
1998

Technical assistance to enhance the institutionalization of operations research within the Philippines Family Planning Program

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**TECHNICAL ASSISTANCE TO ENHANCE
THE INSTITUTIONALIZATION OF
OPERATIONS RESEARCH IN THE
PHILIPPINE FAMILY PLANNING PROGRAM**

PHILIPPINES

Final Report

**ASIA & NEAR EAST OPERATIONS RESEARCH AND TECHNICAL
ASSISTANCE (ANE OR/TA) PROJECT
FAMILY PLANNING OPERATIONS RESEARCH AND
TRAINING (FPORT) PROGRAM**

**USAID Contract No. DPE-C-00-90-0002-10
Strategies for Improving Family Planning Service Delivery**

July 1998

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TECHNICAL ASSISTANCE TO ENHANCE THE INSTITUTIONALIZATION OF OPERATIONS RESEARCH IN THE PHILIPPINE FAMILY PLANNING PROGRAM

This technical assistance project was implemented to support the overall goal of the Asia Near East Operations Research and Technical Assistance (ANE OR/TA) to help strengthen FP/RH operations research (OR) capabilities in the Philippines.

During the extension period of the ANE OR/TA project, four OR studies were implemented in the Philippines dealing with various cross-cutting issues, including a study to assess the feasibility of integrating RTI management within FP/MCH programs; an intervention study dealing with improving quality of care via expanded FP counseling program in Davao del Norte Province; an intervention to address the problem of high unmet need in Pangasinan Province; and an intervention study to increase male involvement in reproductive health in Bukidnon Province. These efforts, along with the start of another project to study factors affecting the use and discontinuation of IUD, have generated demand for technical assistance, along with corresponding personnel needed to provide such assistance, thereby necessitating this TA initiative. Various activities involved in this regard include the provision of advice on technical questions (e.g. research design and instrumentation), serving as resource persons in training on research design and methodology, assisting in data analysis, writing up and disseminating project findings, travel to project sites and various monitoring and coordinating activities.

The following table specifies activities undertaken to fulfill the objectives of capacity building and institutionalization of OR in the country covered under this contract. The personnel involved in each of these activities are also listed as well as the different products, some of which are submitted as annexes to this report.

**Table 1. --Activities undertaken under the Technical Assistance Project,
FPORT, PC-Manila, 1997-98**

Activity	Personnel Involved	Date	Product/Outcome
1. TA provided to Pangasinan Study Team to develop the Algorithm for women with unmet need for FP and switching (UNA). This involved meetings with project directors, serving as resource persons in trainings on UNA and Situation Analysis	M. Costello M.E. Khan* C. Echavez	May '97- May '98	1. SA Instruments 2. Training of SPS on Counseling 3. UNA Algorithm-Community-Based Monitoring Information System 4. Final Project Report
2. Publication of <u>Research Updates</u> and <u>Project Summaries</u> and <u>Policy Brief</u> . The Updates were on the RTI Study, the Davao Study and the Pangasinan Study. The Policy Brief is on <u>Population Momentum and Other Sources of Population Growth: Implications for Program and Policy</u> and <u>Integrating RTI Services in Primary Health Care Centers in the Philippines: Implications for Program Managers</u>	M. Costello M. Maru L. Padilla C. Echavez A. Herrin	Oct.1-30, '97 March 1-31, '98	1. Three <u>Research Updates</u> and <u>Project Summaries</u> 2. Two <u>Policy Briefs</u> (see annexes) 3. Presentation of the Population Momentum Paper in a PopCom - sponsored forum in Cebu City by Dr. Alex Herrin
3. Development (in the local language) and distribution of IEC material on RTI to be used for the community education campaign in Quezon City, Misamis Oriental and Cagayan de Oro City	G. Migallos M. Costello C. Chaves C. Echavez	Oct. 6-15, '98	RTI Primer (see annex)
4. Technical assistance in data analysis of the Davao study in preparation for the National Dissemination Workshop	C. White M. Costello J. Cabigon	May 15-22, '98	Analysis of SA data; paper for the RU; and analysis of the panel survey data

Activity	Personnel Involved	Date	Product/Outcome
5. Development of the SA instrument and Analysis of the IUD Study	J. Tuladhar* M. Costello C.Echavez	June 4-15, '98	SA instruments FGD guide questions Preliminary Tables on SA data
6. Local dissemination workshop on the results of the RTI Study in Cebu City co-sponsored with the Task Force on Reproductive Health	L. Padilla M. Costello C. Chaves C.Echavez, and various physicians and service providers who were part of the intervention study	Jan 15-16, '98	Papers presented by PIs; Presentations of RTI report to members of the academe, CAs, Task Force in R.H. and Social Science
7. Preparation of RTI papers for presentation in Indonesia and the involvement of Dr. Renee Faldas, STD/AIDS, DOH	M. Costello J. Encena C. Chaves C. Echavez R. Faldas	November 15-Dec.2,'97	Three papers on: 1. Syndromic Management of RTI 2. Prevalence of Chlamydia and Gonorrhea in the Philippines 3. Cost Analysis of Integrating RTI Management
8. Development of proposal to hold the National Dissemination Workshop in EDSa Plaza Hotel	M. Maru M. Costello	May 15-16, '98	Proposal for holding of national RU workshop
9. Attendance of DOH on Quality of Care Initiative	M. Costello	Jan 7-9, '98	Paper on Population Council, Manila's Quality of Care Initiatives
10. Finalization (editing, data analysis) of Project reports. Consultations with project investigators	E. Ottolenghi* J. Stoeckel* M. Costello	June 9-18, '98	Final Project reports: Male Involvement; RTI Study; Davao Study; and Pangasinan Study

Activity	Personnel Involved	Date	Product/Outcome
11. TA on data management	F. Arguillas	May 14-15, '98	Training held in Xavier University for the researchers using the ISSA software for data management. Attended by researchers in RIMCU and Central Philippines University, Iloilo City
12. Facilitating the link of research institutions (OR centers) to POPLINE and distribution of PC publications to over 300 individuals and organizations throughout the country.	J. Cabrias	'97-'98	Purchase of CD-ROM for Central Philippine University (Social Science Research Center), Ateneo de Davao Social Research Center, RIMCU, Xavier University. Facilitated the FPS-DOH reconnection to POPLINE.
13. Meetings with the OR Task Force members: First meeting: Reviewed the composition of the OR task force as well as identify probable OR topics/areas Second meeting: Discussed with the POPTECH evaluator re-OR institutionalization Third meeting: Discussed the format of the RU workshop	M.P.Costello C.Echavez OR Task Force Members: A. Herrin, M.A.Costello, L. Muego, E. Despabiladeras, L. Roquero, O. Pagulayan, Z. Zablan, A. Hornido, E. Abocejo,	Jan. 27, '98 Feb. 25, '98 May 8, '98	- clarified OR Task Force membership -identified OR priority areas/topics -came up with an institutionalization plan of OR and research utilization within the DOH - finalized format of RU conference

*Local travel and/or hotel costs only

A copy of the proposal for this project is included in this report as an annex.

ANNEXES

Annex 1

PROPOSAL FOR TECHNICAL ASSISTANCE TO ENHANCE THE INSTITUTIONALIZATION OF OPERATIONS RESEARCH WITHIN THE PHILIPPINE FAMILY PLANNING PROGRAM

Background

The Family Planning Operations Research and Training (FPORT) program was initiated in June 1992 to strengthen family planning OR capabilities in the Philippines. This program was initiated as a means of addressing USAID's strategic objective of "reduced population growth and improved maternal and child health" through the ANE OR/TA.

The OR Country Strategy under the IFPMHP consists of four separate activities: (1) conducting OR training workshops for program managers and researchers, (2) conducting OR studies on cross-cutting issues, (3) technical assistance to the DOH, LGUs and researchers, and (4) carrying out various research dissemination and utilization activities.

During the period June 1992 to July 1995, FPORT undertook five diagnostic studies in collaboration with regional institutions, located throughout the country. Issues addressed include strategies to improve volunteer worker performance, reductions in family planning drop-out rates, the training of service providers, and an evaluation of an industry-based program.

A series of studies on national-level effort to introduce DMPA to the Philippine FP program soon followed. These included assessments of the quality of DMPA service delivery and projections of future demand for this contraceptive.

In January and July 1996, the two OR workshops were held in response to the newly developed OR Country Strategy. These resulted in the eventual development of several OR study proposals, including (1) a study to assess the feasibility of integrating RTI management into the LGU health care system, (2) an intervention study on the provision of improved quality of care via an expanded FP counseling program in Davao del Norte province, (3) an intervention study on an effort to reduce the unmet need for FP in Pangasinan Province, and (4) an intervention study on increasing male involvement in rural communities of Bukidnon Province.

Work has already begun on two of the first two of the above-listed research projects and will soon commence on the others. Overall these efforts have generated an increased demand for TA along with a corresponding personnel needed to provide such assistance. Various activities are involved here including the provision of advice on technical questions (e.g. research design and instrumentation), assistance in writing up and disseminating project findings, travel to project sites and various monitoring and coordinative activities.

Objectives

The three specific objectives of FPORT are (1) the institutionalization of OR within the national FP program, (2) strengthening of OR capacity within selected LGUs and research centers, (3) the conduct of OR studies on various cross-cutting issues. In order to meet these objectives within the context of an expanding FPORT, this technical assistance proposal has been developed.

By providing technical assistance, the Council will help to build the capacity of national and local organization to conduct OR and to use the findings from this research to refine and upscale feasible activities. One of the ways of building capacity is to work together with local counterparts, particularly in developing OR research proposals, designing programs, implementing and monitoring project activities, and disseminating research findings beyond LGU boundaries. The Council therefore plans to work with the staff of the DOH, with LGU officials and with local research institutions in support of the following activities:

1. Implementation and monitoring of the four major studies on cross-cutting issues outlined above;
2. Technical assistance to LGUs, NGOs, and local research institutions to carry out their role in these studies;
3. Technical assistance in disseminating and utilizing OR findings to other LGUs; and
4. Efforts to foster linkages between research institutions, LGUs, the DOH, the ENHR and the national-level OR Task Force to support the full institutionalization of OR within these bodies.

It is proposed under this project to hire at least two consultants/temporary assistants in the implementation of the above activities. These are required for various forms of TA to be provided to project teams, including project monitoring, and report writing. These personnel will likewise assist the country advisor in OR dissemination activities.

Timetable

This technical assistance plan covers the period of 9 months (May 1997-January 1998).

Budget

The following budget outlines project costs in broad categories:

Personnel (two persons for 9 mos. \$1000)	\$18,000
Travel	4,500
Communications, reproduction, supplies and materials	1,000
Meetings (National OR Task Force)	1,450

Total	\$24,950

INTEGRATING RTI MANAGEMENT IN LGU HEALTH CENTERS

Number

1

August

1997

BACKGROUND

Since 1994, the Department of Health (DOH) has been involved in efforts to address the problem of reproductive tract infections (RTIs) among both men and women in the Philippines. A series of training workshops for social hygiene physicians was held in 1995 while a standard STD management guideline was formally launched a year later, under the leadership of the STD/AIDS unit of the DOH. To date, the emphasis has largely been on utilizing the syndromic management guidelines first developed by the World Health Organization.

These developments represent a response to the call for improved reproductive health that emerged from the International Conference on Population and Development which was held in 1994 in Cairo, Egypt. They are supported as well by various studies which have emphasized both the potentially serious consequences of RTIs and the apparently widespread incidence of these diseases both in the Philippines and in other Third World countries.

At present, sexually transmitted diseases are not being treated in most Local Government Units (LGUs) health centers. The prevailing assumption would appear to be that these conditions are concentrated heavily among commercial sex workers (CSWs) and that they can therefore best be treated within the context of the urban-based "social hygiene clinics." This approach, however, is generally unable to cope with RTIs that are noted among members of the general public. For example, individuals who contract an STD from a CSW may end up passing this on to their spouse. Furthermore, RTIs may also be traced to factors other than sexual transmission, e.g. those due to endogenous or iatrogenic causes.

These considerations indicate the need for an integrated approach to RTI case management, i.e. one which will make it possible for a wide range of clients to receive both family planning and reproductive health services in the main health center of their town or city. This means that clinic personnel should be prepared to deal with RTIs, including HIV/AIDS through a variety of complementary mechanisms: risk assessment, diagnosis and treatment services, referrals and public health campaigns.

It is evident that the goal of integration is as yet far from being reached. Even though the social hygiene clinics are available, this approach holds little appeal for the general public, due to its stigmatizing tendencies. Nor can we say that the local health clinics are filling this gap, since current service statistics indicate that they are rarely being used for this purpose. In addition, service providers in these settings tend to manage cases based only on their own particular clinical experience. Most typically, standard procedures are not being followed in these cases.

The RTI Management Study

Given the above situation, the Family Planning Operations Research and Training program (FPORT) of the DOH and the ANE OR/TA Population Council, Manila sponsored a project to study the feasibility of integrating RTI case management within the FP/MCH services of local governmental health centers. RTIs are defined as encompassing all infections in the reproductive tract due to iatrogenic and endogenous causes, including STDs.

This intervention study aimed at, first, strengthening the capacity of local health centers to manage RTI cases and, secondly, at analyzing the eventual costs of this type of programmatic change. More specifically, the intervention was originally projected to include three major types of activities, namely:

- Trainings (training of service providers on RTI case management, refresher training for medical technologists),
- Enhancement of diagnostic and curative capabilities (upgrading of lab facilities, provision of drugs), and
- IEC development and community awareness campaigns.

Before proceeding to carry out these activities, two diagnostic-type studies were conducted in the intervention areas, so as to assess current problems and prospective strategies. These consisted of, first, a series of focus group discussions (FGDs) which dealt with local perceptions and behaviors related to the RTI problem. Subsequent to this, a Situation Analysis (SA) of local health centers was also conducted, with particular focus on the integration (or nonintegration) of RTI concerns within their FP and MCH programs.

Areas chosen for study are reflective of three different community types: the highly urbanized setting of Quezon City, Metro Manila; the intermediate-sized city of Cagayan de Oro, and the towns of Tagoloan and Jasaan, Misamis Oriental province. Two health centers were selected from Quezon City, three from Cagayan de Oro and one each from Tagoloan and Jasaan.

Methodology

An FGD is a small group discussion, usually involving about six to ten participants. In keeping with the standard methodological guidelines for this technique, the groups selected for this study were more-or-less homogeneous along sociodemographic lines (age, sex, community of residence) with the discussion being led by a moderator equipped with a set of guide questions. In all, twelve FGDs were held. All discussions were tape recorded; the resulting set of transcripts came to nearly three hundred pages.

The SA methodology involves sending a specially trained study team (which includes one member with a social science background and a medical doctor) to selected health centers. The team was tasked with checking on the health center's readiness to provide certain services (i.e. to check on its facilities, supplies and staffing) and to collect information (through on-site observations and interviews with clients and service providers) on the actual provision of services. Pre-intervention visits were thus made to all of the seven health centers selected to participate in the study. In all, 22 health center personnel were interviewed along with 38 FP clients. Forty-two observations of client-provider interactions were also carried out.

Findings from the FGDs

In general, female discussants were found to know more than males about the different threats to good reproductive health. Women were quite aware of the possibility of contracting a uterine infection although they were generally unable to give the technical (scientific) names for these

conditions. They perceived such infections as being caused by a too-early return to sexual activity after the birth of a child, large family size, use of the IUD and resort to abortion. They had also heard about conditions characterized by vaginal itching. These can be caused, they felt, by a woman's individual actions (e.g. using sanitary napkins, washing oneself in unclean water) as well as by various sexual practices. In the latter category they mentioned lack of cleanliness on the part of the male partner and the use of certain sex gadgets.

Other conditions mentioned by the female respondents included menstrual-related problems (e.g. dysmenorrhea, menstrual delays, overly heavy menstrual flows), infestation of the pubic area by lice, and uterine cancer. Several discussants felt that the latter problem can be brought on by modern methods of FP, such as pills or the IUD.

Both men and women tended to concentrate on illnesses which were of greatest personal concern to them. As such, men were particularly aware of STDs and AIDS, although these were also mentioned by several women. Having sex with a commercial sex worker was generally seen as the major cause of these conditions although some respondents believed that other modes of interpersonal transmission were also possible (e.g. infection from unclean toilet seats or through shared eating utensils).

Sterility, infertility and impotence were also mentioned, particularly by women. Women who cannot bear a child were thought to have a wrongly positioned uterus. This condition may be brought on by "overwork" but can be treated via massage.

Reactions to persons who have contracted an RTI are context dependent. For men, the tendency is to be sympathetic and helpful if a friend of theirs contracts an STD. For strangers and commercial sex workers, though, there is fear of contamination which makes them want to shun the person.

For males, STDs tend to be viewed as an unfortunate but more-or-less normal occurrence in the life of a man. Women, especially wives, who contract an STD, however, will surely be stigmatized. In general, marital strains can be expected once a married person learns that his or her spouse has an STD. This is why most men will attempt to hide this from their wife, should it happen to them. They would rather talk things over with a close friend or a doctor.

During the time when they are undergoing a cure they would just try to find excuses for avoiding sexual contact with their wife. Whether they would always be able to succeed in this endeavor, though, is by no means certain.

There is a general awareness about condoms as both a FP technique and a means of preventing STDs. Neither men nor women, though, looked favorably upon this method, since it is felt that condoms diminish sexual pleasure and cannot be trusted to always work. Men realize as well that they ought to avoid patronizing commercial sex workers although there seems to be an underlying assumption in this case that "everyone falls sooner or later."

Once an STD has been contracted, various traditional cures may be resorted to. The use of antibiotics is also favored - - in some cases because these were prescribed by a doctor, in others on the advice of a friend. The ideal practitioner to be visited after contracting an STD is a medical doctor who is competent, in private practice and of the same sex as the patient. Privacy and confidentiality are of paramount importance in all such instances.

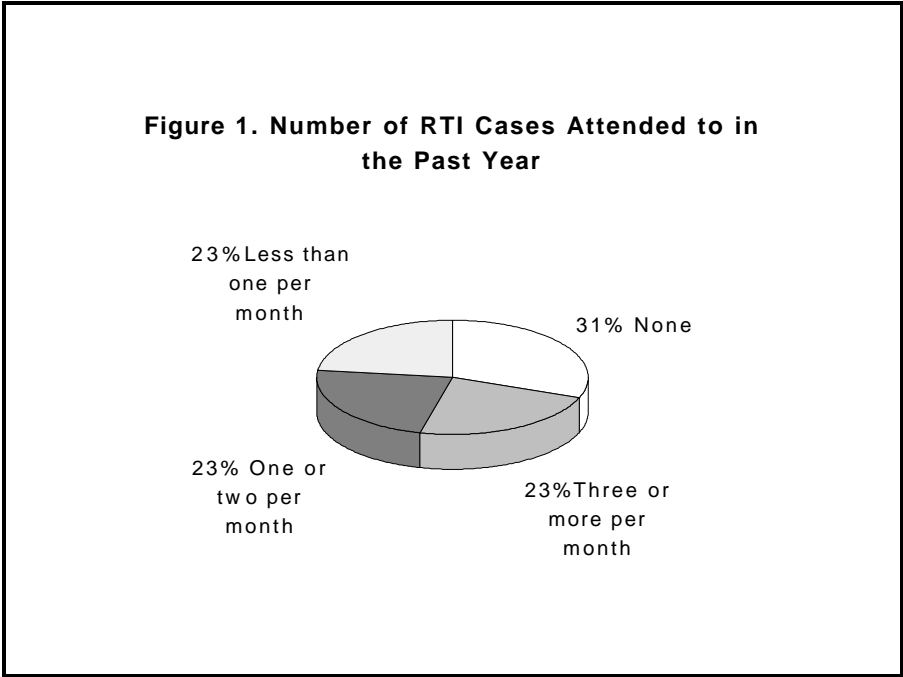
Findings from the Situation Analysis

In general, the clinics were found to be clean, with adequate light and water. Visual and auditory privacy could be had in nearly all examination areas.

Capacities for carrying out lab exams were limited. Microscopes were available in six of the seven centers, but only four had glass slides and none had staining reagents for RTI microscopy. All of the major lab tests for detecting RTIs (gram staining, wet mount smears, Pap smears, KOH preparations) had to be referred to other service delivery points (SDPs).

Four of the seven health centers kept separate records for RTI cases but there was no standard form for these so they were not reported in the regular (monthly) FP statistic reports.

Nearly all of the twenty-two service providers (SPs) interviewed had heard about RTIs. Only three, however, had been trained in RTI management, with even these SPs admitting that they still felt unsure of their abilities in this regard. Most, therefore, said that they refer such cases to some other clinic or SDP. A little more than half of all the respondents said that they had never attended to such a case or that they did so only a few times every year (Figure 1).



All of the service providers agreed that condoms offer protection against STDs; unfortunately, nearly three out of four (73 percent) likewise claimed that contraceptive pills offer the same advantage.

The symptoms of RTIs which were recognized most widely consisted of unusual vagina discharges and lower abdominal pain. Genital sores, fever, painful urination and painful intercourse were all mentioned by less than half of the SPs.

The discussion of topics related to RTIs and STDs was found to be virtually nonexistent during the forty-two observations of client-provider interactions. Neither clients nor providers volunteered any questions or information on this issue. None of the providers discussed a contraceptive method able to offer protection against STDs, RTIs, or AIDS. During history taking and physical exams only five percent or fewer of the SPs asked questions about unusual genital discharges, painful urination or the experience of any other RTI symptom.

Quality of care provided during pelvic examinations was far from optimal. In about half of all cases a completely private and aseptic environment was not ensured. Most women, too, were not informed beforehand as to the exam they would be undergoing or the reason why the SP was calling for this procedure.

Client evaluations of the services provided to them were generally positive. For example, 92 percent were willing to recommend the health center services to their friends. A majority (71 per cent) had already heard about RTIs and/or STDs. Most respondents asserted that they would not feel uncomfortable discussing these topics with a health worker.

Current Activities

Several of the working assumptions which had been used in conceptualizing the study were confirmed by the above findings. In general, neither SPs nor SDPs were found to be well prepared to deal with RTIs. Community awareness is also inadequate, particularly when it comes to such issues as seeking proper medical care for persons infected with STDs, resort to preventive health practices and partner notification. The integration of RTI diagnostic and management services within the local-level health centers is practically nil. As a minimum, improvements need to be made with regard to training, lab facilities, record keeping and drug provision.

Soon after these initial data collection activities had been completed, steps were taken to implement the proposed intervention. A four-day Training Workshop on Integrating RTI Case Management in LGU Health Centers was held on March 18-21, 1997 with twenty-two SPs in attendance. This was followed by an additional training on RTIs (mainly for referral purposes) for midwives in smaller health clinics within the catchment areas of the main health centers included in the study. The refresher-training for medical technologists was also carried out soon after that. Laboratory facilities and equipment were upgraded in all seven main health centers. As a result, simple microscopy procedures can now be carried out in all clinics with medical technologists. Funding sources willing to underwrite the drug provision component of the study were identified.

Even so, further observations have shown that the goal of full-scale integration will not be easily met. In that sense, the present study may be said to provide confirmatory evidence for

a recent, and similar, Kenyan study, which concluded that "there is a considerable amount of work to be done... before a smooth process for providing integrated services is firmly in place" (Twahir, Maggwa and Askew, 1996, p.27)

This conclusion is exemplified by the present study's attempt to upgrade clinic record-keeping procedures for cases of RTI. A special form was prepared for this purpose and distributed to all of the participating clinics. Insofar as the form differed somewhat from the MIS records normally used, it was decided to send the physician-member of the study team to each clinic for a one or two-day visit. During this period the form would be explained more fully and assistance would be rendered for filling it out, as based upon actual case histories.

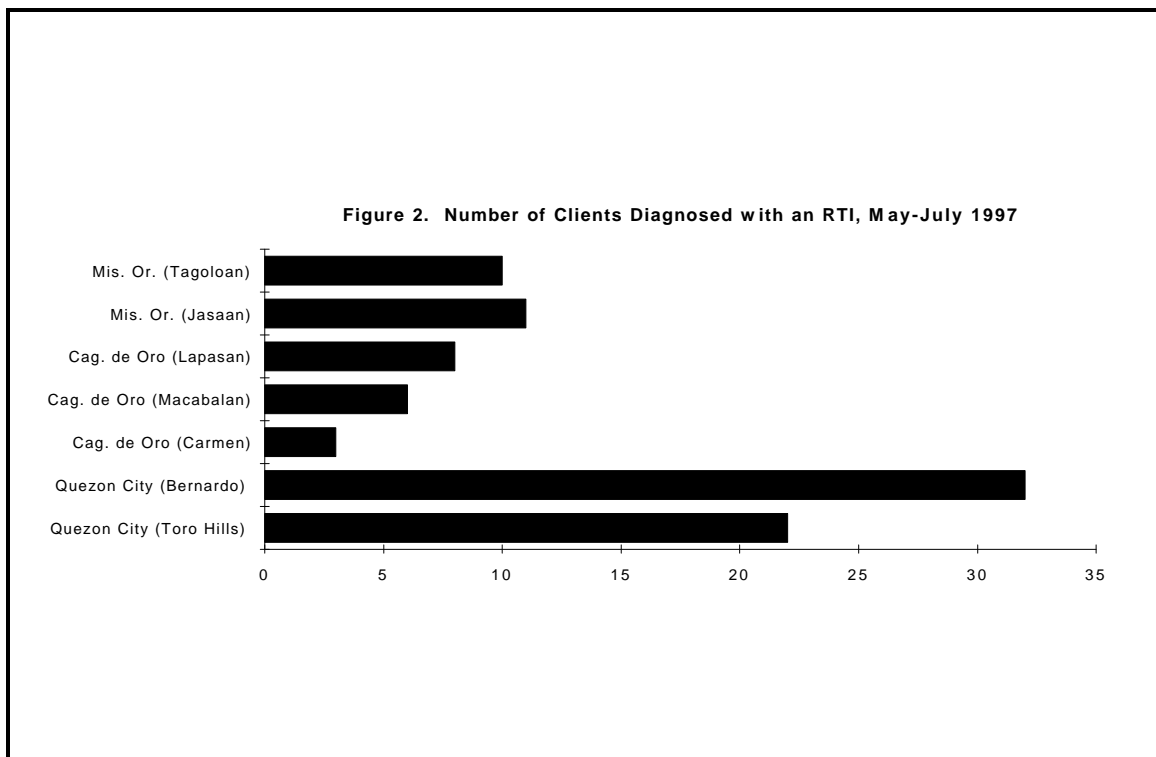
A uniform pattern was soon noted for each of these visits. Time and again, SPs used this occasion to approach the visiting team member to explain and clarify several aspects of the original training, including not only record keeping but also diagnosis and case management. In several instances it was found that clinic personnel had not yet implemented the training guidelines, due perhaps to a lack of experience and confidence on their part. As such, the visiting team member eventually found that he was being asked to stay an average of seven days per clinic, rather than the one or two days originally expected.

What was being borne out of this experience was strong support for the idea of facilitative supervision. By sending its representative to the clinics and re-establishing contact with the SPs, the project was able to motivate and guide them to actually utilize the knowledge and skills imparted during the trains. In that sense, it should not be expected that training alone will suffice, particularly when a major change in an ongoing program is involved.

Preliminary findings from the study would appear to indicate that the intervention has already had a positive impact upon the identification of RTIs among regular FP clients, even in the less urbanized settings of Tagoloan and Jasaan. According to the SA interviews, the median incidence of RTIs that service providers were observing reached no higher than 4 to 6 cases per year. In comparison, no less than ninety-two cases were identified in all of the seven centers during the three-month period from May to July. If these trends were to continue for another nine months, the result would be an average of more than fifty confirmed RTI cases per center per year.

Further analysis of these initial findings would appear to indicate, in fact, that even more cases

could have been identified if full compliance with the intervention had been forthcoming from all seven of the participating health centers. As shown in Figure 2, the number of cases identified for the three Cagayan de Oro clinics are consistently low. One reason for this is that the physicians assigned to these center are only scheduled to visit on a one-half day per week basis. At times (e.g. during trains) even this minimal level of care is not being met. There appear as well to have been some problems with record keeping in at least one of the Cagayan clinics. To the extent, therefore, that these problems could be addressed through further follow-up and advocacy, one result could well be an additional increase in the overall number of RTI cases being identified.



Concluding Observations

Study findings discussed in this report should be considered preliminary in nature, since the RTI Integration Project is still ongoing. Data collection activities will continue until October 1997, with particular attention upon the following issues:

- Diagnosis and treatment of RTI cases,
- Organizational changes (e.g. client loads, referrals) entailed by the integrated approach,
- SP and client assessment of the new approach,
- SP compliance with RTI case management guidelines, and
- Cost analysis.

Detailed clinic records on RTI cases are therefore being kept and a follow-up SA has been scheduled. It is expected that the resulting information will prove helpful in deciding about the desirability and feasibility of policies advocating the nationwide integration of RTI case management within the Philippine Family Planning program. While it is apparent that the project has not yet produced the information needed to fully decide on this, preliminary results presented in this report argue strongly for the need to at least consider such an approach. If the overall goal of the national FP program is to enhance reproductive health, it is apparent that this goal is as yet far from being achieved as far as the management of RTIs are concerned.

Reference

Twahir, Amina, Baker Ndugga Maggwa and Ian Askew. 1996. Integration of STI and HIV/AIDS Services with MCH-FP Services: A Case Study of the Mkomani Clinic Society in Mombasa, Kenya. Operations Research and Technical Assistance Africa Project II, The Population Council.

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For more information on this study, please contact The Population Council, Monteverde Mansions, Unit 2A3, 85 Xavier Street, Greenhills, San Juan, Metro Manila, Philippines. Tel: 63-2-722-6886, Fax: 63-2-721-2786.

IMPROVING FP/RH CLIENT-PROVIDER INFORMATION EXCHANGE: AN INTERVENTION STUDY IN DAVAO DEL NORTE PROVINCE, PHILIPPINES

Number 2

January 1998

Background

In line with the International Conference on Population and Development Program of Action, the population management program in the Philippines has begun to shift its emphasis from contraception to a broader range of reproductive health services, such as maternal and child health and the management of reproductive tract infections.

A major new concern of the program is the provision of improved quality of care. This means that service providers should be ready to take on a more supportive and client-centered perspective. In particular, client-provider interactions should concentrate more on providing information for a free and informed choice than on striving to attain higher levels of contraceptive prevalence or increased couple years of protection against pregnancy (Jain, 1992).

In this context, the Population Council, Manila is undertaking two intervention studies designed to increase the quality of care in family planning and reproductive health service delivery. This report is an update on the quality of care project now being carried out in Davao del Norte province. It provides preliminary data from a series of Situation Analyses recently conducted in that setting by project researchers in collaboration with the Population Council.

Status of the Intervention

The intervention included three major components, the first of which was a training on counseling for health personnel working in local government unit clinics. This was conducted by the AVSC International counseling team using the "GATHER" module and concentrated on the provision of family planning (FP) information as viewed from the client's perspective. Eight major topics were covered:

1. Information about alternative methods,
2. Whether the client would like to switch to another method,
3. Information about other sources of FP supplies,
4. Procedure for using the method selected,
5. Possible side effects of the method,
6. Instructions on what to do in case a problem arises,
7. Duration of effectiveness of each method and
8. Information on follow-up and resupply visits.

It is expected that the training would enhance client-provider information exchange along several dimensions: first, that service providers (SPs) will understand the reproductive intentions and reproductive health needs of their clients and help them to select a method appropriate to their needs and circumstances; second, that SPs will inform clients about available FP methods and clearly explain the proper use of the one selected, where to go for re-supply, and what to do in case of side effects; and third, that SPs will inform clients about the possibility of shifting to another FP method should their current one no longer prove suitable. In general, these changes should work, over time, to increase client satisfaction and continuity of FP use.

Several auxiliary skills were also imparted during the training including the ability to listen to the needs of clients and to draw out information from them. Providers were encouraged to take a less directive approach with clients, e.g. by helping them switch to a new FP method should they experience problems with their current one.

A second project component focused on assisting service providers to deal with identified gaps and weaknesses in service delivery. Monitoring forms and clinic records were modified, so as to reflect new approaches to supervision and counseling. Clinic supervisors (doctors and nurses) were trained in supportive supervision. Actual observations and analyses of client-provider interactions are to be conducted as a regular part of this approach. Service providers may thus be given immediate feedback and assistance, should it become apparent that their counseling techniques were not meeting the expected standard.

Support materials have been prepared. Providers were given a checklist of FP information items which should be discussed with clients during the course of each counseling session. (Separate checklists were prepared for both new and returning clients.) IEC materials were also printed and distributed.

Periodic refresher trains were conducted to ensure a continued review and upgrading in the theory and practice of information exchange. This represented a third major thrust of the project.

Research Methodology

The province of Davao del Norte consists of the provincial capital, Tagum, and twenty-one additional municipalities. These were sorted into ten matched pairs (with Tagum and one other municipality being excluded on grounds that Tagum is too developed and urbanized to allow matching), using such criteria as geographic location, level of urbanization and client-health worker ratios. Within each matched pair one municipality was randomly assigned to the experimental category while the other became part of the control group.

Public sector health services in Philippine municipalities are generally organized along two levels, consisting of a Main Health Center (MHC) or Rural Health Unit (RHU) along with a

number of lower-level Barangay Health Stations (BHS). Main Health Centers are typically located in the town center (poblacion) and may also include two or three barangays within their catchment area. Most are staffed by a doctor, a public health nurse and one or two midwives. In comparison, Barangay Health Stations are generally located in less accessible areas. They are staffed by a midwife who has been employed in either a full-time or part-time capacity.

All medical personnel from the MCH (a doctor, a nurse, one midwife) in the experimental communities were exposed to the training. Midwives working with three randomly selected Barangay Health Stations from these same communities were also trained, thereby bringing the total number of trainees to approximately 60 persons (10 doctors, 10 nurses, 40 midwives).

Training sessions on information exchange were held in January and then again in February 1997 with approximately 30 persons in attendance at each. Data collection began with SP pretests which were carried out immediately prior to each training, in both the experimental and control areas. Questions were asked at this time on FP knowledge, counseling skills, and attitudes towards clients. A post-test on these same areas was also conducted in the experimental communities after the training was completed.

A series of Situation Analyses were conducted in both the experimental and control communities. These included several modules, the first of which concentrated on overall readiness to provide services in the participating clinics. Eleven different readiness dimensions were assessed at this time, including:

1. Number of services provided
2. Accessibility of FP services
3. Physical conditions within the clinic
4. Commodity management
5. Record keeping
6. Management and supervision
7. Readiness to provide information
8. Equipment, supplies and other facilities
9. Commodity inventory
10. Service statistics
11. Training.

Interviews were conducted with both staff members and clients. In addition, observations of client-provider interactions which focussed on several different quality of care dimensions were conducted.

An exit interview of clients supplemented the Situation Analysis. In addition to background information, questions were posed at this time on reproductive intentions, reproductive morbidity, FP history and plans for the immediate future, knowledge about FP methods and service availability, and the client's assessment of the quality of FP services which she had just received.

Follow-up interviews with a large number of married women of reproductive age were also conducted. In this Update, however, we will concentrate only upon research findings from the initial (pre-intervention) Situation Analyses, as were conducted in both the experimental and control communities.

Findings from the Initial Situation Analyses

As would be expected from the matching procedures utilized in this study, the results show few differences between the experimental and the control communities with regard to the readiness to provide services. As reported by the providers, the methods provided by the SDPs are the pill, injectables, condoms, IUDs, natural family planning, LAM and BTI referrals. However, no BTI referrals were found during the inventory proper.

Service provision was short in terms of clinic hours, with only 37 out of 71 SDPs offering services throughout the day (Chart 1). Only 11% of the SDPs had signs informing clients when FP services were available.

Clinic infrastructures were generally dismal: 82% of the clinics did not have piped running water, 37% were not served by electricity, and 23% did not have a working toilet or latrine (Table 1).

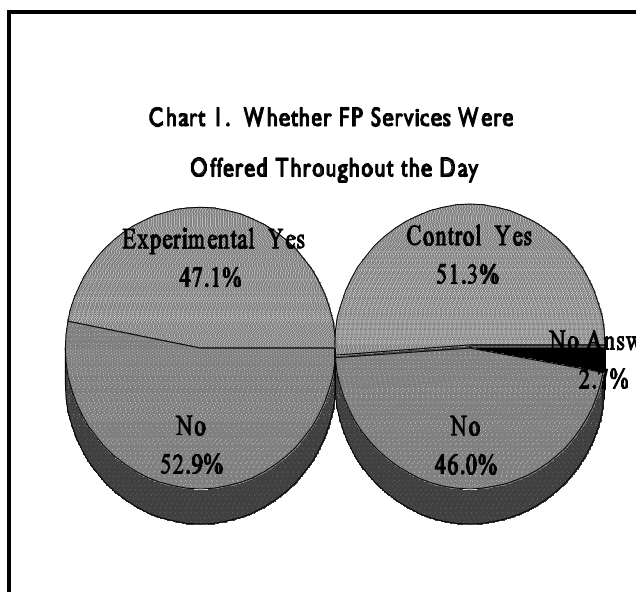
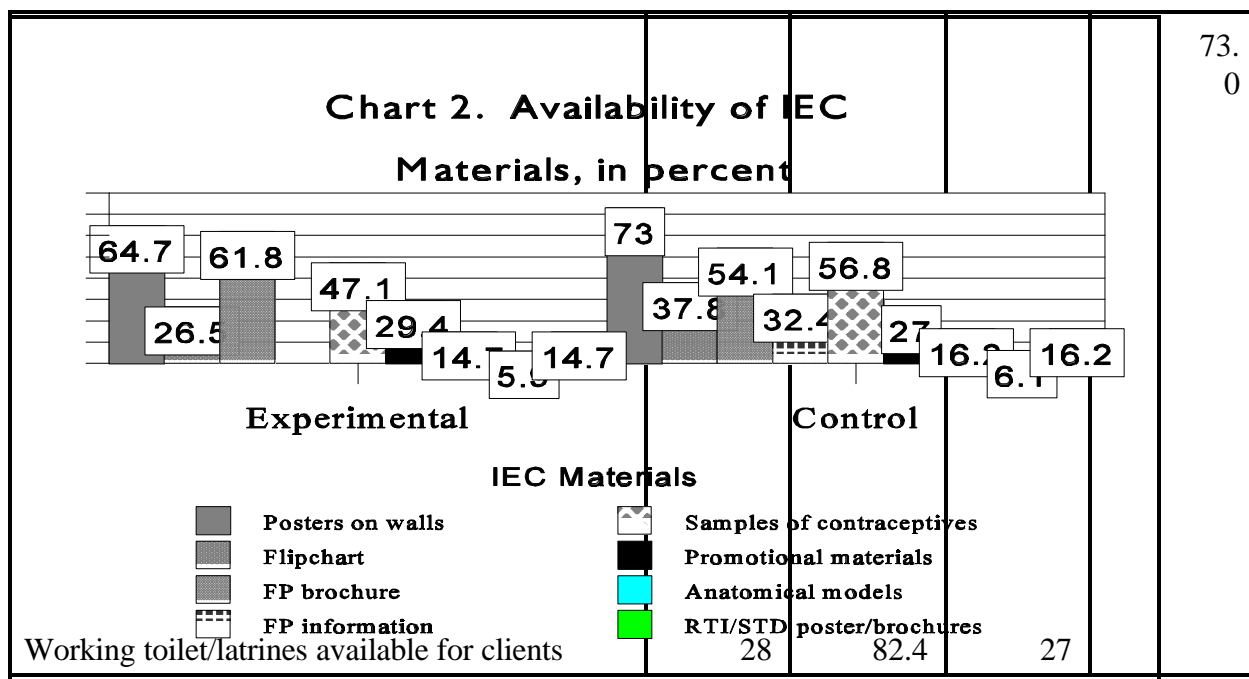


Table 1. Inventory of Physical Facilities

Facility	Experimental		Control	
	No.	%	No.	%
Piped running water	8	23.5	5	13.5
If no running water, adequate supply	18	52.9	21	56.8
Electricity	19	55.9	26	70.3
Waiting room/area for clients	30	88.2	36	97.3



In both experimental and control groups, there was an insufficiency of IEC materials (Chart 2). For example, 40 percent or more of all clinics did not have FP flipcharts, brochures, contraceptive samples, promotional materials, anatomical models or any sort of RTI/STD-related materials. Approximately one in five had never held a "health talk" on FP.

In both groups, basic equipment such as sterilizer, cotton, specula and ovum forceps were frequently absent (Table 2). Service statistics, too, were typically not maintained in a thorough and timely fashion.

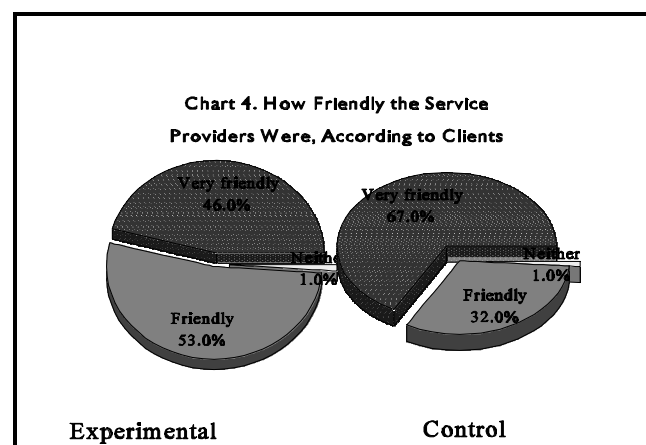
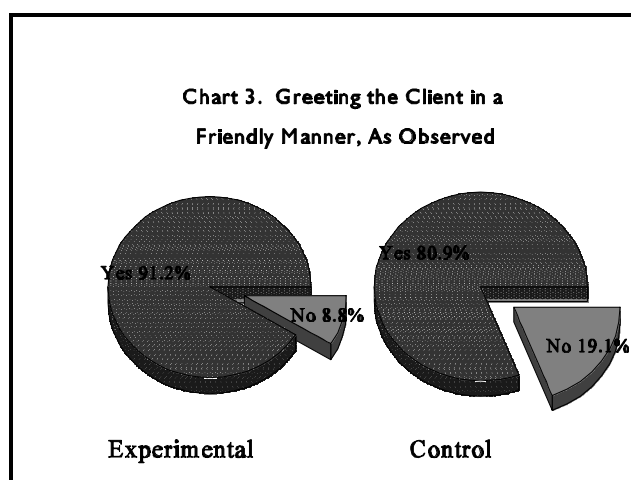
Table 2.-- SDPs Without Equipment and Instruments, in Percent

Equipment/Instrument	Experimental	Control	Equipment/Instrument	Experimental	Control
Sterilizer	47.1	59.5	Examination table	14.7	10.8
Blood pressure apparatus	2.9	2.7	Disposable gloves	38.2	37.8
Weighing scale	11.8	2.7	Stethoscope	14.7	8.1
Flashlight and/or goose neck lamp	38.2	51.4	Non-disposable gloves	85.3	86.5
Microscope	79.4	83.8	Thermometer	17.6	27.0

Uterine sounds	29.4	13.5	Needles & syringes	17.6	18.9
Specula	23.5	5.4	Refrigerator	76.5	70.3
Scissors	8.8	8.1	Generator set	100.0	100.0
Tenacula	35.3	13.5	Slides	29.4	16.2
Gauze	35.3	51.4	Stain/reagents	70.6	81.1
Cotton	29.4	40.5	Ovum forceps	32.4	16.2
Antiseptic	26.5	45.9	Straight forceps	94.1	100.0

Interviews with the SPs showed that their knowledgeability about the proper usage of different FP methods was often vague and sometimes incorrect. On oral contraceptives, for example, nearly all SPs answered that a woman who forgets to take a pill should simply “take the forgotten pill” the next day. (The correct answer to this question is to “take the forgotten pill along with the pill which falls due on the following day.”) All SPs failed to give the proper instructions for cases in which the client has forgotten to take her pills for two days in a row. When asked about the major side effects of the pill (i.e. those calling for a return visit to the clinic), half or more of the SPs failed to mention such conditions as severe chest pain or shortness of breath, high blood pressure, continuous bleeding and severe leg or abdominal pains.

Findings on knowledge about the IUD were not dissimilar. For example, SPs were asked to give the “major problems” which, should they occur, ought to require a return visit to the clinic. No such problem was mentioned by more than a half of the respondents, including such well-known conditions as heavy discharge (cited by only 46 percent), abdominal pain (44 percent), expulsion (39 percent), pain during intercourse (17 percent) and PID (11 percent).



With regard to client-provider interaction, both groups seemed to be providing adequate care. More than half of all clients thought that the midwife had served them in a friendly manner (Chart 3). A majority of the SPs were also observed to give full attention to the client, to show respect for her, and to use simple language (Table 3). Similarly, exit interviews indicate that clients were generally satisfied with the interpersonal relations which they experienced with their SP (Chart 4).

Table 3.-- Quality of Interaction with New Clients, as Observed (Percent)

Rating Points	Experimental	Control
	(N=16)	(N=7)
Service provider gave full attention to and had eye contact with client		
Yes, some of the time	44.0	29.0
Yes, consistently	56.0	71.0
Service provider showed respect for client		
Yes, some of the time	37.0	14.0
Yes, consistently	63.0	86.0
Service provider listened and encouraged client to speak up		
Yes, some of the time	56.0	29.0
Yes, consistently	44.0	71.0
Service provider used simple and easy-to-understand language		
Yes, some of the time	13.0	14.0
Yes, consistently	87.0	86.0

Since a major concern of the Davao project is with “information exchange” it will be useful to note the extent to which SPs are giving and eliciting FP information. As may be seen in Table 4, their record in this regard appears to be adequate for some indicators but poor for others. Thus, information was typically elicited for such basic questions as the clients breastfeeding status, the age of her youngest child, her reason for using FP (spacing vs. limiting) and her total number of children. (SPs asked about these questions in three-fourths or more of the client-provider interactions.) The client's preference for a particular FP method and her FP communication patterns with her spouse were looked into a little less often, while sexual relations, previous discussions with other SPs, previous experience with other methods and the timing of the next preferred birth were asked about in fewer than half of all interactions.

Table 4.--Information Elicited from New Clients, in Percent

Topic	Experimental	Control
Breastfeeding status	62	100
Age of youngest child	62	100
FP plans (space/limit)	94	58
FP method preference	75	43
No. of children	75	86
Nature of sexual relations	19	0
Previous discussions on FP	13	43
Previous experience with FP	37	14
FP discussed with spouse?	50	86
Preferred date of next birth	32	58

Table 5 delves further into this issue by presenting data on whether or not the client was given a thorough physical exam during her first visit to the clinic. It would appear that in most cases this does not occur. To be sure, the client's blood pressure was taken and the date of her last menstrual period was established for most (75 percent or more) cases. For most other medical indicators, though, the record is less impressive. A complete medical history was taken only about half the time, as was also the case for measuring the client's weight. Questions about unusual vaginal bleeding, vaginal discharge, or pelvic pain were asked quite infrequently. Breast exams and physical exams were not conducted in more than half of all cases and pelvic exams were given even less frequently. Warning signs, too, were generally not discussed.

Table 5.--Medical History and Physical Exams Conducted by Service Providers on New Clients, in Percent

History/Exam	Experimental	Control
Asked client about		
medical history	44	57
date of last menses	75	100
vaginal bleeding	19	29
vaginal discharge	6	14
pelvic pain	19	0
STD symptoms	0	0
Took client's		
weight	50	57
blood pressure	69	86
Performed/referred for tests		
RTI/STD test	0	14
physical exam	31	57
breast exam	38	57
pelvic exam	12	29
Discussed warning signs	6	29

Concluding Observations

On balance, it seems fair to conclude that, as of the pre-intervention stage of this study, the quality of care being offered to FP/RH clients in Davao del Norte was not of the highest order. Most SPs did a reasonably good job of treating their clients in a friendly and attentive manner. In a majority of cases, though, they were not making an extra effort to elicit all information needed for correctly diagnosing their clients' needs or for helping them to understand the strengths and limitations (e.g. in the form of warning signs) about their chosen method.

These differences, of course, can entail definite health risks. They may also result in a less effective FP/RH program when discouraged clients eventually become FP discontinuers. It is therefore to be hoped that the proposed intervention on improved quality of care via information exchange will go far towards alleviating these problems.

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Jain, Anrudh K. 1992. *Managing Quality of Care in Population Programs*. West Hartford, Connecticut: Kumarian Press.

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ANNEX 3-C

**IMPROVING QUALITY OF CARE
THROUGH BETTER COUNSELING AND
FOLLOW-UP: AN INTERVENTION STUDY
IN PANGASINAN PROVINCE, PHILIPPINES**

**Number 3
January 1998**

Background

The Philippine Family Planning Program (PFPP) has, since the late 1980s, become a major government health intervention designed to provide couples and individuals with the information and services needed to improve their health and that of their children, as well as to achieve their fertility aspirations. Since the 1994 ICPD Conference held in Cairo, the reproductive health approach in dealing with women's health and reproductive concerns has become a necessary component of this program.

This new paradigm shift is premised on the provision of high quality care to clients by considering their perspective in the selection and delivery of family planning (FP) services. Quality care means that "the provision of service focuses on the individual acceptor" while also emphasizing the role of program managers in making continuous improvements in services so as to help individuals achieve their reproductive goals (Jain, 1992).

In this context, Population Council, Manila has undertaken two intervention studies designed to increase the quality of care being offered by the PFPP. This report is an update on one of these projects, which is now being implemented in Pangasinan province.

The study sites consist of four municipalities in Pangasinan, a large and semi-urbanized province located in Northern Luzon. This setting is an excellent location for testing the impact of improvements in FP service delivery since it is one of the few provinces receiving financial and technical support for strengthening its FP and POPDEV programs. Even so, its overall contraceptive prevalence was only 42 percent in 1996 as compared to the national prevalence of 48 percent. The use of modern methods in Pangasinan is even lower, standing at only 26 percent in 1996 (Republic of the Philippines, National Statistics Office, 1996). Maternal mortality in 1992 was estimated at 183 per 100,000 live births while the infant mortality rate stood at 43 and the total fertility rate still exceeded 4.0.

Interviews with local program managers elicited several reasons for the province's poor performance on these FP program outcome indicators. One such factor was the belief that the outreach structure which is one of the few POPCOM-initiated outreach programs still operating in the country is not being optimally used for follow-up and referral of clients.

Programmatic Context of the Intervention

The Pangasinan FP program purports to utilize a high risk approach for prioritizing women who are in need of FP/MCH services. Such women may be described as belonging to one or more of the following groups: (1) too old (women who are 35 years of age or older), (2) too young (women who are less than 20 years of age), (3) too many (women with four or more previous births) or (4) too soon (women who have given birth within the past two years). In addition, women who have been diagnosed as suffering from certain medical conditions (e.g. anemia, hypertension, peptic ulcer) are also prioritized as high risk cases. This approach is being implemented under the auspices of the community-based FP management information system, or CBFPMIS, of the Provincial Population Office.

The CBFPMIS program was developed with technical assistance from the Management Sciences for Health. It enlists the help of Barangay Service Point Officers (BSPOs) in identifying and serving women in their reproductive years, particularly those with pregnancy-related health risks.

While the high risk approach may be useful for some purposes, it cannot be said to fully reflect the quality of care perspective since it does not take into account the client's reproductive goals. The fact that such a large proportion of women (two-thirds or more for most LGUs) will fall into at least one of the high risk groups outlined above will mean that no effective prioritization can be made. Doubts may also be raised about the extent to which an exclusive emphasis upon high risk women will actually serve to reduce levels of reproductive morbidity. For example, data from the Philippine Safe Motherhood Survey of 1993 generally failed to show significant correlations between either maternal age or parity and the major obstetric complications --hemorrhage, obstructed labor, infection and eclampsia (National Statistics Office and Macro International, 1994).

An alternative strategy has therefore been proposed for this intervention study. This approach trains volunteer outreach workers to contact current and potential FP clients (i.e. all married women of reproductive age that have been identified in the CBFPMIS) to ascertain both their reproductive goals and their contraceptive behavior. A five-question algorithm which serves to identify women with an unmet need for FP will be used for this purpose by the outreach workers who are expected to meet every MWRA in their assigned barangay.

The algorithm begins with the outreach worker asking the woman in question if she is currently pregnant. If she is, there is no current need for FP. The worker therefore limits herself to offering information on the antenatal care and pregnancy management services that are available from the nearest health clinic.

In the case of women who are not pregnant, a second question ("Do you want another child?") is asked. For those answering in the affirmative, the next question looks into the proposed date (whether "soon" or "later") when the client would like this child to be born.

Women who wish to give birth to a child in the near future are again treated as not exhibiting a current need for FP. In such cases, the outreach worker advises her client that FP services

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are available, should she change her mind in this regard.

The last two questions in the algorithm serve the purpose of identifying women with an unmet need for FP. These consist of, first, those women who wish to postpone their next birth (spacers) or to stop childbearing altogether (limiters) but who are not using any form of FP along with, second, those women who are using an FP method but who are not satisfied with it. Both of these latter two groups are considered as constituting women with a high priority need for FP services. As such, the outreach worker advises them about the FP services available in the nearest health clinic. Those who indicated that they are using an FP method but are not satisfied with it will be informed of other methods she might want to switch to. An appointment will be made, and a referral form will be given should the client agree.

Status of the Intervention

The intervention component of the project has thus far proceeded smoothly. To date, the following accomplishments may be noted.

1. Service providers (SPs) and BSPOs have both been trained in the use of the algorithm. Outreach workers were also trained to give useful and brief messages about the FP and antenatal services available in the nearest health clinic, and to establish a link with high priority women. These women will be followed up immediately after their initial appointment, should they fail to appear at that time.
2. Service providers in the clinic were trained in counseling to improve **information exchange** with their clients. This covers several distinct dimensions, including (1) the presentation of a range of method options without promoting a particular method; (2) contraindications and common side effects of the selected method; (3) follow-up requirements and duration of effective use for the method selected; and (4) the possibility of switching the method or the supply source, should either prove not suitable. Counseling techniques adopted under the program emphasize that providers should treat clients with respect and that SPs must solicit all relevant information from their clients. Technical competence and strict adherence to clinical standards are also emphasized.
3. Supervisors and midwives from all levels of the FP/RH service delivery system have been trained in facilitative supervision, so as to improve the management of volunteer outreach activities and ensure the continued implementation of the newly acquired counseling techniques.

These activities were carried out in the two CBFPMIS sites (the municipalities of Bugallon and Pozorrubio) which were selected to serve as the experimental communities. No intervention was put in place in the remaining two municipalities although data collections activities will be carried out in these locations, as well as in the experimental sites.

Status of the Research

Before undertaking the intervention a situation analysis (SA) was conducted in the four study communities. Several research instruments were used in this regard. SA team members looked into the status of the clinic facilities and services, conducted interviews with clients and staff, and observed actual client-provider interactions.

Data gathered through the use of these techniques showed that the experimental and control study areas were more or less similar with regard to counseling and supervision prior to the training intervention. FP counseling and supportive supervision are still at a very low level in all four communities. For example, HIV/AIDS counseling is not available in 39 of the 44 SDPs under study. Only one of the 44 SDPs offered other types of STD counseling. Routine administrative supervision like checking records and supplies emerged as the prevailing type of supervision in both the experimental and control areas. Supportive supervision was therefore lacking in almost all of the SDPs.

Interviews with the SPs established that about 90 percent had not undergone either a training on counseling or an orientation on supervision/evaluation. In contrast, about 82 percent had been trained in interpersonal communication skills. Perhaps as a result of these later trains, most SPs say that they have learned to use various strategies for helping clients to understand more clearly.

Observations of client-provider interactions showed that SPs do not provide high quality care as often as might be wished. For example, only a little more than half gave the client a written reminder notifying her when to return for her next visit. Less than half of the service providers were observed to listen carefully to their clients and to encourage them to speak up.

Even so, few clients were dissatisfied. Nearly all said that they had been provided with a chance to be listened to, enough time to describe their situation, and enough privacy during the consultation. Providers were generally perceived as having talked to them in a friendly and approachable manner. One deficiency that was revealed at this time concerned counseling for side effects. Among those clients who went to the SDP for resupply or follow-up, less than half were asked by the provider if they had been experiencing any problem along these lines.

BSPO Training on the Masterlisting of MWRAs

On July 22-23, 1997, BSPOs in the two experimental communities were briefed about the Algorithm for Prioritizing FP clients based on their Unmet Need. It was emphasized that the masterlisting of MWRAs would now ascertain both their High Risk and Unmet Need statuses. Women with an unmet need were to be given priority attention for referral, follow-up and information about FP/health services.

Earlier masterlisting efforts had resulted in somewhat low coverage rates in three of the four study areas. Given this problem and the need to draw an unbiased sample of MWRAs for the

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Community Survey, the Provincial Population Office of Pangasinan also launched an all-out drive in July and August 1997 to masterlist all MWRAs in each of the four study areas. By early August all four study areas showed masterlisting coverage rates of 92 percent or higher.

The MWRA masterlisting using the Unmet Need Algorithm (UNA) was begun three months later. By mid-February of 1998 this task was 59 percent complete.

Results of the Knowledge Tests

In all, project trains consisted of: (1) a one week live-in training of service providers (public health nurses and midwives) on FP counseling; (2) a one week live-in training of supervisors on supportive supervision in the context of quality of care; and (3) a training of BSPOs on the use of the UNA. The first two of these trains were conducted by personnel from AVSC International.

Two evaluation designs were built into the training of SPs and their supervisors. The first of these allows for a comparison over time (pretest vs. posttest) for the experimental group. If the intervention will actually have an impact, trainees will earn higher test scores as of the end-of-training (posttest) measurement. A second comparison looks at differences in posttest scores between the experimental group and a group of nontrained personnel from the control communities. Findings from both comparisons will be reported in this Update.

Pretest and posttest comparisons were made for three separate topics: contraceptive technology and FP counseling skills, quality of care, and monitoring/supervision. As may be seen in Table 1, the posttest scores are consistently higher than the pretest scores. Differences are particularly striking for questions about contraceptive technology and FP counseling skills.

Table 1. -- Pretest and Posttest Scores of Trainees from the Experimental Communities

Topic	Pretest		Posttest	
	Mean	Std. Dev.	Mean	Std. Dev.
FP Technology/Counseling	7.8	2.7	13.5	3.1
Quality of Care	8.2	1.7	10.4	2.3
Monitoring/Supervision	5.5	1.3	6.2	1.2
Total	21.5	4.1	30.1	4.3

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The effect of the training was also examined by comparing the posttest scores of the experimental and control groups (Table 2). Overall, those who underwent the training on FP counseling (the experimental group) had significantly higher scores, on average, than those who were not so trained. Areas with significant impacts included contraceptive technology, FP counseling skills and quality of care. In the case of the monitoring and supervision topic, which focused on the nature and use of the CBFPMIS and the UNA, the training did not have a significant effect.

Table 2. -- Results of the Knowledge Test for SPs Comparing Posttest Scores for Trainees from the Experimental and Control Groups.

	Number of Cases	Mean	Standard Error	<i>t</i> Value	Significance level
1. On Contraceptive Technology and FP Counseling Skills					
Experimental	24	13.5	.64	4.92	.00
Control	20	9.5	.48		
2. On Quality of Care					
Experimental	24	10.4	.48	4.37	.00
Control	20	7.4	.49		
3. On Monitoring and Supervision					
Experimental	24	6.2	.26	1.49	.14
Control	20	6.7	.15		
4. Overall Scores					
Experimental	24	30.1	.88	5.53	.00
Control	20	23.5	.79		

Table 3 compares the pretest and posttest scores on supportive supervision for trainees from the experimental group with the corresponding scores for control group members. The mean posttest scores of the experimental group are again the highest in this case. When statistical tests were performed for the posttest scores of the experimental and control groups, the results showed a highly significant difference ($t=4.49$, $p<.001$) for the overall knowledge scores. Significant differences were also obtained for the counseling ($p<.001$) and supervision ($p<.01$) categories and were nearly obtained ($p<.10$) for the questions on contraceptive technology. As an overall conclusion, therefore, we can say that the project-related trains have been able to significantly increase the knowledgeability of SPs and

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supervisors on topics which are closely related to the quality of care perspective.

Table 3.--Results of the Knowledge Test for Supervisors, Pretest-Posttest (Experimental Group) and Experimental-Control Comparisons

Topic	Experimental				Control	
	Pretest		Posttest			
	Mean	Std. Dev.	Mean	Std. Dev.	Mean	Std. Dev.
Counseling	7.9	1.9	10.3	1.9	6.4	1.4
Contraceptive Technology	7.9	2.9	9.7	1.8	8.4	1.2
Supervision	2.7	0.9	4.2	1.0	2.7	1.1
Total	18.5	4.3	24.2	4.3	17.6	1.7

Concluding Remarks

Having now demonstrated the need for improved counseling/follow-up services and the effectivity of project trains, the next logical step will be to see if the newly trained SPs will move now towards providing better quality care within the clinic setting. This, in turn, will hopefully alter the FP knowledge, attitudes and practices of clients coming to these clinics. Future Updates will be devoted to providing further information on these issues.

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ANNEX 4-A

POPULATION MOMENTUM AND OTHER SOURCES OF POPULATION GROWTH: IMPLICATIONS FOR PROGRAM AND POLICY

Number 2

October

1997

The Philippine Demographic Situation

The Philippines has one of the fastest growing populations in Southeast Asia. Should its growth rate of 2.35 percent in 1990 remain unchanged, the country's population would double in size to 120 million persons in only 30 years. In 1970 when the growth rate was higher at 3.08 percent, this same doubling process would have taken only 23 years. As such, a modest reduction in the country's growth rate has been achieved although it still remains relatively high.

In 1993, every Filipina would have had, on average, more than 4 children by the time she finished her childbearing. This represented a reduction from the 6 children that Philippine women were averaging 20 years earlier. However, most women would want to have even fewer, as shown by their total wanted fertility rate of just below three children. This discrepancy between wanted and the actual number of children is particularly acute in rural areas of the country (see Table 1).

Table 1.--Wanted and Actual Fertility by Mother's Residence, 1993

Mother's Residence	Total Wanted Fertility Rate	Actual Fertility (TFR)
Urban	2.6	3.5
Rural	3.3	4.8
Total	2.9	4.1

Source: NSO and Macro International, 1994, Table 6.8

The discrepancy between wanted and actual fertility is also associated with maternal educational attainment (Figure 1). In general, less educated women are less able to realize their fertility goals.

Three Sources of Demographic Growth

In general, population growth in countries such as the Philippines may be seen as comprising three separate components: growth due to desired family size, growth due to fertility levels which exceed such desired levels (i.e., growth from unwanted fertility) and growth due to population momentum. This latter concept refers to growth patterns which can be linked to formerly high levels of childbearing insofar as these have brought about a “young” age structure with a large proportion of women in the childbearing ages. On balance, most national FP programs are focused strongly on the unwanted fertility component while showing only a moderate concern for the two other sources of population growth.

Results from a recent analysis of likely growth scenarios for the Philippine population are shown in Table 2. One important conclusion reached by this exercise is that by far the biggest source of future growth will be population momentum.

Figure 1. Wanted and Actual Fertility by Mother's Education, 1993

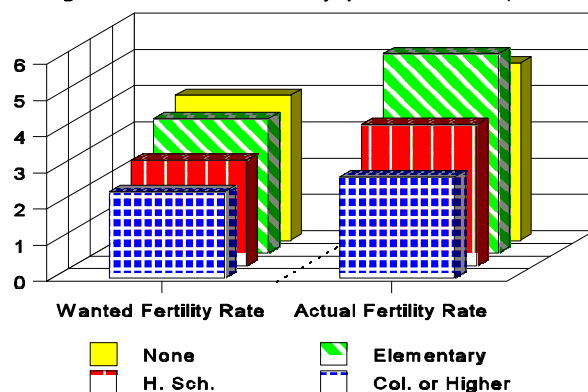


Table 2.-- Projection of Population Size and Sources of Growth, Philippines 2020 and 2040

	Population (in millions)		Percent Distribution	
	2020	2040	2020	2040
Population Projections				
Standard projection (replacement at 2020)	107.4	128.1		
Reduce unwanted fertility by 1995	101.6	118.8		
Replacement at 1995	94.9	107.9		
Decomposition				
Increase due to unwanted fertility	5.8	9.3	15.6	16.1
Increase due to family size preference	6.7	10.9	18.1	18.9
Increase due to momentum	24.6	37.6	66.3	65.1

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Total increase from 1995 population	37.1	57.8	100.0	100.0
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Implications for Program and Policy

There is evidently a great need for policies that will directly address the issue of population momentum. Two ways of doing this are (1) to increase the age at first birth, and (2) to prolong the time period spent between births. In addition to their contributing to reducing population growth, these outcomes are also desirable because they contribute to improved levels of maternal and child health. In most countries, higher levels of educational attainment among females have been associated with increased age at childbearing while the use of contraception within marriage can widen the space between births. Attention must also be paid to the emerging issues of adolescent sexuality and teenage pregnancies.

Table 3 shows the effect of increasing the average age at childbearing on population momentum in the developing world, while Table 4 shows the impact of increased educational attainment on the median age at first birth. On average, women with education up to the secondary level have a median age at first birth of 22.8 years compared to only 19.3 years among those with no education at all. Table 3 indicates that a five-year delay in age at childbearing can eventually reduce population size in the developing countries by 1.2 billion persons via its impact on the momentum factor.

Table 3.--Simulated effect of delayed childbearing on population momentum

Average age at childbearing	Population in 2100 from momentum (billions)	Reduction resulting from delay (billions)
No change	7.3	0.0
Increase of 2.5 years	6.7	0.6
Increase of 5 years	6.1	1.2

Table 4.--Median age at marriage and at first birth, by education, ever married women ages 30-34 in developing countries

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Level of education	Median age at marriage	Median age at first birth
None	17.6	19.3
Primary	19.1	20.2
Secondary	21.7	22.8

While the data summarized here have demonstrated the importance of population momentum, it nonetheless remains true that the problem of unwanted fertility is a critical concern for most national population programs. In the Philippine case, for example, there is a clear need for improving access to reproductive health and family planning services, especially for less educated couples and those living in rural areas.

References:

Herrin, Alejandro and Marilou P. Costello. 1996. *Sources of Future Population Growth in the Philippines and Implications for Public Policy*. The Population Council.

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ANNEX 4-B

INTEGRATING RTI SERVICES IN PRIMARY HEALTH CARE CENTERS IN THE PHILIPPINES: IMPLICATIONS FOR PROGRAM MANAGERS

Number 3
March 1998

Background

The Philippine's Department of Health, in collaboration with the Population Council's Asia Near East Operations Research and Technical Assistance Project, studied the operational implications of integrating reproductive tract infections (RTIs) case management into the Philippine Family Planning/Maternal and Child Health (FP/MCH) Program. A cost analysis of integrating RTI management into clinics with and without laboratory facilities was also done.

This project was implemented in seven health rural health units (RHUs) and the Barangay Health Stations (BHSs) under them. Concentrating on RHUs and BHSs makes this analysis particularly relevant since it is only through the primary health care system that most low-income women are reached.

The first phase of the study consisted of a series of baseline data collection activities. Focus group discussions (FGDs) were conducted among men and women to identify local perceptions and behaviors related to RTIs. These were followed by a modified situation analysis of the local health centers to assess their capacity to provide standardized RTI case management services.

In the second phase, RTI case management services were introduced in the seven clinics. As part of this introduction, the following major intervention activities were carried out:

- (a) Training medical staff to enhance their diagnostic capabilities to identify and manage RTIs with greater skill and confidence.
- (b) Upgrading laboratory facilities as well as ensuring RTI drug provision to support RTI services.
- (c) MIS: Giving service providers technical assistance in maintaining the patient registry and individual treatment records.
- (d) Community education: Distributing fliers for client education. The medical staff also imparted community education through their own outreach efforts, such as pre-clinic lectures and mothers'/fathers' classes.

After a week of facilitative supervision of all trained medical staff on site, a second situation analysis was conducted. Clinic records of RTI cases managed during the six-month observation period in these clinics were subsequently analyzed.

Policy Implications

1. Training to enhance diagnostic and curative capabilities plays a vital role in the management of RTIs.

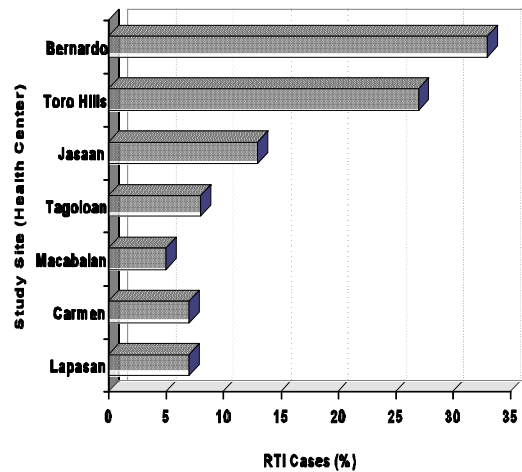
It is clear that additional training and increasing the capabilities of medical staff in the diagnosis

n RTI (May to October 1997)

and treatment of RTIs play a significant role in the management of RTIs.

Before training, the median incidence of RTIs observed at the sampled clinics was 4-6 cases per year. However, during the six-month observation period, 243 cases of RTIs were identified and treated. Figure 1 shows the percentage of RTI clients found in each of the seven health clinics. The increase in RTI cases shows that the training intervention definitely increases the confidence of medical staff to diagnose and treat RTIs. Thus, any future effort to integrate RTI management services into the FP/MCH program must view training as an essential activity.

Figure 1. Number of Clients Diagnosed with



2. Facilitative supervision improves provider confidence in the diagnosis and treatment of RTIs.

The study found that post-training facilitative supervision of service providers improved RTI services. Nurses and midwives were observed to manage RTI cases with more confidence after having been guided for a week by a trained medical doctor from the study team. This is crucial in clinics with heavy client loads or those where the public physician visits only on a weekly basis.

The idea of facilitative supervision played a significant role as it helped the medical staff to feel "empowered" to use their judgement in making a diagnosis. It was noted during project

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monitoring that without such supervision, the attending staff did not implement on their own the standard guidelines for RTI management taught during the training.

3. Partner management as a component of RTI case management must be strengthened.

A typical RTI client is female, married, aged 25 to 39, not gainfully employed and the mother of one to three children. The clientele in the study were mostly female clients who came for FP/MCH services. Only 14% of the clients identified were males. Most of the male clients served were employed in jobs which required them to be temporarily separated from their wives.

The fact that 14% of the clients served were males highlights the associated issues of partner compliance and male involvement in matters pertaining to reproductive health. It is important that partners of patients diagnosed with RTIs get treatment as well. To a large extent, this did not happen in this study. In spite of consistent counseling given to clients regarding the importance of partner management only 17 of the 34 men treated were identified on the basis of their being the sex partner of a female RTI client. Some men, mostly single, went to the clinic on a walk-in basis.

Males need to be more involved in the prevention of reproductive tract infections.

4. The issue of drug provision must be addressed in any integration effort.

The issue of drug provision is important in any RTI integration effort. Most patients in the public health care system cannot afford expensive drugs. RTI drugs are generally given to clients free of charge in the public health system. The reasons for this are:

- a. Drugs are costly and can be a heavy burden on a typical client who has no gainful employment and has an average of three children.
- b. Syndromic management recommends treatment of all suspected pathogens and consequently requires prescribing more drugs.

The local government units (LGUs) should seriously consider allocating a part of their budget for RTI drugs. While a few health centers have successfully addressed this problem, other creative mechanisms can still be explored to ensure its sustainability. One option can be to pass on a portion of the recurring cost of drugs to those who can afford to pay. A price sensitivity study might be considered in this regard before such an option can be implemented. Social marketing studies have shown that the customer is more likely to complete the prescribed course of medicine if he/she attaches a “health value” and an “economic value” to the medication that he/she uses.

5. There is a need to increase IEC efforts to educate and increase awareness about RTI-related issues.

Increased counseling and distribution of leaflets resulted in greater awareness about the new services in the health clinics. It was observed that more patients were being referred from non-intervention areas to clinics where RTI services were available.

The study provided three IEC materials: RTI leaflets (for clients), flow charts and counseling posters (both for the providers). During the final evaluation, it became quite apparent that a more focused and increased IEC material distribution can help significantly in educating clients about RTIs and enabling them to recognize RTI symptoms on their own.

6. A cost analysis can provide program managers with critical information for making important decisions.

The cost analysis showed that the cost per patient in a clinic without a laboratory is about \$14 while the cost per patient in a clinic with a laboratory is \$16. The provision of RTI services in clinics with laboratory facilities entails higher fixed costs. In clinics without laboratories, (that is, where syndromic management was utilized), the bulk of the cost lies in treatment costs.

This finding implies that RTI management with the use of simple lab test and microscopy appears to be more cost effective as the number of clients increase. However, service providers are as yet uncertain whether adding simple lab tests and microscopy in the context of the health center necessarily improves the effectivity of RTI case management.

Next Steps:

- A further study on validating risk assessment and a validation of syndromic management using the gold standard are needed for the Philippine context.
- Effective IEC strategies need to be developed to identify more asymptomatic RTI patients. Effective IEC activities will also help community members do self -screening for possible RTI risks and for RTI clients to understand the importance of partner compliance.
- A price sensitivity study needs to be conducted to validate whether clients would be willing to pay and at what price for the drugs needed for RTI treatment.

The Population Council, Manila

References:

Population Council, 1997. *Situation Analysis of LGU Health Centers*

Population Council, 1998. *Integrating RTI Services into the FP/MCH Program of LGU Centers: Final Report*

ANNEX 6

REPUBLIC OF THE PHILIPPINES
NATIONAL ECONOMIC AND DEVELOPMENT AUTHORITY
COMMISSION ON POPULATION
Welfareville Compound
City of Mandaluyong

28 May 1998

PMD-078-98

DR. MARILOU COSTELLO

Country Advisor
PopCouncil, Manila

Dear Dr. Costello:

The Senior Management Conference recently conducted in Cebu City was very much successful and enriching. Most of the participants find their stay memorable and exciting. We also find all the sessions fruitful and substantive.

We recognize your efforts and hardships in making the said workshop worthwhile, by sending Dr. Alejandro Herrin to be present in your behalf. We salute the services that Dr. Herrin have shown as facilitator. We would like to express our gratitude to him for the quality inputs he has contributed, and most especially to you for your continued support to the program.

May God grant you more blessings to continue serving others and more involvement with the Population Commission.

Thank you.

Sincerely yours,

(Signed)
TOMAS M. OSIAS
Executive Director

cc: Dr. Alejandro Herrin

ANNEX 7

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29 May 1998

Dr. Marilou Palabrica-Costello
Host Country Advisor
The Population Council
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#85 Xavier St., Greenhills
San Juan, Metro Manila

Dear Dr. Costello:

We the undersigned extend our heartfelt thanks to the Population Council for giving us the opportunity to learn the Integrated System for Survey Analysis (ISSA), a data entry operation and program.

Indeed, learning ISSA enable us to improve our skill in data entry and programming. The program handles out-of-range checks and inconsistency. These are tasks done in cumbersome manner before.

Thank you for providing us the opportunity to enhance our skill.

Very truly yours,

(Signed)
Dr. Magdalena C. Cabaraban

(Signed)
Ms. Lita Palma-Sealza

(Signed)
Dr. Vel J. Sumingit

(Signed)
Ms. Cynthia P. Espiritu

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Ms. Rebecca G. Saniel

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Ms. Venus L. Catubig

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Mr. Ramonetto Gervacio

(Signed)
Mr. Karl Alexis Turado