector	–	1	1	–	1
IV. Lighting					
Insufficient lighting	1	–	1	1	–
V. IEC Materials					
Available IEC materials	2	1	3	1	2
VI. Attributes of Counseling Room					
Comfortable	–	2	2	–	2
Clean	–	2	2	1	1
Spacious	1	1	2	1	1
Cool environment	–	1	1	–	1
Dirty	1	–	1	1	–
No. of Responses	**19**	**22**	**41**	**21**	**20**

proposed solution was to rearrange the clinic facility to allow the provision of a space for counseling purposes. The lack of materials and supplies for FP services, such as audiovisual aids (flip charts, posters, and models), IEC materials, and FP commodities for use during counseling, has been identified as another drawback to providing FP counseling. The participants suggested mobilization of other sources of funds to acquire the needed supplies and materials.

Table 81
Supervisors' Description of Facility's Examining Room, by Type of Health Facility and CPR Performance

Supervisors' Description	Facility		Total	CPR	
	Public	Private		High	Low
I. Existing Examining Room					
With more than one examining room	2	2	4	3	1
Doctor's office serves as examining room	–	1	1	–	1
Examining room serves as storage and kitchen	1	–	1	–	1
Counseling room is also the examining room	1	–	1	1	–
II. Privacy					
Has privacy	4	4	8	3	5
No/less privacy	2	–	2	–	2
III. Furnishing, Equipment, and Instruments					
Complete facilities/equipment	3	1	4	2	2
Colorful furnishing	–	1	1	1	0
Old equipment	1	–	1	1	0
IV. IEC Materials					
Complete IEC materials	–	1	1	–	1
V. Lighting and Ventilation					
Poor ventilation and lighting	1	–	1	1	–
VI. Attributes					
Clean	2	7	9	7	2
Orderly	2	5	7	6	1
Dirty	3	–	3	2	1
Small	3	–	3	1	2
Good	1	–	1	–	1
Disorganized	1	–	1	–	1
Dilapidated	1	–	1	–	1
No. of Responses	**28**	**22**	**50**	**28**	**22**

CHAPTER 6

Concluding Remarks and Recommendations

The following conclusions may be drawn from the results of this study:

1. FP is generally demand-driven. Clients' FP behavior is based on a rational and informed choice. FP clients and potential clients clearly articulate their expectations specifying what they seek from the service providers, health centers, and private clinics.
2. Clients of private clinics are very distinct from those of public health facilities. Private clinics serve older, highly educated, and gainfully employed women and/or husbands. City/rural health centers cater to younger, moderately educated, and unemployed women and/or husbands. There is not much difference between the characteristics of potential clients or nonclients of public health centers and those of the private clinics.
3. Unlike in the past years, the quality of FP services currently provided by private clinics is more distinct from that provided by public health centers. This distinction is demonstrated in the attributes (specifically in terms of the regularity and accessibility of FP services), physical structure, facilities, and amenities of clinics/centers, with private clinics demonstrating a higher level of readiness in providing quality health services. Thus, private clinics enjoy a much more advantaged position than public health centers.

Increased private sector participation in the FP service provision seems to have started to take off steadily in areas covered by this study.

4. Clients of private clinics sought more effective and permanent FP methods while those of the public health facilities availed of varying types, from pills and DMPA to condoms and natural FP method. FP counseling in private clinics is provided mainly by clinical workers while in the public health facilities, such is given by both clinical and motivational workers.
5. In general, differences are not clearly demonstrated in the quality of FP counseling being provided in both public and private health facilities. Moreover, expectations of both clients and potential clients did not also vary considerably. FP users in both public and private facilities articulate desired experiences and expectations that address the quality areas on interpersonal relationship skills, cognitive skills, and technical competency in giving complete and accurate information about FP. Clients seem more biased toward counselors who are confident and competent in FP service provision. Potential clients generally put emphasis on better interpersonal relationship skills and technical competency in information-giving. Although more biased towards interpersonal relationship skills, clients also expressed preference for a counselor who is confident in providing adequate information about FP.
6. Demand-driven behavior and rights-based orientation in FP service provision seem quite farfetched from the perspective of clients, potential clients, and other stakeholders. Current views of clients and nonclients regarding the ideal behavior of a client and an ideal FP counseling session seem to be directed more to better treatment or accommodation of clients and less with regard to active participation in the counseling process and CPI situation. Although the asking of questions and the seeking of clarification from the provider were reported, this type of response is not common as compared to answers such as being respectful, being good listeners, and behaving well in the clinic. The clients' and potential clients' view of an ideal counseling session refers to a situation in which they are accommodated well, are greeted with a smile,

and are fully welcomed by the providers. Providing privacy was not much of a concern or a condition in the articulated ideal counseling setting, particularly for the clients of the public health facilities.

7. The concept of FP counseling among stakeholders is much more limited to information-giving as it is with making a decision or coming up with a specific choice of method. Less emphasis was given to affective/emotional FP concerns, active communication, as well as verbal exchange and question clarifications. Clients and potential clients are, nonetheless, concerned with the attributes of the physical and social environment of the clinics and centers. Results from stakeholders' meetings also attest to and confirm these findings.
8. In general, the actual counseling process for both public and private health facilities left much to be desired, as results reflected gaps between what is known and what is being practiced by the providers. This is true in both public and private service providers. Much has to be done to upgrade the counseling as well as cognitive skills and technical competency in quality of care of both public and private FP counselors/providers. Clients expressed the idea that information about FP methods should be completely given to them, and that they should be well-informed in order to prevent complications, correct misconceptions, and further check rumors circulating in the community. Moreover, adequate information-giving and fears of side-effects are not well-addressed in the FP counseling process. This is manifested in the very low rating scores yielded by the providers.
9. Providers have not consistently used the GATHER Approach as a device to help them in the process of providing counseling to clients or potential clients. The assessment of the counseling process also indicated that providers have not consciously followed fully the steps specified in the GATHER Approach. In some instances, providers cut short the counseling process, unmindful of the standards set in FP counseling.
10. The policy of providing quality FP counseling and quality care/service in both public and private clinics is strategically well-placed in that it is incorporated in the

mission, goals, and objectives of the organization. Private clinics further advance their strategic drivers by focusing more on their operations, supervision, and marketing activities. Partnerships and coordination, particularly in the referral system, is well-placed and this should be further enhanced.

11. Support services are much more wanting in the health facilities, particularly for the public health centers. Of importance are the need for filling up existing vacancies or recruiting additional personnel, providing adequate supplies of needed IEC materials and FP commodities, and having access to upgrading and refresher courses in FP as well as provision of quality of care training among front-line service providers.
12. Although supervision, monitoring, and feedback system are in existence, the manner in which they are carried out and organized systematically is not clearly made explicit in a well-designed institutional framework. Thus, monitoring, feedback, and supervision tend to be done sporadically, and at times conducted only when the head/supervisor is available in the facility. A systematic monitoring system also leaves much to be desired. Performance indicators remain to be more target-oriented and unclear, making monitoring difficult and less systematic to undertake. Supportive supervision is not clearly demonstrated, although low-performing providers, particularly in the private clinics, also receive sanctions in certain instances. The information system likewise leaves much to be desired, particularly among the public health centers. It is not clear, however, whether available data gathered from both private and public health facilities are being used as a basis for monitoring and improving performance.

Given the aforementioned results and observations, the following recommendations are offered:

1. Increased technical and financial assistance to strengthen the capacity of public and private service providers to deliver quality FP counseling must be made available. In particular, capacity building with regard to

the aspects of FP counseling, communication, CPI, and quality of care is imperative, particularly for direct providers and/or front-line service providers in both public and private health facilities.

2. The increased level of technical and financial support must vary according to the capacity, level of performance, and strengths of the health facilities. Private and/or NGO-managed/affiliated clinics may have to be assisted in terms of further enhancing the quality of care provision including FP counseling, communication, and CPI. This strategy might be the best way to maintain and keep clients in a sustainable manner. Since private clinics are observed to be adequately ready in providing FP quality care/service, particularly with regard to the provision of a much better physical environment, more efforts will have to be concentrated on further improving the quality of care and counseling process in FP service provision. Private clinics seem to be effective in serving the FP needs of the lower and middle income-level clients.
3. Among the public health service providers, much more is needed in terms of assistance, and this has to be focused on counseling potential clients and new FP acceptors. Public health service providers need to develop a "standard-conscious" orientation when providing FP services, including FP counseling. Capacity building on how to implement quality improvement initiatives and internalization of consciousness of standards must be provided to public health service providers. The approach and strategy, however, must not be a one-shot type but rather a kind that provides experiential learning and the opportunity to develop, practice, and acquire the needed skills related to the task itself. The methodology must be dynamic in order to promote acceptance of ideas/principles and thus promote social learning. Rigidities in the training seem not to work with the providers, creating undesirable feelings towards the FP counseling training, and they tend to shun away from these rigidities either covertly or overtly.
4. Since younger and economically deprived couples are likely to go to public health centers in seeking FP service, much assistance would have to be extended to public

health service providers particularly in rendering FP counseling that is helpful and of higher quality. Aside from capacity building, public health service providers need support in terms of creating a conducive physical and social environment for FP counseling. Thus, some support services will have to be provided. Among these are appropriate and culturally sensitive IEC materials, equipment for educational purposes, training to enhance interpersonal skills (enough to attract new users), and cognitive as well as communicative and educative skills. Management and handling of private concerns of clients need to be enhanced among public health service providers. Support to public health service providers is important because the first line of entry to FP practice in most of the areas covered by this study still seems to be the public health centers, particularly among the younger group of married women.

5. To develop a common perspective and a more convergent view of what FP counseling means, the theoretical meaning of FP counseling in the FP service provision (i.e., as a normative concept; FP counseling in theory is made distinct with what is real or what is actually occurring) clearly needs to be reviewed and subjected to a local critical discourse among technical consultants and trainers of FP-related capacity-building activities. This is important in the light of the major points that have emerged in the results of this study. First, stakeholders, including providers and supervisors, generally perceive FP counseling as information-giving. FP counseling merely is basically perceived as a one-way communication process, the goal of which is to help the client come up with a decision or choice of a particular method. Second, the related literature survey indicates that counseling has been given varying meanings; it is viewed more either as part of the broader spectrum of information exchange and/or CPI. This is imperative in order to identify and discuss thoroughly the standards of FP counseling, cognizant of the situation that service providers simply do not make use of the GATHER Approach in counseling.
6. Partnerships between public and private providers need to be enhanced to strengthen a referral system and to

intercept FP clients who have the capacity to pay for the services. One unintended outcome of the stakeholders' meetings conducted by this study was the provision of opportunities on the part of private providers to market and disseminate information about their FP and maternal health care services to local leaders and government officials. Some local government officials have expressed interest in working with private service providers in rendering FP quality service in their own communities. More marketing and information dissemination strategies of this kind would have to be implemented by the service agents of NGOs in order to effectively market their services.

7. There is a need to shift performance indicators from "target drivers" to "strategic drivers or benchmarks/best practices." Given that quality is the goal, indicators need to be aligned and dovetailed with the expectations and needs of the clients. This is particularly needed among public health service providers, since performance assessment indicators are more directed towards targets which are generally quantitative in nature. Alternative monitoring and assessment indicators for FP counseling and service provision will have to be established, keeping in mind not only the quantitative but also the qualitative aspects of the service process. An example is the institutionalization of a client feedback system in the health facility to determine whether expectations have been met or made known to health staff/authorities. Another is monitoring such issues as fear of side-effects, misconceptions, and misinformation, and the specific initiatives by which these issues were addressed by the providers in the facility.
8. Monitoring of quality care/service should be done regularly and supportive supervision will have to be strengthened. It may appear helpful if a separate capacity-building activity—preferably on the job site, along with monitoring and supervision with a focus on a broader spectrum of FP quality care/service—is conducted among local health managers and supervisors.
9. An institutionalized and continued capacity-building/upgrading program in FP counseling and quality care provision is needed. This program should be made part of

the routine management activities of the health organization and/or health facility. Since a series of FP trainings has already been participated in by the providers, a thorough inventory of FP and Quality Assurance (QA) training needs must be done in various areas to develop more appropriate and culturally sensitive communication and CPI training modules (given various levels of the staff's knowledge or skills) and to determine those who need the training most. Fine-tuning the modules according to the levels of involvement of the staff and their corresponding roles must also be done.

10. The involvement of motivational workers and the specific role they play in the provision of FP counseling must be reviewed and discussed thoroughly among public health service providers, together with their heads/supervisors. This move is in light of the articulated expectations of both the clients and potential clients regarding the need for adequate and correct information about FP and the bias for competent and professional FP counselors.
11. Core messages in communication strategies need to focus more on the expectations of both clients and potential clients. This focusing pertains more to the adequacy and accuracy of FP information and much better interpersonal relationships. Giving importance to persons coming to the clinics and/or health centers and treating them humanely and warmly are also magnetic messages to project marketing to targeted clients. Highlighting better physical and social environments, such as good physical structure and adequacy of facilities and amenities, is another way of attracting clients. Role modeling of males/supportive husbands might do well in the information and promotional campaigns.
12. A program intervention related to the promotion of active participation on the part of the clients in the FP counseling process needs to be developed for both public and private users of FP. Active questioning and empowerment in the interaction process will have to be developed on the part of the clients to specifically address doubts, fears, and concerns in the choice of FP method. Intervention addressing clients' empowerment and ability to ask questions or assert their preference needs to be initiated in some high CPR areas.

Appendix A

Health Facilities Covered by the Assessment Study

AREAS	PUBLIC FACILITIES	PRIVATE FACILITIES
LUZON		
1. Rizal		
• Cainta	Sitio Victoria Health Center (RHU)	Dr. Reyes Clinic
• Antipolo City	Mayamot Health Center (RHU)	Friendly Care
2. Pampanga		
• San Fernando City	San Agustin Health Center (RHU)	FPOP
• Angeles City	Sto. Domingo Health Center (RHU)	Sacred Heart Clinic
VISAYAS		
3. Bacolod City	ABES Health Center	FPOP
	Bata Health Center	Well-Family Midwife Clinic
4. Tacloban City	Sangkahan Health Center	Marie Stopes Clinic
MINDANAO	City Health Center	Well-Family Midwife Clinic
5. Butuan City	Golden Ribbon (BHS)	FPOP
	Limaha Center (BHS)	Well Family Midwife Clinic
6. Davao City	Miniforest Health Center	FriendlyCare
	Bankerohan Health Center	Well-Family Midwife Clinic
NCR		
7. Pasay City	Doña Martha Health Center	Friendly Care
8. Quezon City	Cubao Health Center	Friendly Care

Appendix B

Types and Number of Respondents, by Area and Type of Health Facility

AREA	TYPE	CLINIC	CLIENT	NONCLIENT	PROVIDER	SUPERVISOR	QIQ
LUZON							
Rizal (LP)							
• Cainta	Public	Sitio Victoria Health Center (RHU)	10	10	1	1	2
	Private	Dr. Reyes Clinic	10	10	1	1	1
• Antipolo City	Public	Mayamot Health Center (RHU)	10	10	1	1	2
	Private	Friendly Care - Antipolo	10	10	1	1	1
Pampanga (HP)							
• San Fernando City	Public	San Agustin Health Center (RHU)	10	10	1	1	1
	Private	FPOP	10	10	1	1	1
• Angeles City	Public	Sto. Domingo (RHU)	10	10	1	1	1
	Private	Sacred Heart Clinic	10	10	1	1	1
VISAYAS							
Bacolod City (HP)	Public	ABES Health Center	10	10	2	1	2
		Bata Health Center	10	10	2	1	1
	Private	FPOP	10	10	1	1	1
		Well-Family Midwife Clinic	10	10	1	1	1
Tacloban City (LP)	Public	Sangkahan Health Center	10	10	1	1	1
		City Health Center	10	10	1	1	1
	Private	Marie Stopes Clinic	10	10	–	–	–
		Well-Family Midwife Clinic	10	10	1	1	1
MINDANAO							
Butuan City (LP)	Public	Golden Ribbon (BHS)	10	10	1	1	2
		Limaha Center (BHS)	10	10	1	1	2
	Private	FPOP	10	10	1	1	2
		Well-Family Midwife Clinic	10	10	1	1	2
Davao City (HP)	Public	Miniforest Health Center	10	10	1	1	2
		Bankerohan Health Center	10	10	1	1	2
	Private	Friendly Care - Davao	10	10	1	1	2
		Well-Family Midwife Clinic	10	10	2	1	2
NCR							
Pasay City (LP)	Public	Doña Martha Health Center	10	10	1	1	2
	Private	Friendly Care - Pasay	10	10	1	1	2
Quezon City (HP)	Public	Cubao Health Center	10	10	1	1	2
	Private	Friendly Care - QC	10	10	1	1	2
Total			280	280	30	27	42

Legend:
LP – low performing in CPR
HP – high performing in CPR

Appendix C

Tools Used in Data-gathering

Social Development Research Center
De La Salle University
Taft Avenue, Manila

Respondent Number _____

FAMILY PLANNING COUNSELING CLIENT INTERVIEW SCHEDULE (Ever Used any FP method)

SDP Name: _____ City: _____
District: _____
Date of Interview: _____
Time Begun: _____ Time Finished: _____
Name of Interviewer: _____ Signature: _____
Name of Field Supervisor: _____ Signature: _____
Name of Team Leader: _____ Signature: _____

INSTRUCTIONS TO THE INTERVIEWER: When a family planning (FP) client has finished his/her consultation with the provider, ask him/her if he/she is willing to answer a few questions about the service he/she has received. For household interviews, ask if he/she has gone to the clinic for FP counseling within the past six months. Use the following introduction to gain his/her informed consent:

"Good morning/afternoon. My name is _____ of the Social Development Research Center of De La Salle University. I would appreciate it if you could spare a little of your time to talk about family planning (FP) counseling in the health clinic. My questions will focus primarily on the information you received and your experiences with the staff of the clinic.

"Your honest opinion will be important in our assessment of the FP counseling done here. Rest assured that your answers will be kept confidential. Thank you for your cooperation."

I. BACKGROUND INFORMATION

1. Marital Status: ( ) Single
   ( ) Married
   ( ) Separated
   ( ) Widowed
   ( ) Others (Specify:_____)

2. Age: _____
3. Occupation: _____
4. Highest Educational Attainment: _____
5. Religion: _____

II. BASELINE DATA

For male respondents, go to items 3 & 4 then proceed to Section III

1. How many pregnancies have you had?_____
2. How many were born alive?_____
3. How many living children do you have and what are their ages?_____

CHILDREN	AGES
Child 1	_____
Child 2	_____
Child 3	_____
Child 4	_____
Child 5	_____
Child 6	_____

4. Have you been ligated/vasectomized? Yes___ No___
   (If yes or the respondent is male, proceed to Section III)

5. (If not ligated) Are you currently pregnant? Yes___ No___
   (If yes, continue until 5.1b; if no, proceed to 5.2a)

   5.1a If yes, how many months pregnant are you?_____
   5.1b At the time you became pregnant,
   ... did you want to become pregnant? Yes___ No___
   ... did you prefer to wait until later? Yes___ No___
   ... did you not want to become pregnant at all? Yes___ No___
   Proceed to ——▶ 6

Ask only if the respondent is not pregnant, otherwise NA.

   5.2a If not pregnant, do you want another child?
   (If no, proceed to 5.2c) Yes___ No___
   5.2b When would you like to have the next child?_____

5.2c (If not pregnant and does not want another child) Are you currently doing something to avoid the pregnancy? Yes___ No___
(If no, proceed to 5.2h)

5.2d If yes, what specifically is your method? _____

5.2e When did you start using this method? _____

5.2f Did you consult and receive FP counseling before or during the use? Who did the counseling, a public or private doctor/nurse/midwife? Yes___ No___
Please specify: Who? Agency? _____

5.2g Are you happy with your method? Yes___ No___
Reason/s: _____

5.2h If not using any FP method, why? _____

6. Were you visited by an FP program worker in your home within the last six months? Yes___ No___
If yes, how many times? _____ Reason/s: _____

7. Have you visited a health facility for any reason within the last six months? Yes ____ No ____
If yes, what is this facility?
   1 — city health office
   2 — barangay health station
   3 — government hospital
   4 — private clinic
   5 — lying-in clinic
   6 — NGO clinic
   7 — Others (Specify: _____)

8. Did any health personnel of the facility talk to you about an FP method? Yes____ No____ Who was this? _____

III. OVERALL PERCEPTIONS OF FP SERVICES

I'd like you to think about the last time you visited the health facility for FP services.

A. How would you describe the physical environment of the clinic?

_____

_____

1. What did you like about the clinic environment? Why?

_____

_____

2. What did you not like? Why?

_____

_____

B. How would you describe the counseling of the FP provider/s?

_____

_____

_____

_____

1. What was the provider's behavior during your counseling?

_____

_____

2. Did the provider encourage you to ask questions? Talk freely? Yes___No ___(Cite specific example/s)

_____

_____

3. Did the provider listen to your concerns/problems regarding FP counseling? Yes___ No___ (Please elaborate)

_____

_____

4. Did the provider understand any problems you had regarding FP counseling? Yes___ No ___(Please elaborate)

_____

_____

5. Did he/she do something to help you solve this/these problem/s? Yes___No ___(Cite specific experience)

_____

_____

6. When would you say that an FP provider is skilled/knowledgeable in giving counseling?

_____

_____

7. Was the provider trustworthy? Why or why not?

_____

_____

8. What did the provider do during the counseling that you liked? Disliked? Why?

_____

_____

9. Do you frequently ask questions? Why or why not?

_____

_____

10. Were you given enough time to get all the information you needed?

_____

_____

C. If you have a married relative interested in FP, would you recommend that he/she go to this facility?

1. Why or why not?

_____

_____

2. Should your relative go somewhere else? Yes___ No ___

_____

_____

3. Where?

_____

_____

4. Why?

_____

_____

D. Which methods have you heard about and ever used, and do you know where they can be availed of?

Instruction: Please allow multiple responses to this question before probing. Use the following codes for answering columns A & B: 1–Yes, spontaneous; 2–Yes, probed; 3–No; 4–Not Applicable.

If at least one "yes" is given in column B, ask the following questions:

METHODS	A. HEARD ABOUT (IF ANSWER IS NO, PROCEED TO NEXT METHOD)	B. EVER USED (IF YES, PROCEED TO NEXT COLUMN)	C. KNOW WHERE TO AVAIL OF THE METHOD (1—YES, SAME BARANGAY; 2—YES, ANOTHER BARANGAY)
1. Pill (Women can take a pill everyday.)			
2. IUD (Women can have a loop or coil placed inside them by a doctor or nurse.)			
3. Injections (Women can have an injection by a doctor or nurse which prevents them from becoming pregnant for several months.)			
4. Condom (Men can put a rubber sheath on their penis during sexual intercourse.)			

5. Ligation/female sterilization (Women can have an operation to avoid having any more children.)			
6. Vasectomy/male sterilization (Men can have an operation to avoid having any more children.)			
7. Calendar, rhythm, periodic abstinence (Every month, when women are sexually active, they can avoid having sexual intercourse on the days of the month they are most likely to get pregnant.)			
8. Mucus, Billings, ovulation (Women can monitor cervical mucus to determine the days of the month they are most likely to get pregnant.)			
9. Basal Body Temperature (Women can monitor their body temperature to determine the days of the month they are most likely to get pregnant.)			
10. Sympto-thermal (Women can monitor both cervical mucus and basal body temperature to determine the days when they are likely to get pregnant.)			
11. Lactational Amenorrhea Method or LAM (Method used by a woman with a baby who is less than six months old, whose period has not returned, and who breast-feeds the baby day and night without supplementation to avoid pregnancy)			
12. Have you heard of other methods that women and men can use to avoid pregnancy? Please specify: _____			

What was the first method you ever used? _____

How many living children did you have at that time? _____

In what year and month did you first use an FP method? _____

How old were you when you started using an FP method? _____

E. To be answered by those who have used an FP method or have gone to health clinics to consult about FP methods:

METHODS	START OF USE (MM/YY)	CONSULTED ANY HEALTH SERVICE PROVIDER?	RECEIVED FP COUNSELING?	NAME OF SERVICE PROVIDER (SPECIFY IF PUBLIC OR PRIVATE)
1. Pill				
2. IUD				
3. Injections				
4. Condom				
5. Ligation/female sterilization				
6. Vasectomy/male sterilization				
7. Calendar, rhythm, periodic abstinence				
8. Mucus, Billings, ovulation				
9. Basal Body Temperature				
10. Sympto-thermal				
11. Lactational Amenorrhea Method or LAM				
12. Other methods that women and men currently use to avoid pregnancy? Please specify: _____				

F. Inclusion of breast-feeding as an FP method during FP counseling:

1. Did you know about Lactational Amenorrhea Method or LAM?

_____

_____

2. Do you have any idea as to how breast-feeding prevents pregnancy?
Yes ____ No ____(Please elaborate)

_____

_____

3. If breast-feeding, how often do you breast-feed your child?

_____

_____

4. Other than breast milk, did you give other forms of liquids and food supplements to your child during the first six months of life?
Yes ____ No ____(Please specify)

_____

_____

IV. EXPECTATIONS (IDEAL) REGARDING FP SERVICES

Now, we would like you to imagine the **ideal** meeting with a provider to discuss FP. What do you think all FP facilities should be like? What should the health facility look like?

Reminder: Please emphasize the word ideal to contrast it with actual experience.

A. Describe the physical environment.

_____

_____

B. What would the FP providers be like?

_____

_____

1. How would they greet/receive you?

_____

_____

2. How would they behave/interact with you?

_____

_____

3. Would the providers give correct and/or complete information on the FP method you're using?

_____

_____

C. As a client, how should you behave/interact with the service provider?

_____

_____

D. What would make you feel comfortable about asking questions?

_____

_____

E. Does your local health facility offering FP counseling differ from this ideal facility? Yes ___ No ___

1. What are some reasons for these differences?

_____

_____

2. What would be the first thing you would change about your health facility to make it closer to this ideal? (List changes to be made in order of priority.)

_____

_____

THIS IS THE END OF THE INTERVIEW.
THANK YOU VERY MUCH FOR YOUR PARTICIPATION!

Social Development Research Center

De La Salle University
Taft Avenue, Manila

Respondent Number _____

FAMILY PLANNING COUNSELING NONCLIENT INTERVIEW SCHEDULE

(Never Used any FP method)

SDP Name: _____ City: _____
District: _____
Date of Interview: _____
Time Begun: _____ Time Finished: _____
Name of Interviewer: _____ Signature: _____
Name of Field Supervisor: _____ Signature: _____
Name of Team Leader: _____ Signature: _____

"Good morning/afternoon. My name is _____ of the Social Development Research Center of De La Salle University. I would appreciate it if you could spare a little of your time to talk about family planning (FP) counseling in the health clinic. My questions will focus primarily on the information you received and your experiences with the staff of the clinic.

"Your honest opinion will be important in our assessment of the FP counseling done here. Rest assured that your answers will be kept confidential. Thank you for your cooperation."

I. BACKGROUND INFORMATION

1. Marital Status: ( ) Single
   ( ) Married
   ( ) Separated
   ( ) Widowed
   ( ) Others (Specify: _____)
2. Age: _____
3. Occupation: _____

4. Highest Educational Attainment: _____
5. Religion: _____

II. BASELINE DATA

For male respondents, go to item 3 then proceed to Section III

1. How many pregnancies have you had? _____
2. How many were born alive? _____
3. How many living children do you have and what are their ages? _____

CHILDREN	AGES
Child 1	_____
Child 2	_____
Child 3	_____
Child 4	_____
Child 5	_____
Child 6	_____

4. Are you currently pregnant? Yes ___ No ___
(If yes, continue until 4.1b; if no, proceed to 4.2a)
4.1a If yes, how many months pregnant are you? _____
4.1b At the time you became pregnant, Yes___ No___
... did you want to become pregnant? Yes___ No___
... did you prefer to wait until later? Yes___ No___
... did you not want to become pregnant at all? _____
Proceed to ⟶ 5

Ask only if the respondent is not pregnant, otherwise NA.
4.2a If not pregnant, do you want another child? Yes___ No___
4.2b When would you like to have the next child? _____

5. Were you visited by an FP program worker in your home within the last six months? Yes___ No___
If yes, how many times? _____ Reason/s? _____

6. Have you visited a health facility for any reason within the last six months?
If yes, what is this facility?
1 – city health office
2 – barangay health station
3 – government hospital
4 – private clinic
5 – lying-in clinic
6 – NGO clinic
7 – Others (Specify: _____)

7. Did any health personnel of the facility talk to you about an FP method? Yes___ No___ Who was this? _____

III. OVERALL PERCEPTIONS OF FP SERVICES

Suppose a friend (if male, use wife or sister) of yours wanted to go to the local health facility for FP services tomorrow and he/she wanted to hear your opinion about what he/she should expect...

A. How would you describe the physical environment of the clinic to him/her?

_____

_____

1. What do you think he/she would like about the clinic environment? Why?

_____

_____

2. What do you think he/she would not like? Why?

_____

_____

B. How would you describe the health providers working there?

_____

_____

_____

1. What would the provider's behavior be during the counseling?

_____

_____

2. Would the provider encourage you to ask questions? Talk freely?
Yes____ No ____(Please elaborate)

3. Would the provider listen to your concerns/problems regarding FP counseling? Yes____ No ____ (Please elaborate)

_____

_____

4. Would the provider understand any problems you have regarding FP counseling? Yes____ No ____(Please elaborate)

_____

_____

5. Would he/she do something to help you solve your problem regarding FP counseling? Yes____ No ____(Please elaborate)

_____

_____

6. When would you say that an FP provider is skilled/knowledgeable in giving FP counseling?

_____

_____

7. Would the provider be trustworthy? What made you say/think so?

_____

_____

8. What would the provider do during your counseling that you will like? Dislike? Why?

_____

_____

9. Would you frequently ask questions? Why or why not?

_____

_____

10. Would you be given enough time to get all the information you need?

_____

_____

C. Would you recommend that your married relative, or a relative needing FP services, go to the health facility for FP?

1. Why or why not?

_____

_____

2. Should your friend go somewhere else? Yes ____ No____

_____

_____

3. Where?

_____

_____

4. Why?

_____

_____

IV. EXPECTATIONS (IDEAL) REGARDING FP SERVICES

Now, we would like you to imagine the **ideal** facility providing FP services—what you think all FP facilities should be like.

Reminder: Please emphasize the word ideal to contrast it with actual experience.

A. What would this facility look like? Describe the physical environment.

_____

_____

_____

B. What would the FP providers be like?

_____

_____

_____

_____

1. How would they greet/receive you?

_____

_____

2. How would they behave/interact with you?

_____

_____

3. Would the providers give correct and/or complete information on the FP method you're using?

_____

_____

C. As a client, how should you behave/interact with the service provider?

_____

_____

D. What would make you feel comfortable about asking questions?

_____

_____

E. What would the providers do to make you comfortable?

_____

_____

F. Does your local (government/nongovernmental) health facility offering FP differ from this ideal facility? Yes ____ No ____

1. What are some reasons for these differences?

_____

_____

2. What would be the first thing you would change about your health facility to make it closer to this ideal? (List changes to be made in order of priority.)

_____

_____

V. SOURCE OF INFORMATION

Where did you get your ideas about FP services and counseling?

_____

_____

_____

_____

THIS IS THE END OF THE INTERVIEW.
THANK YOU VERY MUCH FOR YOUR PARTICIPATION!

Social Development Research Center

De La Salle University
Taft Avenue, Manila

FAMILY PLANNING COUNSELING PROVIDER IN-DEPTH INTERVIEW GUIDE

SDP Number: _____ City: _____ District: _____
Name of Clinic: _____ Date of Interview: _____
Name of Interviewee: _____
Name of Interviewer: _____
Signature of Team Leader: _____

INSTRUCTIONS TO THE INTERVIEWER: The Clinic Head has granted clearance for the interview that you will conduct. It is important to **probe frequently** in conducting this interview. The main goal is to get a clear understanding of the underlying causes for performance gaps and to come up with potential strategies for addressing those causes. Some probes are suggested as a different way to phrase a question to ensure that the respondent understands the original intent of each question. In addition to these probes, simply probing the question "Why?" or "How?" will help you get to the true underlying cause of performance gaps. You should capture the provider's information in clear, bullet-point statements. Do not rush; complete each question by recording complete answers. This interview is divided into seven sections that represent different factors that affect providers performance related to their ability to provide quality family planning (FP) counseling. This interview should take no more than one hour.

Your audience for this tool is/are the provider/s at the clinic who provide/s FP counseling to clients; they should provide answers to the questions contained in this interview. There may likely be more than one provider who provides FP counseling. Interviewers should collect information from all providers who give FP counseling. Providers at the clinic who only refer clients to another provider should not participate. The providers who do participate will also be the providers whom the interviewers will both observe and audiotape during the actual FP counseling session. Start the interview with the following introduction:

"Good morning/afternoon. I am _____ of the Social Development Research Center of De La Salle University. I would appreciate it if you could spare me a little of your time to talk about family planning (FP) counseling in the health clinic. We have received permission from the clinic supervisor to conduct this interview.

"Your honest opinion will be important in our assessment of the FP counseling done here. Rest assured that your answers will be kept confidential. Thank you for your cooperation."

BACKGROUND INFORMATION

1. Sex: _____
2. Marital Status: _____
3. Age: _____
4. Position: _____
5. No. of Yrs. in the Above Position: _____
6. No. of Yrs. Working in the Present Facility/Clinic: _____
7. Highest Educational Attainment: _____
8. Religion: _____
9. Languages Spoken: _____

Do you have reservations about giving FP counseling? If yes, why?

_____

_____

IN-DEPTH INTERVIEW

Section One: Job Expectations for Delivering Quality FP Counseling

1. Do you know what is expected of you (by your supervisor/client) in terms of your interaction with clients?

   _____

   _____

2. Do you know what is expected of you (by your supervisor/client) in terms of the counseling you give to clients?

   _____

   _____

3. How are these expectations relayed and given to you?

   _____

   _____

4. Have you received within the last seven years (or since 1995) training on FP counseling?

   _____

   _____

5. How should you be helped to better understand what is expected of you with regard to FP counseling? What people, events, or information would assist you in learning more accurately your role as a provider of FP counseling?

_____

_____

Section Two: Skills and Knowledge in FP Counseling

1. What FP training have you received in the last seven years (or since 1995)? [This includes FP clinical and counseling training courses. Write information in the spaces provided in the table below.]

TRAINING COURSES PARTICIPATED IN	YEAR YOU RECEIVED THE TRAINING (FROM 1995 TO THE CURRENT YEAR)	GROUP THAT PROVIDED THE TRAINING	WHAT YOU LIKED MOST IN THE TRAINING COURSE
a.			
b.			
c.			
d.			
e.			
f.			
g.			

2. Which of the training courses above did you like most? Why? Least? Why?

_____

_____

_____

3. Do you feel you have all the knowledge and skills necessary to effectively counsel clients on FP?

4. What knowledge and skills do you need to effectively counsel clients on FP?

5. Do you feel you have all the skills necessary to effectively communicate with clients about FP?

6. What skills do you need to effectively communicate with clients about FP?

7. What knowledge or skills about FP counseling should be acquired and developed by the other providers working in this clinic for them to counsel clients effectively on FP?

8. If you could choose a way to increase your knowledge about counseling and interacting with clients about FP, what would this be? Describe this way to increase knowledge about FP counseling. Why do you prefer this way?

9. Are you aware of established standards of quality FP counseling?

10. If yes, what are these standards?

11. Did your supervisor sit down with you to discuss these standards? What did he/she discuss with you?

12. Have you heard of the GATHER Approach? What do you know of this approach?

13. Do you use the GATHER Approach when you provide FP counseling?

14. How do you incorporate the GATHER Approach when you provide FP counseling? At what point during the counseling do you use the GATHER Approach?

15. What is FP counseling to you? How should FP counseling be done?

Section Three: Feedback on FP Counseling

1. How do you know that you are interacting well with clients when you counsel them on FP? Describe and give indicators (i.e., specific behaviors that show service providers are interacting well with clients).

2. Does anyone such as your clinic director, supervisor, clients, community members, or peers give feedback on your performance as a provider of FP counseling? (If yes, list those who provide feedback.)

3. How do they give you their feedback? (For example, individual meetings, group meetings, written reports, information solicited from other providers on your performance, and opinions/perceptions of clients)

4. Do you want more feedback from your supervisor about the way you communicate with clients about FP counseling?

5. If yes, who is this supervisor from whom you would like to receive feedback? Why do you wish to receive feedback from this person?

6. What types and/or specific ways of feedback about the way you provide FP counseling do you find helpful? (For example, feedback cards, verbal feedback, group talks, individual reports, collecting input from clients/peers)

7. What types and/or specific ways of feedback about the way you provide FP counseling are **not** helpful?

Section Four: Environment and Tools for Quality FP Counseling

1. Ask questions to find out: a) whether the following items exist or are available at the facility; and b) how these items affect the provider's ability to provide counseling and to communicate with clients:

   a. Electricity/light source

   b. Physical space that allows for privacy

   c. Basic furnishings that allow for client comfort

COUNSELING MATERIALS	AVAILABLE AT CLINIC TODAY? (ENCIRCLE YES OR NO)	DO THESE MATERIALS HELP YOU PROVIDE EFFECTIVE FP COUNSELING? (ENCIRCLE YES OR NO)
a. Thiaart posters	Yes No	Yes No
b. Other FP method posters	Yes No	Yes No
c. Flip charts	Yes No	Yes No
d. Brochures (collect copies, if possible)	Yes No	Yes No
e. Service delivery guidelines	Yes No	Yes No
f. Sample methods	Yes No	Yes No
g. Physical models for demonstration	Yes No	Yes No
h. Cue cards	Yes No	Yes No
i. Audiovisual equipment	Yes No	Yes No

2. Means of transportation for any community education efforts: How do you go/travel to attend community education efforts? Are the trips convenient for you?

_____

_____

3. Maintenance system: How is the clinic kept clean and orderly?

_____

_____

4. Resupply system for counseling job aids: What do you do when you run out of counseling job aids?

_____

_____

5. Resupply system for FP methods: What do you do when you run out of supplies for FP methods?

_____

_____

6. Recordkeeping system: How are records of clients kept and updated?

_____

_____

7. Name one or two environmental factors that can contribute most to your ability to improve your communication and interaction with FP counseling clients. (For example, strong support from supervisor to provide FP, effective supervision in providing FP counseling, adequate supply of FP methods, and adequate training on FP counseling)

_____

_____

8. Name one or two tools that can contribute most to your ability to improve your communication and interaction with FP counseling clients. (For example, flip charts, actual FP methods, videos in waiting room, posters)

_____

_____

Section Five: Motivation and Incentives for Effective Client-Provider Communication

1. How do you get recognition for effective interaction with and counseling of clients?

_____

_____

2. Other than salary, what are the existing mechanisms to recognize good staff performance?

_____

_____

3. Besides bonuses or salary increases, what would motivate you to do even better in your interactions with clients?

_____

_____

Section Six: Organizational Support for Client-Provider Communication

1. Did you encounter problems in communicating with clients about FP?

_____

_____

_____

2. Do you get help to solve these problems? If yes, how?

3. What expectations of the clinic do you have that you think would enable you to perform effectively your FP counseling responsibilities?

4. What are your expectations of an ideal FP client? How should he/she behave during the counseling process? (Should the client ask questions, be assertive, request method, choose method, and/or the like?)

5. What do you think should FP clients do to make your job as an FP counseling provider easier?

THIS IS THE END OF OUR IN-DEPTH INTERVIEW.
THANK YOU VERY MUCH FOR YOUR COOPERATION!

Social Development Research Center

De La Salle University
Taft Avenue, Manila

FAMILY PLANNING COUNSELING SUPERVISOR INTERVIEW GUIDE

SDP Number: _____ City: _____ District: _____
Name of Clinic: _____ Date of Interview: _____
Name of Interviewee: _____
Name of Interviewer: _____
Signature of Team Leader: _____

INSTRUCTIONS TO THE INTERVIEWER: Clearance for this interview has been granted.

"Good morning/afternoon. I am _____ of the Social Development Research Center of De La Salle University. I would appreciate it if you could spare me a little of your time to talk about family planning (FP) counseling in the health clinic. We have received permission from the clinic supervisor to conduct this interview.

"Your honest opinion will be important in our assessment of the FP counseling done here. Rest assured that your answers will be kept confidential. Thank you for your cooperation."

BACKGROUND INFORMATION

1. Sex: _____
2. Marital Status: _____
3. Age: _____
4. Supervisory Position: _____
5. No. of Yrs. in the Above Position: _____
6. No. of Yrs. Working in the Present Facility/Clinic: _____
7. Highest Educational Attainment: _____

8. Training Received from 1995 to Present on the Supervision of FP Counselors

YEAR	TRAINING RECEIVED	TRAINING GIVEN BY	TRAINING GIVEN AT

9. Religion: _____
10. Languages Spoken: _____

INTERVIEW PROPER

1. Who are the persons in the clinic/health center who directly interact with the FP counseling clients? What are their position titles, degrees, training, and responsibilities/tasks relevant to client-provider communication?

NAME OF CLINIC STAFF	POSITION TITLE	DEGREE/S	TRAINING RECEIVED	TASKS/ RESPONSIBILITIES
a.				
b.				
c.				
d.				
e.				

2. Does your clinic have enough personnel assigned to give FP counseling? Is there currently any vacancy for an FP counseling provider in your clinic?

3. Aside from FP services provision, what are the other health services provided by the clinic/health center?

4. When is FP counseling given in this clinic/health center? What are the types of services that include FP counseling? What is the clinic schedule for FP services (days and hours)?

PROGRAMS	DAYS	HOURS
a.		
b.		
c.		
d.		
e.		

5. What are the geographical areas served by this clinic/health center?

6. What are the overall goals or mission of the clinic, in brief?

7. Is FP counseling included in the clinic's goals/mission, or is it addressed specifically in the goals/mission of the clinic?

8. What are the performance objectives for this current year and month (e.g., the desired number of clients, increased revenues, and client satisfaction)?

9. Is FP counseling addressed specifically in the performance objectives?

10. What are the overall site strategies employed to accomplish these goals and objectives?

11. Is FP counseling addressed specifically or included in these strategies?

12. Does the clinic staff have annual, quarterly, or monthly action plans?

13. Is FP counseling addressed specifically or included in these action plans?

Note to the Interviewer: For question #14, please give the dates relative to the date of this interview.

14. How many FP client visits do you have on record for the year 2001, the previous month (June 2002), the previous week, and yesterday?

    The previous week in question here is from _____ to _____, 2002.

	2001		PREVIOUS MONTH		PREVIOUS WEEK		DAY BEFORE VISIT	
Clinic Name	New	Cont	New	Cont	New	Cont	New	Cont

15. What are the primary reasons for these FP visits to/in the clinic?

16. Method-specific information:

	DEPO	PILLS	IUD	NORPLANT	CONDOM	LAM/ BREAST-FEEDING	NATURAL
Information or method provided?							
Cost or donation for the commodity received?							
Stock out in last six months?							

17. Did you have revenues during the **previous month** from FP services and products? How much was the revenue last month?

_____

_____

_____

18. How much is the annual site budget?

_____

_____

PhP/$ _____

19. What is the amount or the percentage of the total site budget dedicated specifically to FP? In what budget item are FP services/programs included? What percentage of this budget item is dedicated to FP programs?

_____

_____

_____

20. General physical description of site:

a. Waiting rooms (i.e., IEC materials available, cleanliness, areas in which to sit, organization, etc.)

_____

_____

b. Counseling rooms (i.e., rooms other than the waiting room that are private [auditory and visual privacy],etc.)

_____

_____

c. Examining rooms (i.e., their cleanliness, organization, privacy, etc.)

_____

_____

21. Processes:

First, ask if there are established processes related to each item below. Although we are looking for information in general, if a process exists, ask to see if it relates to provision of FP counseling. Also, ask respondent to give only a brief description of the process.

a. Staff supervision: Do you give feedback? How do you give it? What do you expect from your FP counselor/s?

_____

_____

b. How do you assign specific personnel to be FP counselors?

_____

_____

c. What kind of training do you look for in an FP counseling?

_____

_____

d. In managing the health personnel, how do you recruit, hire, do performance reviews, motivate/reward, discipline, and fire them? Please tell us about the way you do these things.

_____

_____

e. What requirements/skills are needed for a health provider to become an FP counselor?

_____

_____

f. Do you have systems of collecting and using data (e.g., health needs assessments, client service utilization data) in this clinic/health center? Please tell us about the kinds of data you collect and whether or not you use them. For what purposes do you use them?

DATA COLLECTED/GATHERED	USED OR NOT IN THE CLINIC OR CENTER	FOR WHAT SPECIFIC PURPOSES DO YOU USE THEM?

g. Have you undertaken initiatives to improve the quality of health services in the clinic/health center? What are these?

_____

_____

h. What do you do to ensure there is delivery of quality service?

_____

_____

i. What do you do to ensure regular availability and procurement of FP supplies and commodities? Please describe the system and the process of procuring, storing, and controlling the quality (including consideration regarding expiration dates) of the FP supplies.

_____

_____

j. How is FP counseling in the health facility affected by: a) the availability of FP supplies and commodities; b) the system of procuring these supplies and commodities?

_____

_____

k. Do you have an ongoing assessment of the quality of services provided? Please describe how you are doing this ongoing assessment.

_____

_____

_____

THIS IS THE END OF THE INTERVIEW.
THANK YOU VERY MUCH FOR YOUR PARTICIPATION!

Observation Guide

Quick Investigation of Quality (QIQ) for Clinic-based FP Services

Instruction to Observer:

When a family planning client arrives at the health facility, ask him/her if he/she is willing to let you observe and tape-record the visit with the provider. It is essential that you gain his/her informed consent before beginning the observation and taping, so the following greeting should be given. After reading the greeting, sign and date the statement that indicates whether or not the client agreed to participate.

Greeting

"Hello. My name is _____ and I am a researcher/interviewer from De La Salle University. We are doing a survey to find out about the services provided at this clinic. The information from the survey will be used to improve the quality of services in this and other clinics. The clinic has given us permission to do the survey and we are asking all family planning (FP) clients who visit the clinic today to participate. We would like to ask your permission to observe and tape-record your visit with the clinic staff.

"Your participation is extremely important, but it is entirely voluntary. You do not have to be observed nor do you have to answer any questions if you do not want to. You will not be denied any services if you decide not to participate. If you agree to participate in the survey, you can change your mind at any time during the visit or the interview. I will not write down your name and everything you tell me will be kept strictly confidential. During your visit, I will be sitting a little away from you and the clinic staff. There are no risks or direct benefits to you from participating in the survey but your participation will contribute to improving services in this and other clinics."

- Do I have your permission to continue?
  YES _____ NO _____

READ AND SIGN THE FOLLOWING:

IF YES, SIGN AND DATE THE STATEMENT BELOW AND CONTINUE WITH THE OBSERVATION.

I certify that I read the statement above to the client and he/she agreed to participate in the study.

Signed _____ Date _____

IF NO, SIGN AND DATE THE STATEMENT BELOW AND THEN STOP AND WAIT FOR ANOTHER CLIENT.

I certify that I read the statement above to the client and he/she did not agree to participate in the study.

Signed _____ Date _____

Observation Guide for Counseling and Clinical Procedures

Observation ID number: ☐☐

01 Health Facility (Name & Number) : _____ ☐☐☐

02 City (Name & Number) : _____ ☐☐☐

03 Region (Name & Number) : _____ ☐☐

04 Provider (Name & ID Number): _____ ☐☐

05 Date of Observation : _____

Day	Month	Year
☐☐	☐☐	☐☐

06 Observer (Name & Number) : ☐☐

07 Type of Facility Where Observation Took Place:

- ☐ Rural/urban health station
- ☐ Barangay health station
- ☐ Barangay supply office
- ☐ Government hospital
- ☐ Private hospital
- ☐ NGO clinic
- ☐ Other:

08 If government facility, is this facility Sentrong Sigla-certified?

☐ Yes ☐ No

09 Locality of Facility

☐ Rural ☐ Urban ☐ Per-urban

10 Time Observed Session Began: _____ : _____ ☐☐ ☐☐
(Use military time)

11 Provider providing MOST of the counseling session:

☐ Nurse ☐ Nurse-Midwife ☐ Doctor
☐ Health Worker ☐ Other: _____

12 Sex of Provider:

☐ Female ☐ Male

Counseling Observation Guide
FOR ALL CLIENTS

Mark (X) as appropriate

13 Family planning status upon arrival at this facility:
☐ Nonuser, but with past use ☐ Current user
☐ Nonuser, no past use ☐ Not determined

14 Language spoken during counseling session:

☐ Tagalog ☐ Ilocano ☐ Cebuano ☐ Other: _____

15. Did the provider:	Yes	No
A. Ask open-ended questions		
B. Encourage client to ask questions		
C. Treat client with respect		
D. See client in private		
E. Discuss a return visit		
F. Ask client his/her concerns with any method		
G. Use other visual aids (method, brochure)		
H. Use client record form to record information		
I. Verbally assure client of confidentiality		
J. Use an FP flip chart		
K. Give client IEC material to take home		
L. Record client in register		
M. Review client's previous record		
N. Inform client why they are recording information		

16. Information Discussed: Mark who initiated the conversation or mark "not discussed"	Provider	Client
A. Current age		
B. Marital/relationship status		
C. Number of living children		
D. Desire for more children		
E. Timing of next child		
F. Current pregnancy status		
G. History of pregnancy complications		
H. Partner's attitude about FP (approve/disapprove)		
I. Multiple/single sexual partner(s)		
J. Partner with multiple/single sexual partner(s)		
K. HIV/AIDS and STIs discussed		
L. History/signs/symptoms of STIs		
M. Client breast-feeding or not		
N. Past FP method use		
O. Date of last menstrual period (LMP)		

17 Outcome of visit:

☐ Counseling provided, no method given/accepted

☐ Continuing clients/same method:
- ☐ resupply/routine follow-up
- ☐ restart method (< 6 months)
- ☐ discuss problem with method

☐ New clients/changed method:
- ☐ receive method first time
- ☐ restart (> 6 months)
- ☐ switch contraceptive method

18 Method actually received/prescribed (new clients) or came/left with (continuing clients):

☐ Pill
☐ IUD
☐ Injectable
☐ NORPLANT
☐ Female sterilization
☐ Condom
☐ Spermicide
☐ Rhythm/periodic abstinence
☐ LAM
☐ Condom + Other: ____
☐ Other: _____
☐ No method

NEW CLIENTS ONLY
Mark (X) as appropriate

19 Client stated preference for method:

☐ Pill
☐ IUD
☐ Injectable
☐ NORPLANT
☐ Female sterilization
☐ Condom
☐ Spermicide
☐ Rhythm/periodic abstinence
☐ LAM
☐ Diaphragm
☐ Condom + Other: ____
☐ Other: _____
☐ Preference not discussed (GO TO Q23)
☐ No preference (GO TO Q23, No preference only)

20 Preferred method received (for clients who state a preference):

☐ Yes
☐ No → (GO TO Q22)

21 Provider determined client's reason for method selection:

☐ Yes
☐ No

(GO TO Q23)

MARK ONLY IF CLIENT DID NOT RECEIVE PREFERRED METHOD	
22. Reason preferred method not received:	(X)
A. Not available in clinic that day	
B. Not available at all	
C. Not available, referred to another source or clinic	
D. Not appropriate method (contraindications)	
E. No appropriate provider available that day	
F. Provider recommended another method	
G. Changed mind after listening to provider	
H. Client did not make choice at time of session	
I. Client not at risk of pregnancy	
J. Pregnancy suspected	
K. Told to return during menses	
L. Client could not pay for services today	
M. Other: _____	
N. Not clear why	

NEW CLIENTS BY METHOD RECEIVED OR PRESCRIBED
Encircle the method that the client received or was prescribed and mark (X) as appropriate.

23. Method Selection Matrix

(See guidelines next page)

	Yes	No
A. How to use		
B. Side-effects		

Did Providers:	Pill	IUD	Injectable	NORPLANT	Female Sterilization	Condom	Rhythm/ Periodic Abstinence	LAM
A. Check blood pressure								
B. Check/ask pregnancy								
C. Ask about smoking								
D. Ask about breast-feeding								
E. Provide condoms or cycles								
F. Ask about chronic health problems								
G. Ask about allergies to latex								
H. Ask about last delivery date								
I. Ask about pregnancy complications								
J. Ask about regularity of menstrual cycle								

24. Provider gave accurate information about key point:

CONTRACEPTIVE METHODS GUIDELINES		
Method	**How to Use**	**Side-effects**
Pill	Must be taken everyday	Nausea, spotting
IUD	Should check strings	Menstrual bleeding
Injectable (i.e., Depo-Provera)	Provides protection for three months	Menstrual changes
NORPLANT	Provides protection for five years	Menstrual changes
Female Sterilization	Can never become pregnant again	Pain at surgical site
Condoms	Use once	Allergy to latex
Spermicide	Must be inserted 15-60 minutes before intercourse	Tissue irritation
Rhythm/Periodic Abstinence	Should not have sexual intercourse during the fertile period	
LAM	Should not use once menstrual period has returned	
Diaphragm	Must leave in place six hours after intercourse	Bladder infection

Do not mark **Q25** if client has selected condoms as his/her method.

25. Did the provider:	Yes	No
A. Explain method does not protect against STIs and AIDS		
B. Encourage use of condoms as 2nd method		

Clinical Observation

26. Clinical provider same person who provided counseling:

☐ Same person (GO TO Q29) ☐ Different person

27. Provider performing MOST of clinical examination:

☐ Nurse ☐ Nurse-Midwife ☐ Doctor
☐ Health Worker ☐ Other: _____

28. Sex of Provider:

☐ Female
☐ + Male

29. Observation conducted for:	Yes	No
A. Client received injectable – if yes, complete section A		
B. Client underwent pelvic exams – if yes, complete section B		
C. Client had an IUD inserted – if yes, complete section C		

For each item, mark (X) "yes," "no," or "N/A" (not applicable) as appropriate.

A. Injectable (Depo-Provera)

30. Did the provider:	Yes	No	N/A
D-1. (NEW CLIENT) Reconfirm client's method choice			
D-2. (NEW CLIENT) Verify if client is not pregnant			
D-3. (CONTINUING CLIENT) Give injection at correct time			
D-4. Wash hands before injections			
D-5. (If reusable) Use newly reprocessed needle and syringe			
D-6. Stir/mix bottle before drawing dose			
D-7. Clean and air-dry injection site before injection			
D-8. (If gluteal) Inject in upper outer quadrant			
D-9. Draw back plunger before injection			
D-10. Allow dose to self-disperse instead of massaging			
D-11. Dispose of sharps in puncture-resistant containers			

B. Pelvic Exam

31. Did the provider:	Yes	No	N/A
P-1. Ensure client has privacy			
P-2. Prepare all instruments before exam			
P-3. Wash hands before exam			
P-4. Use sterilized or high-level disinfected instruments for each exam			
P-5. Put on new or disinfected gloves before exam			
P-6. Inspect the external genitalia			
P-7. Ask the client to take slow, deep breaths, and relax all muscles			
P-8. (If used) Explain speculum insertion procedure to client			
P-9. Inspect the cervix and vaginal mucosa			
P-10. Perform bimanual exam gently and without discomfort to client			
P-11. Ensure that instruments and reusable gloves are decontaminated			

C. IUD Insertion

32. Did the provider:	Yes	No	N/A
I-1. Ensure client has privacy			
I-2. (NEW CLIENT) Reconfirm client's method choice			
I-3. Use sterilized or high-level disinfected instruments			
I-4. Wash hands before putting on gloves			
I-5. Glove hands			
I-6. Conduct speculum exam for RTI/STIs before bimanual exam			
I-7. Conduct bimanual pelvic exam			
I-8. Visualize cervix during cleaning			
I-9. Use tenaculum			
I-10. Sound the uterus before IUD insertion			
I-11. Use the no-touch technique for inserting the IUD			
I-12. Wash hands after removing gloves			
I-13. Ask client to wait/rest for at least 15 minutes after insertion			
I-14. Wipe contaminated surfaces with disinfectant			
I-15. Ensure that instruments and reusable gloves are decontaminated			

33. Time Observed Session Ended: □□:□□
(use military time)

Appendix D

Other Tables

Table 29
Clients' Responses during the Counseling Session (In Percent)

Clients' Responses	Facility		Total	CPR	
	Private	Public		High	Low
Provider Encouraged Clients to Ask Questions					
Yes	85.71	87.86	86.79	89.29	84.29
No	14.29	12.14	13.21	10.71	15.71
Total	**100.00**	**100.00**	**100.00**	**100.00**	**100.00**
No. of Cases	**140**	**140**	**280**	**140**	**140**
Provider Listened to Client's FP Concern					
Yes	97.84	94.20	96.03	97.84	94.20
No	2.16	5.80	3.97	2.16	5.80
Total	**100.00**	**100.00**	**100.00**	**100.00**	**100.00**
No. of Cases	**139**	**138**	**277**	**139**	**138**
Provider Showed Understanding of Client's FP Problem					
Yes	95.71	93.53	94.62	95.71	93.53
No	4.29	6.47	5.38	4.29	6.47
Total	**100.00**	**100.00**	**100.00**	**100.00**	**100.00**
No. of Cases	**140**	**139**	**279**	**140**	**139**
Provider Initiated Solution to Client's FP Problem					
Yes	94.24	92.56	93.55	93.57	93.53
No	5.76	7.14	6.45	6.43	6.47
Total	**100.00**	**100.00**	**100.00**	**100.00**	**100.00**
No. of Cases	**139**	**140**	**279**	**140**	**139**
Provider Was Trustworthy					
Yes	98.57	95.68	97.13	96.43	97.84
No	1.43	4.32	2.87	3.57	2.16
Total	**100.00**	**100.00**	**100.00**	**100.00**	**100.00**
No. of Cases	**140**	**139**	**279**	**140**	**139**
Provider Gave Complete Information to Clients					
Yes	94.96	87.68	91.34	92.03	90.65
No	5.04	12.32	8.66	7.97	9.35
Total	**100.00**	**100.00**	**100.00**	**100.00**	**100.00**
No. of Cases	**139**	**138**	**277**	**138**	**139**
Clients Asked Questions during the Counseling Session					
Yes	75.00	69.85	72.46	76.09	68.84
No	25.00	30.15	27.54	23.91	31.16
Total	**100.00**	**100.00**	**100.00**	**100.00**	**100.00**
No. of Cases	**140**	**136**	**276**	**138**	**138**
Reasons Clients Ask Questions during Counseling Session					
To clarify methods/side-effects	58.10	65.26	61.50	63.81	58.95
For additional knowledge on FP methods	34.28	27.37	31.00	29.52	32.63
Provider encouraged the client to talk	6.67	4.21	5.50	3.81	7.37
So client won't forget	0.95	1.05	1.00	1.91	–
To talk about family life	–	1.05	0.50	–	1.05
So client will be encouraged to use FP	–	1.05	0.50	0.95	–
No. of Responses	**105**	**95**	**200**	**105**	**95**

Clients' Responses	Facility		Total	CPR	
	Private	Public		High	Low
Reasons Clients Don't Ask Questions during Counseling Session					
Provider explained the method well	51.43	41.46	46.05	60.61	34.88
Know details already	20.00	14.63	17.10	9.09	23.26
Just listened	8.57	12.20	10.53	12.12	9.30
Ashamed with other clients	11.43	2.44	6.58	9.09	4.65
Provider was in a hurry	–	12.20	6.58	3.03	9.30
No FP problems	5.71	4.88	5.26	3.03	6.98
No chance to ask	–	7.32	3.95	3.03	4.65
Client doesn't stay long	2.86	2.44	2.63	–	4.65
It was an informal interaction (outside)	–	2.43	1.32	–	2.32
No. of Responses	**35**	**41**	**76**	**33**	**43**
Client Will Recommend the Primary FP Facility					
Yes	98.56	95.00	96.77	96.40	97.14
No	1.44	5.00	3.23	3.60	2.86
Total	**100.00**	**100.00**	**100.00**	**100.00**	**100.00**
No. of Cases	**139**	**140**	**279**	**139**	**140**
Situations that Will Make Clients Comfortable in Asking Questions					
Friendly provider	35.29	32.35	33.82	27.74	40.00
Provider is sensitive to client's needs	14.71	9.56	12.13	15.33	8.89
Knowledgeable provider	13.24	10.29	11.77	8.03	15.56
Good-natured provider	9.56	12.50	11.03	8.03	14.07
Privacy/confidentiality is observed	8.82	12.50	10.66	13.87	7.41
Attentive provider	5.15	8.82	6.99	10.22	3.70
Provider encourages client to ask questions	8.09	3.68	5.88	6.87	5.19
Trustworthy provider	3.68	7.35	5.51	8.76	2.22
Provider is not discriminating	1.47	1.47	1.47	0.73	2.22
Good building structure	–	0.74	0.37	–	0.74
Good clinic ventilation	–	0.74	0.37	0.73	–
No. of Responses	**136**	**136**	**272**	**137**	**135**
Presence of Differences between the Ideal and the Actual FP Facility					
Yes	68.84	76.64	72.73	75.00	70.37
No	31.16	23.36	27.27	25.00	29.63
Total	**100.00**	**100.00**	**100.00**	**100.00**	**100.00**
No. of Cases	**138**	**137**	**275**	**140**	**135**

Table 30
Nonclients' Responses during the Counseling Session (In Percent)

Nonclients' Responses	Facility		Total	CPR	
	Private	Public		High	Low
Description of Provider's Behavior during the Actual Counseling					
Good interpersonal communication skills	73.03	75.84	74.44	79.52	70
Good at attending to client's needs (counseling)	20.23	15.73	17.98	12.05	23.16
Good at information-giving (teaching)	1.69	2.82	2.25	3.61	1.05
Committed to work	2.25	0.56	1.40	1.20	1.58
Strict	0.56	2.25	1.40	0.61	2.11
Quality service provided yet affordable	1.12	1.12	1.12	1.20	1.05
Didn't explain the method well	0.56	1.12	0.84	0.61	1.05
Didn't give enough time to client	0.56	0.56	0.56	1.20	–
No. of Responses	**178**	**178**	**356**	**166**	**190**
Provider Listened to Nonclient's FP Concern					
Yes	94.78	96.32	95.56	96.40	94.66
No	5.22	3.68	4.44	3.60	5.34
Total	**100.00**	**100.00**	**100.00**	**100.00**	**100.00**
No. of Cases	**134**	**136**	**270**	**139**	**131**
Provider Showed Understanding of Nonclients' FP Problem					
Yes	94.93	94.03	94.49	94.93	94.03
No	5.07	5.97	5.51	5.07	5.97
Total	**100.00**	**100.00**	**100.00**	**100.00**	**100.00**
No. of Cases	**138**	**134**	**272**	**138**	**134**
Provider Initiated Solution to Nonclients' FP Problem					
Yes	90.37	93.33	91.85	92.70	90.98
No	9.63	6.67	8.15	7.30	9.02
Total	**100.00**	**100.00**	**100.00**	**100.00**	**100.00**
No. of Cases	**135**	**135**	**270**	**137**	**133**
Characteristics of an Ideal FP Counseling Provider					
Easily understood by clients	24.81	26.92	25.87	27.41	24.19
Knowledgeable	20.16	23.08	21.62	24.44	18.55
Helps client solve FP problem	10.08	16.15	13.13	10.37	16.13
High volume of patients	10.85	6.92	8.88	10.37	7.26
Trained and credible	12.4	4.62	8.49	6.67	10.48
Experienced in using and dispensing FP methods	5.43	7.69	6.56	4.44	8.86
Knows how to deal with clients	7.75	3.85	5.79	6.67	4.84
Gives correct information to clients	5.43	2.31	3.86	6.67	0.81
Efficient workflow	0.77	3.85	2.32	–	4.84
Clients did not experience any unpleasant side-effects	0.77	3.08	1.93	1.48	2.42
Honest	1.55	–	0.77	0.74	0.81
Good listener	–	0.77	0.39	–	0.81
Patient	–	0.76	0.39	0.74	–
No. of Responses	**129**	**130**	**259**	**135**	**124**

Nonclients' Responses	Facility		Total	CPR	
	Private	Public		High	Low
Provider Was Trustworthy					
Yes	96.43	95.28	95.88	94.12	97.71
No	3.57	4.72	4.12	5.88	2.29
Total	**100.00**	**100.00**	**100.00**	**100.00**	**100.00**
No. of Cases	**140**	**127**	**267**	**136**	**131**
Provider Gave Complete Information to Nonclient during Counseling Session					
Yes	94.96	87.86	91.34	92.03	90.65
No	5.04	12.32	8.66	7.97	9.35
Total	**100.00**	**100.00**	**100.00**	**100.00**	**100.00**
No. of Cases	**139**	**138**	**277**	**138**	**139**
Behavior of Provider Liked Most by Nonclients					
Explains the method well	29.17	34.33	31.90	31.30	32.37
Good attitude towards clients	35.83	20.89	27.95	24.35	30.94
Gives good advice on sexuality and FP	9.17	12.68	11.02	6.07	15.11
Gives clients freedom to choose	5.00	7.46	6.31	8.70	4.32
Listens attentively to clients	4.17	5.97	5.12	9.57	1.43
Answers all questions well	3.33	5.97	4.72	6.07	3.60
Uses IEC materials during counseling	2.50	4.48	3.54	5.22	2.16
Honest	2.50	1.49	2.00	–	3.60
Anticipates clients' needs	2.50	1.49	1.97	2.61	1.43
Uses simple terms when counseling	1.67	2.25	1.97	1.74	2.16
Gives IEC materials to take home	1.67	0.75	1.18	1.74	0.72
Explains side-effects	0.83	0.75	0.79	0.87	0.72
Efficient	0.83	–	0.39	0.87	–
Familiar with the client	0.83	–	0.39	–	0.77
Helps clients choose FP method	–	0.75	0.39	0.87	–
Not boring	–	0.75	0.39	–	0.72
No. of Responses	**120**	**134**	**254**	**115**	**139**
Presence of Differences between the Ideal and the Actual FP Facility					
Yes	73.97	77.78	75.74	69.70	81.43
No	26.03	22.22	24.26	30.30	18.57
No. of Cases	**136**	**136**	**272**	**132**	**140**

Table 31
Other FP Counseling-related Information

FP Counseling Included in Goals/Mission	Facility		Total	CPR	
	Public	Private		High	Low
Included in clinic goals/mission	9	5	14	8	6
Addressed specifically	4	4	8	3	5
Doesn't know/no idea	–	2	2	1	1
No. of Cases	**13**	**11**	**24**	**12**	**12**
FP Counseling Addressed in Performance Objectives					
Yes	11	9	20	9	11
No	1	1	2	1	1
No. of Cases	**12**	**10**	**22**	**10**	**12**
FP Counseling Addressed in Site Strategies					
Yes	11	9	20	11	9
No	2	–	2	–	2
No. of Cases	**13**	**9**	**22**	**11**	**11**
Provider Feels He/She Has All the Knowledge and Skills to Effectively Counsel Clients					
Yes	6	4	10	6	4
No	10	10	20	11	9
No. of Cases	**16**	**14**	**30**	**17**	**13**

Table 49
Distribution of FP Method Stocks that Ran Out in the Past Six Months and Ways of Ensuring Availability of FP Supplies and Commodities, by Type of Health Facility and CPR Performance

Stocks that Run Out in the Last Six Months	Facility		Total	CPR	
	Public	Private		High	Low
• Injectables					
Yes	2	1	3	2	1
No	9	6	15	7	8
No. of Cases	**11**	**7**	**18**	**9**	**9**
• Pills					
Yes	5	2	7	2	5
No.	6	6	12	7	5
No. of Cases	**11**	**8**	**19**	**9**	**10**
• IUD					
Yes	–	1	1	–	1
No	10	7	17	9	8
No. of Cases	**10**	**8**	**18**	**9**	**9**
• Condom					
Yes	2	2	4	2	2
No	9	6	15	7	8
No. of Cases	**11**	**8**	**19**	**9**	**10**

Ways to Ensure Availability of FP Supplies	Facility		Total
	Public	Private	
Efficient reporting/requisition system	11	6	17
Efficient distribution/delivery system	5	5	10
Assigning a specific supply officer	2	1	3
Keeping extra or buffer stocks	1	5	6
Client provides supply for self	2	2	4
Emergency procurement as needed	2	2	4
Proper storage	3	–	3
Donations/other sources	1	–	1
No. of Responses	**27**	**21**	**48**
No. of Cases	**13**	**11**	**24**

Table 56
Position and Degree of Staff, by Type of Health Facility and CPR Performance

Position	Facility		Total	CPR	
	Public	Private		High	Low
Midwife/PHM/RHM	18	2	20	8	12
Nurse/PHN	7	–	7	3	4
Nurse supervisor/coordinator	4	3	7	3	4
Clinic assistant	–	4	4	1	3
FP counselor	–	3	3	2	1
Clinic manager	–	3	3	2	1
Medical technologist	2	1	3	2	1
Field educator	–	2	2	2	–
Physician	1	–	1	1	–
BHW	1	–	1	–	1
No. of Responses	**33**	**18**	**51**	**24**	**27**
Degree					
B.S. Nursing	11	10	21	10	11
B.S. Midwifery	16	4	20	9	11
B.S. Medical Technology	3	1	4	2	2
B.S. Nursing undergrad	1	2	3	2	1
Master in Public Health	2	–	2	1	1
B.S. Community Health	–	1	1	–	1
No. of Responses	**33**	**18**	**51**	**24**	**27**
No. of Cases	**13**	**11**	**24**	**12**	**12**

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About the Research Team

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Dr. Loyd Norella is an Assistant Professorial Lecturer at the Psychology Department of the DLSU Graduate School, and a Research Fellow of the SDRC. He obtained his Doctor of Medicine from the University of the Philippines–Manila and is currently pursuing his Ph.D. in Counseling Psychology at De La Salle University. Likewise, he is a Medical Specialist in Venerealogy and Reproductive Health at the Remedios AIDS Foundation, and Chief Consultant of Primefil Psychological Services. His research interests focus mostly on reproductive health, sexuality, and sexually transmitted diseases. He has presented papers in conferences here and abroad including the 4th Health in Difference Conference in Sydney, Australia and the 6th Asia Pacific Social Sciences and Medicine Conference in Kunming, China.

Dr. Jose Alberto "Jo-Al" Reyes is currently an Associate Professor at the Counseling and Educational Psychology Department of De La Salle University. He completed his Ph.D. in Counseling Psychology at Washington State University where he merited the Leroy Olsen Memorial Award for excellence in Counseling Psychology. Recently, he obtained a citation from the National Academy of Science and Technology (NAST) as an Outstanding Young Scientist in the Field of Psychology. He received his M.A. and B.A. degrees in Psychology from the University of the Philippines. His research interests include the cross-cultural study of personality, the appraisal of emotions, and counselor supervision. He has published research articles in the European Journal of Personality, Journal of Cross-Cultural Psychology, Journal of Personality, and Cognition and Emotion.

Ms. Cristina "Cristy" Rodriguez is an Assistant Professor at the Behavioral Sciences Department and Research Fellow at the SDRC of De La Salle University. She obtained her M.A. degree in Demography from Xavier University and her B.A. in Behavioral Sciences from De La Salle University. She also completed a special training on qualitative data analysis at the Royal Institute and the Universiteit van Amsterdam in 1997, and was a visiting researcher in reproductive health at the Liverpool School of Tropical Medicine in England in 1996. She has been involved in a number of research projects on health and family planning issues. As a resource person, she has delivered papers in local and international conferences including that on immunization in 1996 in the Netherlands.

QUALITY OF FAMILY PLANNING COUNSELING
LENS FROM STAKEHOLDERS

is the first definitive study on the state of family planning (FP) counseling in the Philippines.

In this landmark volume, clients, nonclients, providers, and supervisors assess the FP counseling process and methods; personnel; client-provider interaction (CPI); management and support system; as well as the physical environment of selected public health centers and private clinics nationwide.

Instruments, findings, and recommendations of this research—reviewed by the Center for Communication Programs of the Johns Hopkins University Bloomberg School of Public Health—will serve as valuable resource for policymakers, program managers, academics, and groups involved and/or interested in counseling Filipinos on FP methods.

DISCOVER, among others, the gap between the ideal and the actual service facility as well as the socioeconomic and environmental factors and tools to ensure the success of an FP program.

KNOW the concerns, needs, and perceptions of stakeholders, particularly

- *Clients'* reasons for referring others to FP providers, their proper behavior during counseling, and their concept of a model counselor;
- *Nonclients'* frequently asked questions relative to FP and their idea of a conducive clinical environment;
- *Providers'* qualities liked most by clients and communicative/ motivational skills needed for effective counseling; and
- *Supervisors'* initiatives to improve the quality of health services, and requisites of and crucial training areas for FP counselors.

LEARN how the researchers rate FP providers' delivery of services based on the latter's use of the GATHER APPROACH in counseling.

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Johns Hopkins University
Center for Communication Programs
Bloomberg School of Public Health
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Nonclients' Responses	Facility		Total	CPR	
	Private	Public		High	Low
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Total	**100.00**	**100.00**	**100.00**	**100.00**	**100.00**
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Table 31
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No	1	1	2	1	1
No. of Cases	**12**	**10**	**22**	**10**	**12**
FP Counseling Addressed in Site Strategies					
Yes	11	9	20	11	9
No	2	–	2	–	2
No. of Cases	**13**	**9**	**22**	**11**	**11**
Provider Feels He/She Has All the Knowledge and Skills to Effectively Counsel Clients					
Yes	6	4	10	6	4
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No. of Cases	**16**	**14**	**30**	**17**	**13**