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Factors affecting the family planning program drop-out rate in Bukidnon, Philippines

Lita Sealza

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**FACTORS AFFECTING THE FAMILY
PLANNING PROGRAM DROP-OUT
RATES IN BUKIDNON PROVINCE,
THE PHILIPPINES**

PHILIPPINES

Lita Sealza

Final Report

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**RESEARCH INSTITUTE FOR MINDANAO CULTURE
XAVIER UNIVERSITY**

THE POPULATION COUNCIL

**ASIA & NEAR EAST OPERATIONS RESEARCH AND
TECHNICAL ASSISTANCE PROJECT**

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EXECUTIVE SUMMARY

Background. This study has involved interviews with a randomly selected sample of 389 family planning (FP) acceptors from twenty barangays in Bukidnon province. The respondents were currently married women who had either continued to use family planning since their initial acceptance (current users) or who had stopped using FP altogether (drop-outs). Findings from the present study is expected to shed light on several aspects of the drop-out problem namely:

1. How extensive is this problem and how accurate are the DOH records in this regard?
2. How do FP acceptors view their local FP clinic and the services offered therein?
3. What reasons are given by the drop-outs for their decision to stop using FP?
4. What are the factors associated with dropping out?

The Extent of the Drop-out Problem. The study found that 30.8 percent of the women who had adopted FP at some time in 1992 had dropped out of the program as of the survey date (September to October, 1993).

Clinic records about current FP users were found to be fairly accurate. The DOH classification (current users, drop-outs and switchers) was found to be correct in 73.4 percent of all cases.

Views and Experiences Regarding the Local FP Clinic. Only 9 percent of the respondents said that they were dissatisfied with their visits to the clinic. Another 53 percent said they were "satisfied" while 38 percent claimed to be "very satisfied." Clients who were "dissatisfied" reported inavailability of supplies as their reason. These respondents also

tended to be critical of the local midwife for various reasons, e.g. that she is "not available", too "strict", or "unfair" in giving out medicines and supplies.

Overall, a little less than ten percent of the resp[ondents had never been given any lecture about FP. Another 61 percent had received a lecture about only one method. These statistics do not show the FP clients as being given a wide variety of choices.

Most respondents (83 percent) felt that their FP trainor had been "friendly and approachable." They also gave favorable assessments with regard the trainors' ability to "clearly explain" the method, to show how to use it, and to explain its advantages. There was, however, less agreement with the idea that the trainors had dealt adequately with the method's disadvantages and potential side effects.

Exposure to IEC materials on FP was relatively high. Only 24 percent of the respondents said they had never been so exposed. Home visits by FP providers, however, were rare, with 76 percent of the respondents not experiencing these.

Respondents gave several suggestions as to ways in which the program could be improved. The most commonly cited themes in this regard included the following:

1. There should be a permanent supply of contraceptives on hand.
2. There is a need for an intensive FP information campaign (e.g. seminars, house-to-house visits).
3. The midwives and motivators should develop friendly relations with local residents.
4. FP acceptors could be mobilized to teach/motivate other potential clients.
5. Free medicines should be provided by the local clinic.
6. Midwives/motivators should follow up the FP acceptors to monitor their progress.

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

Factors Related to Dropping Out. Factors associated with the decision to terminate FP use may be seen as falling within three major categories, i.e. those relating to (1) the individual acceptor (2) the method accepted and (3) the quality of services provided by the local clinic.

Client Factors. When drop-outs were compared to current users they were found to be significantly more likely to possess the following characteristics:

1. A lower level of educational attainment,
2. A lower rating on a scale of household economic status (ownership of consumer items),
3. A smaller likelihood of having been employed during the past year,
4. A greater number of previous pregnancies, and
5. Less favorable attitudes toward FP.

For the attitudinal factor it is interesting to note that the attitudes of the husband were a better predictor of current use than those held by the respondent herself.

Various other factors (e.g. age, religion, ethnicity) were not found to be significantly related to current user status.

FP Method. Dropping out was highest among respondents who had accepted condoms (37.8 percent), followed by pill users (with a 34.3 percent drop-out rate) and IUD acceptors (every one of whom was still using some FP method as of the survey date).

Program Factors. In general, provision of improved services ("quality of care") was found to be associated with lower levels of dropping out. Among those respondents who said that their FP trainor was "friendly and approachable", drop-out rates were significantly lower than for those who did not feel that way. Similarly, those who reported themselves as "satisfied" or "very satisfied" with local services were found to be less likely to drop out. A summary index of client-provider interaction was formed from various items. Current users gave significantly higher scores to their trainors on this scale than did the drop outs. Particularly important in this regard was the experience of having been told the advantages of the method in question (thereby strengthening client motivation for continued use) and its potential side effects (thereby helping the client to become less alarmed about these experiences when they did happen). Clients who were only given an orientation on one method were found to be less likely to continue using FP than those exposed to a wider variety of choices.

Interviews with FP Service Providers. Service providers were found to be well experienced. A good number of them had both theoretical and practical training in providing contraceptive pills and condoms. However, only 40 percent had been trained for IUD insertion and removal.

Facilities and Services in the Health Clinics. Most clinics observed the official opening time. The number of days allotted for family planning were not uniform. While some have FP services for five days, others offer this on only one day.

Infrastructure facilities of the clinics were far from ideal.

Eleven SDPs, for example, did not have piped running water at the time of the visit.

IEC materials were found to be available in almost all clinics. Most clinics were also rated "clean" by interviewers. Equipment in most clinics was often being used for non-family planning services. Some clinics experienced shortages or depletions in their stock of FP supplies.

Commodities were stored according to their expiration date in all 20 clinics. Storage facilities for contraceptives were also found to be adequate.

Visits by supervisors were not regular in some clinics. Services in all twenty clinics were provided free, although some would at times ask for a minimal donation.

Health Provider-Client Interaction. Most health providers were observed to be friendly and approachable. Discussion of possible side effects was rarely carried out during the consultation.

It was observed that in some consultations some methods were overemphasized to the exclusion of others. This was particularly true for the IUD, pills and condom.

Program Implications. Some of the major implications of the study for the current FP program are listed below:

1. The FP drop-out phenomenon continues to be pervasive in Bukidnon, although levels are perhaps not quite as high as is sometimes believed. The major problem in this regard appears to be the widespread belief that the various FP methods (especially pills) cause harmful or disturbing side effects.
2. A large majority of FP acceptors claim to be satisfied with the current program. Most also perceive the FP personnel as competent and friendly. Sustaining proficiency and favorable attitudes of personnel towards work would prove advantageous to the program.
3. Some programmatic weaknesses were also uncovered, however. Acceptors were generally not given an orientation on a wide variety of FP methods. Discussions of the side effects issue were often missing. Home visits by program personnel are rare.
4. Respondents gave several suggestions for improving the program, focusing in particular upon improvements in the logistics system and a more intensive educational/motivational campaign.

5. The drop-out problem appears to be most prevalent among poorer and less educated women, housewives (i.e. those not gainfully employed), those with many previous pregnancies and with less favorable attitudes toward FP. Strengthened efforts to reach out to these groups will be needed.
6. Campaigns to bring about more favorable opinions toward FP should focus on husbands as well as on the wife.
7. Increased use of the IUD should help to bring about declines in the drop-out problem. However, efforts to convince more women to use this method should not run counter to the goal of free and informed choice of method by the client.
8. Greater emphasis on high quality FP services (quality of care) will help to reduce FP drop-out rates. Providers should be competent and friendly, and concerned as well with fulfilling client expectations. They should offer a wider variety of FP choices, bringing out in a clear and objective fashion the advantages, disadvantages, and possible side effects of each method.
9. A number of local government executives are not supportive of the FP program. Convincing them of the importance of the program should be given priority.
10. Some FP clinics are not well equipped. An effort to upgrade these facilities will help improve the delivery of services.
11. Some FP services providers have not yet been trained. For example, about fifty percent of the clinics in Bukidnon are not prepared to provide IUD insertion and removal services. Providing the staff with appropriate training for this will be a help.

INTRODUCTION

The Philippine Family Planning Program (PFPP) has enjoyed mixed success since its initiation more than two decades ago. On the one hand, birth rates are in fact moderately lower now than they were at the beginning of this period. It is evident, though, that many problems are as yet not solved, including low prevalence rates, heavy reliance upon the less effective methods and difficulties in mustering adequate political support for the program.

One factor which has consistently plagued program managers deals with the tendency of family planning (FP) acceptors to eventually become "drop-outs". Indeed,

"records show that around 50 percent of users drop out of the program yearly. Despite this, very little time is devoted by motivators to the remotivation of dropouts. This is due to the overemphasis in the past on generating new acceptors" (POPCOM, 1989).

The situation in the Southern Philippine province of Bukidnon, site of this diagnostic study, is even worse. Data from the Northern Mindanao (Region X) office of the Department of Health (DOH) indicate that more than half (60 percent) of all acceptors in this province subsequently become drop-outs.

This study aims to shed light on several aspects of the drop-out problem in Bukidnon, namely:

1. How extensive is this problem and how accurate are the DOH records in this regard?
2. How do FP acceptors view their local FP clinic and the services offered therein?
3. What reasons are given by the drop-outs for their decision to stop using FP?
4. What are the factors associated with dropping out?

Previous Studies

A handful of studies have already been conducted on the drop-out problem as it has manifested itself in the Philippine context. Unfortunately, most of these were carried out during the 1970s, thereby making their applicability to the present situation somewhat precarious. However, a review of these efforts could prove helpful in defining the general parameters of the present study.

The first question concerns the gravity of the drop-out problem. The 50 percent figure now being admitted to by program officials certainly does not look to be an auspicious one. Even so, there are at least some reasons for believing that the situation may be somewhat less bleak than these data indicate. For one thing, it is quite possible that there are some "unregistered users" who have continued to resort to the method initially accepted even though they never bothered to go back to the health clinic. This may happen, for example, in cases where the time costs involved were perceived as being too high to warrant such a revisit. Many of these continuing users may be getting their contraceptives from some alternative supply source, such as private sector outlets. Then there are the "method switchers" who, after experiencing some dissatisfaction with their first method, may have moved on from there to try some other technique. This pattern may be particularly common among lower status Filipinos, who, studies show, are not at all averse to engage in self-diagnosis and self-medication (e.g. Arce and Go, 1972). Thus, one Philippine study found that 62 percent of all program drop-outs were still using one or another contraceptive method, thereby indicating that "not visiting a clinic does not necessarily imply contraceptive discontinuation" (Anonymous, 1988).

Some so-called "drop-outs" may only have moved away to a different barrio or town. Others may be menopausal or family planning "spacers". This latter situation does, of course, imply that additional fecund women are now being exposed to the risk of pregnancy, but it is important to identify such cases since they cannot really be taken as evidence for program "failure".

An optimistic interpretation of the drop-out phenomenon may thus be made. Such a conclusion, however, may well be premature insofar as other indicators point in an opposite direction. An early study of the drop-out phenomenon thus concluded that "program effectiveness is limited" insofar as "there is a great deal of dissatisfaction with the ...techniques

made available to clients" (Ballweg and Mac Corquodale, 1974, p. 94). A subsequent analysis by Valera-Cabigon (1985, p. 9) similarly found a "consistently higher proportion of stoppers than current users.... (thereby indicating) the need for greater efforts to motivate these women to continue usage of family planning." Comparisons with other countries in the region also appear to show that the drop-out phenomenon may be particularly problematic in the Philippine setting.¹

These diverging interpretations would seem to indicate that there is a need to empirically assess the current DOH estimates of program drop-outs. The present study will be able to accomplish this objective by following up those acceptors now listed as drop-outs to determine what their actual status really is.

A second rationale for the study concerns the insights it can offer into the reasons why so many women in the province have decided to stop using family planning. Descriptive statistics on this issue could go far towards pinpointing problem areas that could be addressed by program management. Previous Philippine studies on the topic have shown drop-outs to be generally concerned about contraceptive "side effects", particularly among those using the more effective methods like pills and the IUD (e.g. Ballweg and Mac Corquodale, 1974; Cabigon, 1980; Navarro, 1979). Again, however, such analyses are not only dated but often fail as well to clarify a number of finer points, such as the precise nature of such perceptions and the means by which continuing users with similar experiences are as yet willing to go on utilizing the method. There is also some uncertainty as to the other major reasons for contraceptive discontinuation once the side effects issue has been accounted for. Thus, some studies view the next major reason for dropping out as being due to pregnancy (whether this was consciously desired or the result of method failure is often not clear), while others see it as being due to objections on the part of the husband and such vague categories as "lack of motivation" and "inconvenience".

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

Using comparative data from a recent regional analysis (Tsuya, 1991, Table 8), the following current-to-ever user ratios were computed: Hongkong (88.9), Korea (83.3), Singapore, (82.6), Thailand (76.8), Japan (75.0), Indonesia (68.4), Malaysia (66.2) and Philippines (62.1).

A third area which can be investigated by this study concerns the social, economic and psychological correlates which are associated with drop-outs as compared to continuing users. Very little work has been done on this question in the Philippines with the only findings to date indicating that contraceptive discontinuation seems to be rather higher among women using some of the less effective methods (rhythm, condom) and those living a considerable distance from the local health clinic (POPCOM, 1989; Anonymous, 1988).

Statement of the Problem

This study concerns itself with three interrelated issues. First, what is the actual extent to which family planning acceptors in the study area are dropping out of the program? Second, what are the reasons given by drop-outs for choosing this course of action? And, third, what are the major correlates (social, psychological, economic, locational, program-related) of dropping out from the program?

Hypotheses

Figure 1 presents a simplified conceptual framework for the study's correlational analysis. Factors have been categorized within three major blocks, the first of which concerns the background characteristics of the respondents. Included herein are her age and parity, her level of educational attainment, labor force participation, religion, the household's income, ethnicity and the distance between home and the nearest family planning clinic.

The second block represents a set of "interactionist" and program related factors. These include the strength of husband-wife communication linkages, the wife's knowledge of and attitudes toward family planning, contact with family planning providers (clinic personnel, volunteer health workers), access to IEC materials on family planning, and the particular method used. We have also included "quality of care" in this block, as will be operationalized by questions on (1) the availability of free and unrestricted choice in selecting a method, (2) provision of family planning information by clinic staff and (3) the degree of satisfaction with the clinic services received. Various dimensions are also involved in the third block of factors (i.e. the study's dependent variables). For one thing we have two possible definitions of drop-out status: that provided by the DOH and that which will be based on the actual

interview. In this study more emphasis will be given to the latter measure since (1) it reflects the acceptors' "true" situation as of the study date and (2) this approach avoids the problem of a tautological relationship in which at least one of the independent variables ("contact with family planning providers") also becomes defined as an essential component of the dependent variable itself.²

A number of hypotheses may be derived from Figure 1. These would include, but are by no means limited to, the following:

- a) Clients who have less contact with FP providers are more likely to drop out.
- b) Clients who have less access to IEC materials are more likely to drop out.
- c) Drop-out rates are likely to vary according to the method used.
- d) Clients who experience a lower quality of care are more likely to drop out.
 - d1: Clients who were not given the chance to choose their FP method would be more likely to drop out.
 - d2: Clients who were not given enough FP information would be more likely to drop out.
 - d3: Clients who were not satisfied with the clinic services received would be more likely to drop out.
- e) Dropping out is associated with various characteristics of the client, e.g. age, education, religion, etc.

² The DOH statistics define pill and condom users as drop-outs if they fail to report to the clinic on their next resupply date.

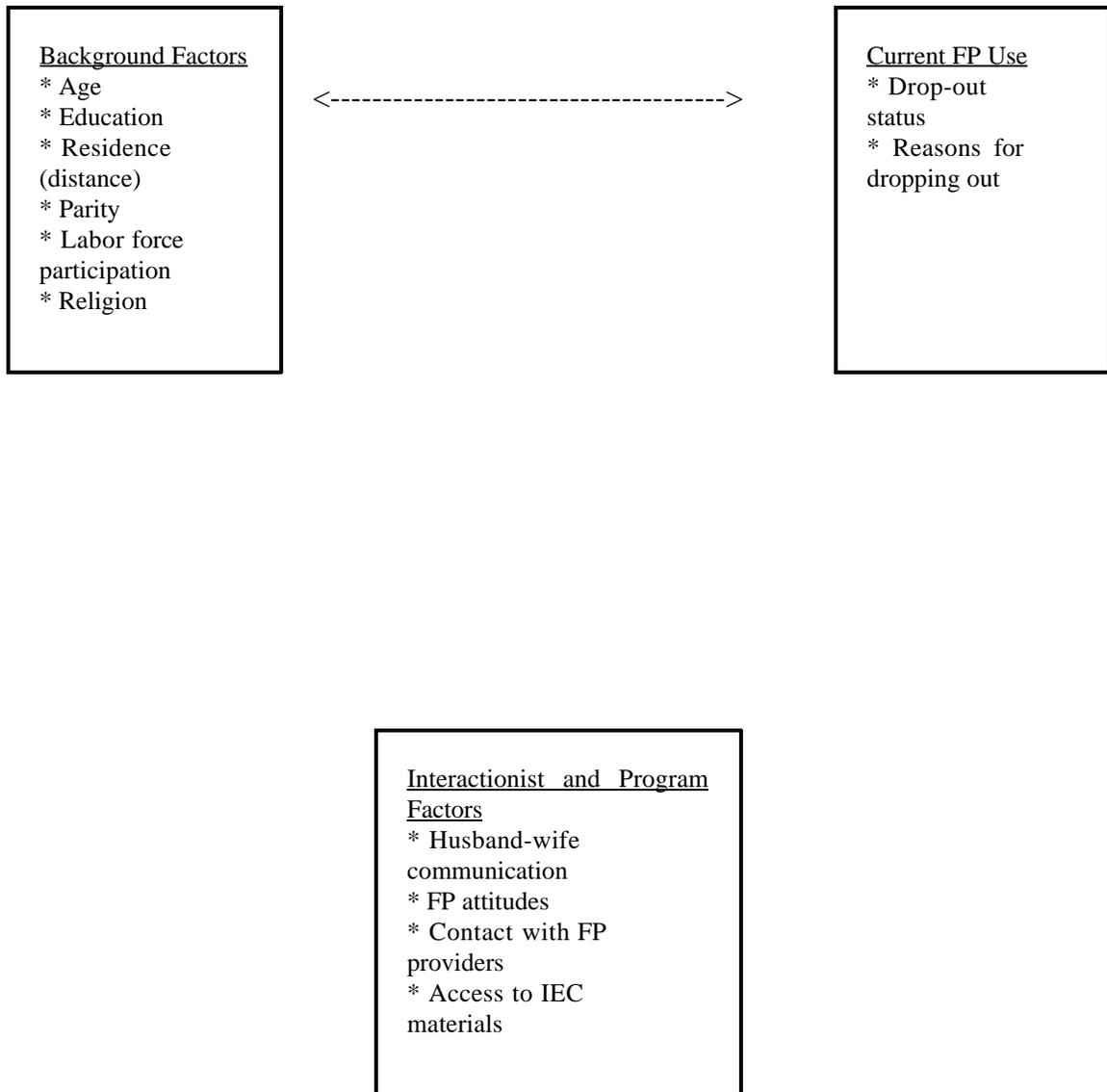


Figure 1. Conceptual Framework

Data Collection

Data for this study were collected with the use of a structured interview schedule. An English schedule was first designed and translated into the local dialect, Bisayan. This was pre-tested in areas not included in the survey and corrections were made on the basis of the pretest results. Experienced interviewers and field supervisors of the Research Institute for Mindanao Culture were recruited and trained for this study. The respondents were currently married women, 15 to 49 years of age, who were listed by the DOH as previous or current users of pills, the IUD or condoms. No proxy respondents were allowed and interviewers were asked to make up to four callbacks to the respondent before a replacement was made. Project supervisors were assigned to help interviewers in the field and to conduct field editing. They also conducted re-interviews upon a subsample of respondents to verify data entries and responses.

One staff member from each clinic was interviewed to obtain information about her experiences with providing family planning services. Twenty health providers served as respondents for this purpose. Field supervisors conducted all the staff interviews.

An inventory of facilities for family planning was also conducted in the twenty clinics sampled. Actual observation of client-provider interaction in seventeen clinics was completed.

Sampling

This study utilized a multi-stage sampling design. The first stage was the purposive selection of the province of Bukidnon, the province with the highest drop-out rate in Region X. A stratified probability proportionate to size (PPS) sampling design was adopted to select the sample barangays. The respondents were drawn from the list of 1992 family planning acceptors (available at the different DOH clinics) in each sampled barangay by systematic random sampling.

Sample size was 400 cases.³ These were taken from a second-stage sample of 20 barangays. Thus, the "ideal number" of respondents for each barangay under the PPS design was 20.

Both continuing users and drop-outs were interviewed. The methodology involved locating a total of 406 randomly selected acceptors (including replacements) interviewing them in their homes and determining at that point their current status with regard to family planning use. Continuing users, actual drop-outs (vs. those listed as drop-outs by the DOH) and method switchers were identified and interviewed.

The twenty barangays sampled were:

- | | |
|-------------------------|----------------------------------|
| 1. Bangcud, Malaybalay | 11. Anahawon, Maramag |
| 2. Casisang, Malaybalay | 12. Pob. Pangantucan |
| 3. Linabo, Malaybalay | 13. San Jose, Quezon |
| 4. Kibanggay, Lantapan | 14. Dumalama, Quezon |
| 5. Lurugan, Valencia | 15. Don Carlos Sur, Don Carlos |
| 6. Sinayawan, Valencia | 16. Pob. Kitaotao |
| 7. Batangan, Valencia | 17. Kianggat, Danggagan Fernando |
| 8. Little Baguio, San | |
| 9. Pob. South, Maramag | 19. Natulongan, Kibawe |
| 10. Base Camp, Maramag | 20. Malinao, Kadingilan |

³ This was determined according to a method outlined by Fisher, Laing, Stoeckel and Townsend (1991, p. 45). If we assume that the DOH records are accurate, the proportion of drop-outs is 0.60 and of non drop-outs is 0.40. The level of significance is .05; so Z is therefore equal to 1.96. Setting the degree of accuracy at 0.05, we thus have:

$$n = \frac{(1.96)^2 (.60) (.40)}{(.05)^2} = 369$$

(Sample size was then rounded upwards to 400 to allow for the possibility that the DOH estimate on drop-outs is not perfectly accurate.)

The actual number of respondents visited came to 406 women. The record of FP acceptors in one sampled barangay was found to be amiss. The first six women from this barangay who were interviewed were non-users. This prompted the field supervisor to make verification. It was found that the listing of FP acceptors was completely fictional. To avoid further delays, this particular barangay was eventually replaced.

Operational Definitions of Variables

Most of the variables outlined in Figure 1 are standard sociological factors, thereby eliminating the need to formally define them at this point. Two separate definitions may be cited for contraceptive discontinuation ("dropping out"). The first approach is that taken from the DOH record keeping system. This defines a pill or condom acceptor as having subsequently dropped out of the program if the person concerned fails to report to the clinic on the next resupply date. IUD discontinuation, in contrast, refers to a user whose IUD has been expelled or removed. In contrast, we also have a behavioral (survey-based) definition in which the emphasis is upon actual discontinuation rather than upon keeping pre-arranged appointments at the clinic. As noted earlier, the major emphasis of this study has been upon the second of these two perspectives.

"Family planning attitudes" refers not only to the respondent's assessment of family planning in general but also to perceptions about the various methods available (e.g. effectivity, convenience, aesthetic considerations) and to fertility-related attitudes, most particularly the desire for additional children.

"Quality of care" is defined by the present study as the knowledgeable use of the method by the client, the quality of client-provider interaction during FP orientation, the degree of satisfaction experienced by the clients during visits to the clinic for any family planning related reasons, and the client's having been given a free choice of methods to use.

LIMITATION OF THE STUDY

This study was limited to the province of Bukidnon, a large, landlocked province in Central Mindanao. Although rural-urban stratification was considered in the selection of barangays, urban barangays in Bukidnon are not actually as densely populated and urbanized as in other barangays throughout Region X, thereby constraining the writer from making approximate generalization for the region as a whole.

THE FAMILY PLANNING ACCEPTORS OF BUKIDNON

The Extent of the Drop-out Problem

Of the 406 currently married women sampled from the list of 1992 FP acceptors only 389 were interviewed. Seventeen women were found to be never users or non-acceptors of family planning. Of these never users, one was a never married woman. Breakdown by FP status and method used is thus shown below:

Current Users:

Pills	151	37.2
Condom	7	1.7
IUD	56	13.8

Switchers	54	13.3
-----------	----	------

Drop-Outs:

Pills	106	26.1
Condom	14	3.5
Changed Clinic	1	0.2

Never Users	17	4.2
-------------	----	-----

TOTAL	406	100.0
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Actual interviews reveal more than half (52.7%) of the women interviewed to be currently using pills, condom and the IUD, while another thirty per cent (29.6%) had stopped using the method they originally accepted at the clinic. Seventeen women were found to be not using any family planning method. Most of the current users and drop-outs were pill users. None of the women interviewed were IUD drop-outs.

DOH records, on the other hand, showed there were 271 current FP users constituting 66.7 % of the total sample and 123 drop-outs which was 30.3% of the total sample.

Table 1 shows a comparison of the number of acceptors by FP status based on actual interviews and based on DOH records. The DOH records showed more

current users and drop-outs than were revealed during the actual interviews. In comparison, a fairly large number of switchers (54 cases) were found during the actual interviews, as compared to only 3 cases listed on the DOH records.

Nevertheless, clinic records were found to be fairly accurate. Actual interviews did not show a large number of inconsistencies with the DOH categorization of the respondents.⁴ These categories were current users, drop-outs, and switchers. The DOH classification was found to be correct in 73.4 percent of all cases.

The study also found that 30.8 percent of the women who had adopted FP at some time in 1992 had dropped out of the program as of the survey date (September-October 1993). This figure is lower by 29.2 percent from the 60 percent drop-out rate which had been reported earlier for Bukidnon indicating that the dropping out phenomenon is becoming somewhat less pervasive in the province. This lower level can also be attributed to the fact that, as far as recording at the DOH is concerned, clients are considered dropped if they fail to come to the clinic for their next resupply. Thus, a client can be recorded as drop-out when in fact she is still currently using a method.

⁴ This includes the six women interviewed in one sampled barangay which was replaced due to erroneous listing (see Footnote 3). However, it should perhaps be added at this point that our accuracy estimates would have been lower if the field supervisors had continued looking for respondents from the fictional family planning acceptor list given to them in one of the sampled barangays.

TABLE 1. Comparison of Family Planning Status of the Woman Based On Actual Interviews* and DOH Records.

Interview Status	RHS/BHS/TCL Status							Total
	Current User	Current User	Current User	Switcher	Drop-out Pills	Drop-out Condom	Drop-out IUD	
Current user -Pills	147				4			151
Current user - Condom		7						7
Current user - IUD	1		55					56
Switcher	17	4	4	2	19	7	1	54
Drop-out - Pill	28			1	77			106
Drop-out - Condom		4				10		14
Changed - Clinic					1			1
Never User	8	5			4			17
TOTAL	201	20	59	3	105	17	1	406

* Numbers located along the diagonal (indicated by underscoring) represent all cases where the DOH records agree with findings from the actual interview.

From Table 1, the following sub-tables show comparison of DOH records by result of actual interviews by FP status of woman and method used. Table 1a shows about 75 percent of current users (according to DOH records) who were found to be actually using the method at the time of the survey. Table 1b shows only seventy one percent of the recorded DOH drop-outs to have really dropped out of FP use. Tables 1c, 1d, and 1e show the differences between DOH classification based on clinic records and classification based on actual interviews. One of the most important observations from these three subtables concerns the relationship between drop-out status and the type of method originally accepted. As may be seen therein, every one of the IUD acceptors were still using a FP method as of the survey date. In comparison, only 61.8 percent of the pill acceptors and 48.6 percent of the condom acceptors could lay claim to this same status. Clearly, continuation rates in Bukidnon, and possibly in other areas of the Philippines (Laing, 1985) would be increased if more women would accept the IUD.

are using the method ascribed to them	74.6
have switched	9.3
have dropped out	11.4
never used	4.6
	<hr/> 100.0

Table 1b. Percent of all drop-outs according to DOH who:

have actually dropped out	70.7
are still using the method (at same or different clinic	4.1
have switched to another method	22.0
never used	3.3
	<hr/>
	100.1

Table 1c. Percent of all those who started on pills who later

	(Actual)	Accdg. to DOH Records
stayed on pills	49.7	65.7
dropped out	34.3	34.3
switcher	12.1	-
never used	3.9	-
	<hr/>	<hr/>
	100.0	100.0

Table 1d. Percent of all those who started on condom who later

	(Actual)	DOH Records
stayed on condom	18.9	54.1
dropped out	37.8	45.9
switched	29.7	-
never used	13.5	-
	<hr/>	<hr/>
	100.0	100.0

Table 1e. Percent of all those who started on IUD who later

	Actual	DOH Records
stayed on IUD	91.7	98.3
dropped out	0.0	1.7
switched	8.3	-
	<hr/>	<hr/>
	100.0	100.0

SOCIO-ECONOMIC-DEMOGRAPHIC CHARACTERISTICS AND FAMILY PLANNING STATUS

Age of Respondents

The youngest respondent interviewed for this study was 18 years old and the eldest was 46. The mean age of all respondents was 29.3 years, while their median age was 28.0 years.

Table 2 shows the distribution of respondents by age and drop-out status. Overall, the drop-outs appear to be somewhat concentrated in the youngest and oldest groups. A chi square test, however, did not show significant association between age of respondent and family planning status.

Table 2. Family Planning Status By Age of Respondent

Age of Respondent	FP Status		Total
	Current User	Drop-out	
< 25	57 66.3	29 33.7	86
25 - 29	94 71.8	37 28.2	131
30 - 34	66 69.5	29 30.5	95
35 - 39	38 70.4	16 29.6	54
40 & over	14 60.9	9 39.1	23
TOTAL	269 69.2	120 30.8	389

$\chi^2 (4df) = 1.53, n.s.$

Number of Pregnancies and Number of Children Still Living

All the women in the study have had at least one pregnancy. This is a reflection of the Philippine cultural pattern which encourages newly married and childless couples to have a baby as soon as possible. Almost forty percent (39.3%) had at least 2 to 3 pregnancies and another thirty six percent (36.5%) had 4 to 6 pregnancies.

Women with seven or more pregnancies constituted more than fifteen percent (15.7%) of the total FP acceptors interviewed. Of these women forty seven percent were family planning drop-outs and the remaining fifty three percent were current users.

Number of pregnancies was found to be significantly associated with the family planning status of the woman (see Table 3). That is, women with greater number of previous pregnancies were more likely to be drop-outs than women who had fewer previous pregnancies.

Two women in the study still do not have living children and understandably, these two women have also dropped out of family planning use. While it might be expected that women with more living children would be more diligent in their practice, this study found the contrary. Women who have more living children were more likely to drop out.

Most current users as well as drop-outs have two to three living children, 47.6% and 36.7% respectively. Table 4 shows the distribution.

Table 3. Total Number of Pregnancies by FP Status of Woman.

Total # of Pregnancies of Respondent	FP Status		Total
	Current User	Drop-out	
1	26 78.8	7 21.2	33 8.5
2 - 3	114 74.5	39 25.5	153 39.3
4 - 6	97 68.3	45 31.7	142 36.5
7 & over	32 52.5	29 47.5	61 15.7
TOTAL	269 69.2	120 30.8	389 100.0

X^2 (3df)= 11.51, $p < .01$.

Table 4. Total Number of Children Still Living by Family Planning Status of Woman.

R's Number of Children Still Living	FP Status		Total
	Current User	Drop-out	
0 - 1	36 69.2	16 30.8	52 13.4
2 - 3	128 74.4	44 25.6	172 44.2
4 - 6	86 66.7	43 33.3	129 33.2
7 & over	19 52.8	17 47.2	36 9.2
TOTAL	269 69.2	120 30.8	389 100.0

X^2 (3df)= 7.12, $p < .06$.

Highest Grade Completed of Respondents

Two of the sampled 1992 FP acceptors have never been to school. One fourth finished their elementary studies (Grade 6) and a little more than one fifth had at least some elementary education. Fifteen percent finished high school. Of the 58 women who have reached college, 25 or 43% were able to finish.

Mean number of years completed in school was 7.6 years. The current users were better off in terms of educational attainment. Their mean number of years completed in school was 8.0 compared to the drop-outs who recorded only 6.6 years.

Almost one half of the women who finished Grade 3 or lower and more than one third of those who were either Grade 4 or Grade 5 were family planning drop-outs while only about fourteen percent (13.8%) of those who reached college and twenty four percent of those who finished high school have dropped out of family planning use.

The chi-square test showed a significant relationship between highest grade completed of the woman and her family planning status. It was found that women with lower educational attainment were more likely to drop out.

Table 5. Highest Grade Completed of Respondent By Family Planning Status of Woman.

Highest Grade Completed of Respondent	FP Status		Total
	Current User	Drop-out	
0 to Grade 3	15 51.7	14 48.3	29 7.5
Grade 4 to Grade 5	33 57.9	24 42.1	57 14.7
Grade 6	63 63.6	36 36.4	99 25.4
High School 1 to High School 3	64 72.7	24 27.3	88 25.4
High School Graduate	44 75.9	14 24.1	58 14.9
College 1 to College 4	50 86.2	8 13.8	58 14.9
TOTAL	269 69.2	120 30.8	389 100.0

X^2 (5df)= 18.59, $p < .002$.

Labor Force Participation

Most of the women in the study (64.8%) were full-time housewives. Of the working women, there were more who worked only part of the time during the last 12 months.

More than one third of the housewives dropped out of family planning use while only 15 percent of those who worked full-time were FP drop-outs. Chi-square test showed a significant relationship between family planning use and working as shown in Table 6.

The type of job the woman held also had something to do with currently using or dropping use of family planning. Those engaged in professional, technical, administrative, executive, managerial and sales jobs were more likely to continue use of family planning than those engaged in farming, fishing, production processing work, crafts and service related occupations. It is thus apparent that it is actually not work per se that has the most impact on drop-out status but, rather, the type of work carried out. When the woman is employed on a permanent basis and in a formal sector or high paying job, the conditions will then be found which are most favorable for continued FP use.

Table 6. Number and Percent Distribution of Whether or Not Respondent Worked for Pay/Salary/Profit During the Last 12 Months By Family Planning Status.

Did R work for pay/salary/profit during the last 12 months?	FP Status		TOTAL
	Current User	Drop-out	
YES, for the full 12 months	46 17.1	8 6.7	54 13.9
YES, but only part of the time	63 23.4	20 16.7	83 21.3
NO	160 59.5	92 76.7	252 64.8
TOTAL	269 69.2	120 30.8	389 100.0

X^2 (2df)= 12.07, $p < .002$.

Table 6a. Number and Percent Distribution of Type of Work Respondents Held During the Last 12 Months By Family Planning Status of Woman.

Family Planning Status	Work A *	Work B*	TOTAL
Current User	62	47	109
	86.1	72.3	79.6
Drop-out	10	18	28
	13.9	27.7	20.4
TOTAL	72	65	137
	52.6	47.4	100.0

X^2 (1df)= 4.00, $p < .04$.

*Work A - Professional, Technical, Administrative, Executive, Managerial & Sales Occupations.

Work B - Farming, Fishing, Production Processing Work, Crafts and Service Occupations. Related

Religion

One respondent indicated she did not belong to any religious group. Eighty-five per cent of the women were Roman Catholics and another fifteen per cent belonged to other religious groups like the Philippine Independent Church, the Seventh Day Adventist, the Fundamental Baptist, Born Again Christian, Iglesia ni Kristo, Protestant, Pentecostal and Jehovah's Witness.

Religion was found to have no significant relationship with continued use of family planning as opposed to dropping out. This supports the findings from other studies on this topic, most of which do not show a strong impact on the part of the religious factor (Cf. Palabrica-Costello, 1991).

Table 7. Religion by Family Planning Status of Woman.

Religion of Respondent	FP Status		Total
	Current User	Drop-out	
Roman Catholic	232 70.3	98 29.7	330 85.1
Others	36 62.1	22 37.9	58 14.9
Total	268 69.1	120 30.9	388 100.0

$$X^2 (1df) = 1.57, n.s.$$

Household Income

More than one fifth of the respondents (22.1%) had incomes below P 10,000.00 per year. Of these, forty two percent had incomes below P 6,500.00, an income much lower than the annual poverty threshold for Region X, which was P 6,564.00 as of 1991.⁵

⁵ Based on the 1991 Poverty Threshold prepared by the TWG on Poverty Determination, NSCB.

Eleven households or about three percent (2.8%) had incomes above 100,000.00.

Most households had yearly incomes which ranged between P10,000.00 and P 20,000.00. The lowest annual income reported was P2,000.00 and the highest income reported went as high as P300,000.00.

The annual mean income for all households was P 25,859.44. However, half of the households were earning only P 17,000.00 or less per year.

More than one third (34.7%) of the women who belong to households with less than P 20,000.00 annual earnings were family planning drop-outs. In comparison, this same statistic for women in households with income of P 30,000.00 or more was a mere twenty percent. This indicates that women who belong to low-income households were the most likely group to drop out.

Table 8. Household Income by Family Planning Status of Woman.

INCOME	FP Status		Total
	Current User	Drop-out	
< 10,000.00	57 66.3	29 33.7	86 22.1
10,000 - 19,999	85 62.5	51 37.5	136 35.0
20,000 - 29,999	46 69.7	20 30.3	66 17.0
30,000 - 39,999	32 78.0	9 22.0	41 10.5
40,000 +	49 81.7	11 18.3	60 15.4
Total	269 69.2	120 30.8	389 100.0

$$X^2 (4df) = 9.09, p < .05.$$

Ownership of Consumer Durables

One fourth (25.4%) of the study respondents belong to households without any appliance or consumer durable available. Forty eight per cent had at least one appliance available. Usually this consisted of a small radio. Only 13.4% owned a television set and very few owned a refrigerator, electric iron, electric fan, wallclock or other household conveniences.

Table 9 shows that women who belong to households which have none or less than three consumer goods were more likely to drop use of family planning when they were compared to women with at least three or more consumer goods at home.

Table 9. Ownership of Consumer Goods by Family Planning Status of Woman.

Ownership of Consumer Durables	FP Status		Total
	Current User	Drop-out	
None or at least 2 consumer goods at home	215 66.0	111 34.0	326 83.8
With at least 3 or 4 consumer goods at home	27 87.1	4 12.9	31 8
With 5 or more consumer goods at home	27 84.4	5 15.6	32 8.2
TOTAL	269 69.2	120 30.8	389 100.0

$$X^2 (2df) = 9.72, p < .01.$$

Ethnicity

Language spoken by the respondent at home when still young was used as an indicator of ethnicity for this study.

Most of the respondents (74%) spoke Cebuano at home when they were still young. Eleven percent spoke Ilonggo and six percent spoke Boholano. Dialects spoken in Luzon

provinces were spoken by only about five percent of the respondents.

There were only 13 respondents who spoke the Manobo dialect when they were young and six of them dropped the use of family planning. The only respondent who reported she spoke the Muslim dialect when she was young incidentally was also a family planning drop-out.

Although chi square test did not show significant relationship between language spoken at home when still young and family planning status, there is the tendency of the tribal/muslim speakers to drop the use of family planning.

Table 10. Language Spoken at Home When Still Young By Family Planning Status of Woman.

Language spoken at home when still young	FP Status		Total
	Current User	Drop-out	
Luzon: Tagalog, Ilocano, Pampagueno, Bicolano	14 77.8	4 22.2	18 4.6
Visayas: Cebuano, Ilonggo Boholano, Waray	248 69.7	108 30.3	356 91.8
Tribal/Muslim	7 50.0	7 50.0	14 3.6
TOTAL	269 69.3	119 30.7	388 100.0

X^2 (2df)= 3.08, n.s.

FAMILY RELATED FACTORS AND FAMILY PLANNING STATUS

Husband and Wife's Attitude Towards Family Planning

The decision whether to use or not to use family planning depends to some extent on the attitude of the husband and the wife towards a particular method or towards family planning in general.

Table 11 shows that a majority of the wives had a more favorable attitude towards the general concept of family planning with more than 90 percent showing approval among both current users and drop-outs. However, it is interesting to note that the attitudes of the husband were a better predictor of current use than attitudes held by the respondent herself. This means that the more favorable the attitude of the husband towards family planning, the less the tendency of the wife to drop-out.

Husband's attitude towards pills, IUD and condom is significantly associated with family planning use as borne out by the chi square tests. This is also true to the wives in two of the four comparisons (pills and condom use).

Husband's approval of the use of family planning by the wife was one of questions the providers ask their clients before finally giving her the method to adopt or use. This assumes therefore that the couple had discussed the topic prior to the visit to the clinic. This study attempted to find out from the study women whether their husbands agree or disagree to the use of family planning.

Table 11. Husband and Wife's Attitude Towards Family Planning By Family Planning Status of Woman.

	FP Status		Significance
	Current User	Drop-outs	
Husband:			
1. Towards FP in general (% who thinks it is very good)	97.7	93.9	p < 0.05
2. Towards Pills (% who thinks it is very good)	58.0	40.7	p < 0.002
3. Towards IUD (% who thinks it is very good)	31.8	20.4	p < 0.03
4. Towards Condom (% who thinks it is very good)	7.1	16.2	p < 0.01
Wife:			
1. Towards FP in general (% who thinks it is very good)	94.4	93.3	n.s
2. Towards Pills (% who thinks it is very good)	62.2	47.5	p < 0.006
3. Towards IUD (% who thinks it is very good)	32.9	25.9	n.s.
4. Towards Condom (% who thinks it is very good)	8.0	19.3	p < 0.02

Almost half of the husbands (46.5%) agree to the use of family planning to avoid or stop pregnancy and about one fourth (24.9%) say that they agree with its use for the purpose of spacing or delaying pregnancy. On the other hand, most of the husbands who disagree with it do so because of side effects..ls1

Table 12. Husband's Reaction to Family Planning by Family Planning Status of Woman.

Reaction of Husband to family planning	FP Status		TOTAL
	Current User	Drop-out	
Agree:			
- agrees to the use of FP to space or delay pregnancy	67 24.9	30 25.0	97 24.9
- agrees to the use of FP to avoid/stop pregnancy	126 46.8	55 45.8	181 46.5
- agrees to the use of FP to alleviate financial condition of the family	32 11.9	12 10.0	44 11.3
- agrees to the use of FP to have more time for the children & to give them brighter future	23 8.6	4 3.3	27 6.0
- agrees to the use of FP to give time to the wife to help earn for the family	4 1.5	3 2.5	7 1.8
- agrees to the use of FP as long as it is free from side effects	7 2.6	3 2.5	10 2.6
Disagree			
- disagrees to the use of FP because of its many side effects	4 1.5	6 5.0	10 2.6
- disagrees to the use of FP to control/limit pregnancy	2 .7	1 .8	3 .8
Nuetral:			
- neither agrees nor dis-agrees, will only abide with what God will give them	1 .4	2 1.7	3 .8
- agrees on using some of the methods and dis-agrees on some	-	1 .8	1 .3
No idea/no comment/ don't know	3 1.1	3 2.5	6 1.5
TOTAL	269	120	389

Person Making Decisions in the Family

In more than one half (57.6%) of the households, it is the husband who makes the decisions in the family. More than one third (35.5%) of the women reported decisions in the family are jointly made by both the husband and the wife and only about eight per cent (7.5%) reported that decisions are made by the wife.

Husband-Wife Discussion About Family Planning and Other Family Matters

Family concerns like number of children, religion, family planning, education of the children, extra income, discipline of the children, wife's work outside the home, buying or selling of consumer durables, and future plans are some of the important topics often discussed by married couples. In this study, more than one half (57.3%) of the women reported they discussed frequently these topics with their husbands, but a substantial percentage (42.7%) also said they never or only occasionally did this.

Respondents were also asked whether they have discussed about family planning during the past twelve months. Table 13 shows that women who "sometimes" or "never" discussed family planning with their husbands during this period were somewhat more likely to be drop-outs.

Table 13. Husband-Wife Discussion About Family Planning During the Last Twelve Months by Family Planning Status of Woman.

Did you & your husband talk about FP during the last 12 months?	FP Status		Total
	Current User	Drop-out	
Frequently	161 72.2	62 27.8	223 57.3
Sometimes	86 68.3	40 31.7	126 32.4
Once in a while/ Never	22 55.0	18 45.0	40 10.3
TOTAL	269 69.2	120 30.8	389 100.0

X^2 (2df)= 4.77, $p < .09$.

FAMILY PLANNING PROGRAM RELATED FACTORS AND FAMILY PLANNING STATUS

Access to IEC Materials on Family Planning

The availability of IEC materials on family planning was checked by asking respondents if they have seen such materials at the clinic. The women were asked if materials like posters, comics, books, magazines, charts, brochures and calendars were available at the clinic and whether or not they were able to read these materials.

Exposure to IEC materials on FP was relatively high among Bukidnon FP acceptors. Seventy six percent admitted having been exposed to various IEC materials both at the clinic (usually print materials) and through the broadcast media (70.3 percent reported having heard of FP from this medium).

Posters are the most common IEC print material at the clinic. About two thirds of the respondents reported that FP posters were available at the clinic, and only 45% were able to read copies of this print material. Other print materials like comics, books, magazines, charts, brochures and calendars were available according to less than 50 percent of the respondents and the number of those who were able to read copies of these materials were much fewer.

Only a little more than one fifth of the women said print materials on family planning were available in other places aside from their family planning clinic.

Table 15 shows that more than one third of those with no or very limited exposure to IEC materials on family planning have dropped out. The percentage who were exposed to such materials, however, was also about the same. Thus, there was no statistically significant relationship for this comparison.

Table 14. Print Materials Seen and Read and Broadcast Programs on Family Planning Heard

Print Materials	Available in clinic? (yes)		Able to read copies of these materials		Available in other places (Yes)		Able to read copies of materials	
	f	%	f	%	f	%	f	%
Posters	254	64.0	180	45.3	91	22.9	3	0.8
Comics	141	35.5	103	25.9	39	9.8	16	4.0
Book	77	19.4	36	9.1	23	5.8	9	2.3
Magazines	62	15.6	25	6.3	13	3.3	3	0.8
Charts	171	43.1	127	32.0	59	14.9	3	0.8
Brochures	92	23.2	52	13.1	-	-	-	-
Calendars	7	1.8	4	1.0	-	-	-	-
Heard about FP from the broadcast media (radio, TV)			Yes - (n=279) 70.3%				No - (n=118) 29.7%	

Table 15. Exposure and Access to FP Materials (Print and Broadcast) By Family Planning Status of Woman.

Exposure and Access to FP Materials	FP Status		Total
	Current User	Drop-out	
With no or very limited exposure	60 64.5	33 35.5	93 23.9
With fairly good exposure	209 70.6	87 29.4	296 76.1
Total	269 69.3	120 30.8	389 100.0

X^2 (1df)= 1.23, n.s.

Home Visits by FP Providers

FP providers are expected to visit their clients in their homes. This is to help the clients with whatever problems may crop up as well as help them sustain their interest in continuing to use the method. It should be noted, however, that the FP providers have other functions in the clinic aside from providing family planning services.

This study revealed that home visits by FP providers were apparently rare, with 76 percent of the respondents saying they had never experienced this. Only about one fourth (24.4%) or 95 of the study respondents reported they were visited by the clinic staff in their homes. More than seventy five per cent of the drop-outs were never visited by family planning providers. Again, however, the comparative level among the current users was equally high. As such, the chi square test found no significant association between drop-out status and having been visited by providers in their homes.

Table 16. Visits by Family Planning Providers to Clients' Homes by Family Planning Status of Woman.

Have you been visited by FP providers at home?	FP Status		Total
	Current User	Drop-Out	
YES	67 70.5	28 29.5	95 24.4
NO	202 68.7	92 31.3	294 75.6
Total	269 69.2	120 30.8	389 100.0

$$X^2 (1df) = .11, n.s.$$

Distance Between Home and Clinic

The nearest house to the FP clinic is only two meters away according to two of the respondents while the farthest is 29 kilometers as reported by one respondent. Half of the respondents live within 1000 meters of the clinic.

Table 17 displays mean distance from the respondents home to the nearest family planning clinic by family planning status. One way analysis of variance did not show any significant relationship between distance and drop-out status.

Table 17. Mean Distance from Respondents' Home to Nearest Family Planning Clinic by Family Planning Status of Woman.

FP Status	Mean Distance (in meters)
Current Users:	
Pills	1273.09
IUD	1363.04
Condom	1137.14
Switchers	1429.74
Drop-Outs:	
Pills	1401.54
Condom	828.57
Change Clinic	350.00
Never Users	1152.50

F= .48, n.s.

Because very few of the respondents live far away from the clinic, most of them (63.5%) only walk or hike to the clinic. The most that respondents spent for fare (round trip) was ₱20.00 and the least was ₱2.00. When we compare those who had to pay for their trip with those who spent nothing on this (Table 18) it turns out that those who had to spend for fare were less likely to drop out. This may indicate that they were truly interested in family planning, even to the point of spending money for it.

Table 18. Amount Spent for Fare (Round Trip) by Family Planning Status of Woman.

Fare (round trip) from residence to clinic	FP Status		Total
	Current User	Drop-Out	
None (hike)	158 64.0	89 36.0	247 63.5
P2.00 or more	111 78.2	31 21.8	142 36.5
Total	269 69.2	120 30.8	389 100.0

X^2 (1df)= 8.52, $p < .003$.

QUALITY OF CARE

Selected quality of care indicators were used by the study. These included availability of free and unrestricted choice in selecting a method, provision of family planning information by the clinic staff, and the extent to which the women were satisfied with the services they received from the clinic.

Family Planning Lectures Attended

Family planning lectures are regularly conducted at the different service delivery points. The family planning providers have had sufficient training in this regard. To find out how these lectures or trainings affected the use of family planning, the women were asked about their experience in this regard.

A little less than ten percent reported that they had never been given any lecture on FP. This leaves a strong majority (90.5% or 352 women) who claimed they were given some lecture or training on family planning before they started using a method. Of these however, 67.3% (or 237 women) said that they had received information on one specific method only. These statistics do not show the FP clients as being given a wide variety of choices, a pattern which seems to be a dysfunction so far as the drop-out problem is concerned. As shown in

Table 19, those who received information on only one method were more likely to drop out than those who were exposed to a wide variety of alternatives.

Table 19. Family Planning Methods Learned by Family Planning Status of Woman.

FP Status	FP Lecture Coverage		Total
	One Method	Two or More Methods	
Current Users	157 66.2	87 75.7	244 69.3
Drop-Outs	80 33.8	28 24.3	108 30.7
Total	237 67.3	115 32.7	352 100.0

$$X^2 (1df) = 3.22, p < .07.$$

Almost all of the lectures were conducted in government clinics. Only one acceptor asserted she had hers in a private clinic. Most of the lectures (87.2%) were conducted by the Family Planning Midwife. Others were given by a doctor (1.7%), a nurse (8.2%) or a volunteer worker (3.1%).

A strong majority (98.2%) claimed that they were free to choose the family planning method to adopt. While it is good to know that no form of coercion was used at this point, we should also note that this is contrary in some way to the earlier finding about the coverage of the lecture attended (most received information on one method only). If they heard about only one method, this indicates they were not really free to choose from among the several FP methods.

More lectures (57.7%) lasted for less than thirty minutes. Thirty per cent went on for less than an hour, and only twelve per cent took more than one hour. This validates the responses of the women on the coverage of the lecture provided by the clinic staff. In the space of less than half an hour, the lecturer would not be able to introduce all the family planning methods. Also, the data on Table 20 show that women who listened to family planning lectures for less than half an hour were more likely to drop out compared to those who were given lectures for at least an hour.

Table 20. Time Trainor Spent Talking About FP by Family Planning Status of Woman.

How much time trainor spent talking about FP?	FP Status		Total
	Current User	Drop-Out	
< 30 minutes	133 65.5	70 34.5	203 57.7
30 minutes to than 1 hour	82 77.4	24 22.6	106 30.1
1 hour & over	29 67.4	14 32.6	43 12.2
Total	244 69.3	108 30.7	352 100.0

X^2 (2df)= 4.67, $p < .10$.

The respondents were also asked to describe their family planning lecturer. Most respondents (83 percent) felt that their FP trainor had been "friendly and approachable." The chi square test showed a significant relationship between family planning status and having friendly and approachable trainors. Almost half (46.7%) of those who described their trainor as unfriendly had later dropped out of the program. Table 21 shows this finding.

Table 21. Respondents' Description of their FP Trainor by Family Planning Status.

Was your FP trainor friendly and approachable	FP Status		Total
	Current User	Drop-Out	
YES	212 72.6	80 27.4	292 83.0
A little/No	32 53.3	28 46.7	60 17.0
Total	244 69.3	108 30.7	352 100.0

X^2 (1df)=8.69, $p < .003$.

Another indicator of quality care is the quality of interaction that takes place between the client and the provider during the training or lecture. This is very important because the information the client receives is supposed to help her in determining the family planning method that will really suit her. In this study, several components of the training were reviewed with the clients to determine whether the information they got was complete or comprehensive.

The respondents gave favorable assessments with regard the trainors' ability to clearly explain the method, to show how to use the method and to explain its advantages. They felt, however, that the trainors had not dwelt adequately with the method's disadvantages and probable side effects. Table 22 shows that women who attended a lecture where the trainor was able to explain the possible side effects, and where the trainor was able to explain the advantages of the method were less likely to drop use of family planning.

Table 22. Client-Provider Interaction During Training by Family Planning Status of Woman.

	FP Status		X ² Values
	Current User	Drop-Out	
Did trainor clearly explain the method? (% Yes)	95.1	90.7	X ² = 2.41, n.s.
Did trainor demonstrate how to use the method? (% Yes)	93.4	91.7	X ² = 0.36, n.s.
Did trainor explain the possible side effects of method? (% Yes)	75.8	64.8	X ² = 4.54, p < .03
Did trainor explain what to do if complications/problems occur before scheduled visit to FP Clinic? (% Yes)	86.1	81.5	X ² = 1.21, n.s.
Did trainor explain the advantages of the method? (% Yes)	88.1	79.6	X ² =4.35, p < .03
Did trainor explain the disadvantages of the method? (% Yes)	70.1	63.9	X ² = 1.32, n.s
Summary Index (average score)	5.0861	4.7222	F = 4.02, p <.05

Visits to the Family Planning Clinic

Acceptors were instructed to return (on a scheduled basis) to the clinic either for re-supply or check-up. A majority (75.8%) of the FP acceptors visited their clinic at either one-month or two-month intervals. More than half of them, in fact, visited their clinic once a month, among whom more than one third (34.8%) had dropped the use of family planning. For those who visited their clinic less frequently (once in 6 months or only once, twice or thrice since accepting a method), less than one fourth (23.8%) had dropped. This shows that clients who were expected to return to the clinic every month for a new supply of contraceptives were less likely to stay with the program than were those who were required to return on a less frequent basis. Table 23 shows the distribution.

Table 23. Frequency of Visiting the FP Clinic by Family Planning Status of Woman.

Frequency of Visit to FP Clinic	FP Status		Total
	Current Users	Drop-Out	
Once a month	152 64.5	81 35.5	233 15.9
Once in 2 months	65.2 40	34.8 22	59.9 62
Once in 3 months	45 86.2	7 13.5	52 13.4
Once in 6 months//once a year/once,twice or thrice since accepting a method	32 76.2	10 23.8	42 10.8
Total	269 69.2	120 30.8	389 100.0

$$X^2 (3df) = 10.64, p < 0.01.$$

The respondents were also asked if they were made to wait before they were attended to during their visits to the clinic. Almost two thirds (63.5%) claimed they were immediately attended to and 36.5 percent reported they were made to wait. About 14 percent of those who were made to wait also claimed they were made to wait for a long time. In general, clients who had been made to wait were not more likely to drop out from the program.

Perhaps this occurred because client turnover tends to slow down somewhat in clinics where the staff take a thorough-going and supportive approach to FP provision.

Table 25 reveals that about thirty eight percent of the respondents were very satisfied with their visits to the FP clinic. Of these women, about seventy three percent (72.6%) were current users. A little more than half of the women (52.7%) revealed they were satisfied while 9.4% said they were dissatisfied. As expected, those who reported themselves as "satisfied" or "very satisfied" with their clinic's services were found to be less likely to drop out.

More than half of those who were "satisfied" or "very satisfied" reported that they felt this way because the staff at the clinic were accomodating and approachable. Another frequently cited reason concerned the steady availability of family planning supplies (Please see Tables 25a and 25b). On the other hand, most of those who were dissatisfied reported inavailability of supplies as their reason for this (Table 25c). These respondents also tended to be critical of the local midwife for various reasons, e.g. that she is "not available", "too strict", or "unfair" in giving out medicines and supplies.

Table 24. Number and Percent of FP Acceptors who were and not Made to Wait by Family Planning Status.

Do you have to wait before being attended to at the clinic?	FP Status		Total
	Current User	Drop-Out	
No, I'm always attended to immediately	171 69.2	76 30.8	247 63.5
Yes, but only for a short time	84 68.3	39 31.7	123 31.6
Yes, I have to wait for a long time	14 73.7	5 26.3	19 4.9
TOTAL	269 69.2	120 30.8	389 100.0

$$X^2 (2 \text{ df})= 0.22625, \text{ n.s.}$$

Table 25. Satisfaction with Visits to FP Clinic by Family Planning Status of Woman.

How satisfied were you with your visits to the FP Clinic?	FP Status		Total
	Current User	Drop-Out	
Very satisfied	106 72.6	40 27.4	146 37.9
Satisfied	145 71.4	58 28.6	203 52.7
Dissatisfied/Very dissatisfied	17 47.2	19 52.8	36 9.9
Total	268 69.6	117 30.4	385 100.0

X^2 (2 df)= 9.47, $p < 0.01$.

Table 25a. Reasons Given by Very Satisfied Acceptors.

Reason	f	%
FP supplies are always available	33	22.6
FP Clinic offers good service - practice first come first served basis	24	16.4
Supplies are free	6	4.1
FP Clinic is near our place	1	0.7
Staff are accomodating and approachable	75	51.4
Midwife is always available	2	1.4
Staff do not stop motivating clients for FP	2	1.4
FP methods had been thoroughly explained to us	2	1.4
My problem in family planning was solved	1	0.7
Total	146	100

Table 25b. Reasons Given by Satisfied Acceptors.

Reasons	f	%
FP supplies are always available	49	24.1
FP Clinic offers good service - practice first come first served basis	41	20.2
Supplies are free	6	3.0
FP Clinic is near our place	7	3.4
Staff are accomodating and approachable	87	42.9
Midwife is always available	3	1.5
Staff do not stop motivating clients for FP	2	1.0
They also give lectures on health	1	0.5
FP methods had been thoroughly explained to us	2	1.0
My problem in family planning was solved	5	2.5
Total	203	100

Table 25c. Reasons Given by Dissatisfied Acceptors.

Reasons	f	%
Midwife is not fair in giving supplies	4	11.1
Midwife is strict/cranky/irritable	4	11.1
Midwife is not always available	6	16.7
Midwife do not entertain us immediately	4	11.1
Supplies are not always available in the clinic	12	33.3
Medicines/supplies are for sale	2	5.6
Midwife sometimes do not examine our blood pressure	2	5.6
Not contented with the way services are provided	1	2.8
They don't give enough information about the methods of family planning	1	2.8
Total	36	100

SUGGESTIONS FOR IMPROVING FP SERVICES: CLIENTS' VIEWS

Very relevant suggestions were also given by a majority of the study respondents (356 women) when they were asked their views on how family planning services at the clinic could be improved. Most of the suggestions given were attainable. They included concerns for improving logistic support, personnel, information, education campaign (IEC), and specific services.

On logistics, respondents believed that providing a permanent supply of contraceptives/medicines at the clinic (31.2%), including more complete FP facilities at the centers (3.9%) as well as providing free medicines (8.1%) will help improve the services at the clinic.

Some respondents (8.1%) also suggested mobilizing family planning acceptors/users to motivate/teach other women about family planning. Intensive FP information campaign/seminars including house to house visits and conducting trainings in the clients' homes was suggested by almost one third of the women (31.2%).

Other suggestions included very specific services, details of which are shown in Table 26.

Table 26. Number and Percent Distribution of Suggestions for Improving Services in the FP Clinic.

Suggestions	Frequency	%
A. Logistics:	(154)	(43.3)
There should be a permanent supply of contraceptives/medicines	111	31.2
FP equipment/facilities should be complete	14	3.9
Free medicines should be provided	29	8.1
B. Personnel:	(57)	(16.0)
Assign permanent doctor and midwife	21	5.9
Assign additional midwives in the center	7	2.0
Mobilize FP acceptors/users to motivate/teach other women about family planning	29	8.1
C. Information, Education, Campaign (IEC)	(126)	(35.4)
Conduct intensive FP information campaign/seminars through house-to-house visits and trainings	111	31.2
Increase people's awareness of the FP services available at the clinic	15	4.2

Suggestions	Frequency	%
D. Specific Services:	(92)	(25.8)
Provide free consultation/examination	4	1.1
Provide FP services daily, e.g. Midwife or BHW should report to the clinic daily	9	2.5
Midwives/motivators/BHW should develop friendly and harmonious relationships with women in the area	33	9.3
Midwives/motivators should always conduct follow-up to monitor the progress of their FP users	24	6.7
Doctors/Midwives/BHW should show dedication in their works		
Midwives should be more attentive to problems/complaints of their clients	7	2.0
	4	1.1
Midwives/motivators should also introduce NFP		
Midwives should perform IUD insertion and ligation services in the BHS	3	0.8
Midwives/motivators should introduce all methods of FP and not only limit to selected methods	3	0.8
Conduct survey of all women and distinguish facilitate easy follow-up	4	1.1
Number of Woman = 356	1	0.3

Note: Total percent is more than 100% as some respondents gave more than one reply.

THE FP DROP OUTS

As noted earlier, acceptors of pills, condoms, and the IUD in 1992 are the subject of this study. Of the three groups of acceptors, dropping out was highest among those respondents who had accepted condoms (37.8 percent). The pill users followed second with a 34.3 percent drop-out rate. On the other hand, every one of the 1992 IUD acceptors was still using some FP method as of the survey date. It should be noted however, that about fifty percent of the government clinics in Bukidnon are not yet ready to provide services for IUD acceptors.

It is interesting to note that the clients who were expected to return to the clinic every month for a new supply of contraceptives (the pill and condom users) were less likely to stay with the program than were those who were required to return on a less frequent basis. In Bukidnon, pill and condom users are expected to visit the clinic once a month for re-supply.

Reasons for Dropping Out

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

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

A detailed listing of their reasons for stopping use of the method originally accepted are shown in Table 27.

Table 27. Reasons for Dropping Out by Method Used.

Why did you stop using this method?	Method Used			
	Pills		Condom	
	f	%	f	%
<u>Due to side effects:</u>				
-experienced breathing difficulty	2	1.9		
-menstrual flow (very little)	4	3.9		
-can't sleep	1	.9		
-felt very weak	1	.9		
-developed allergy			1	7.1
-no specific symptom given	60	56.6	2	14.3
<u>Personal Reasons:</u>				
-due to poor health	5	4.7		
-over 35 years old	4	3.8		
-want another child	6	5.7		
-lazy to visit clinic	1	.9		
-afraid of side effects	2	1.9		
<u>Method Related Reasons:</u>				
-method inconvenient to use	2	1.9		
-got pregnant while using	1	.9	1	7.1
<u>Clinic Related Reasons:</u>				
-center far from place				
-no permanent midwife	2	1.9		
-advised by midwife to stop	3	2.8		
-supplies not available at clinic	1	.9		
			3	21.4
<u>Other Reasons:</u>				
-husband died	1	.9		
-husband is temporarily away			1	7.1
-husband's objection/not comfortable with method			6	42.9
Total	106		14	

This portion of the report will discuss the results of interviews conducted with the health clinic staff, the actual observation of client-provider interaction by the research staff, the results of the inventory of facilities for family planning available at the FP clinics, and the research utilization conference/workshop.

THE FP SERVICE PROVIDERS

Twenty health providers were interviewed to obtain information about their experiences with providing family planning services. One FP service provider from each clinic was interviewed consisting of eighteen midwives, one nurse and one Barangay Health Worker.

The health providers interviewed were experienced in providing FP services. The average number of years reported was 11.9 years of FP service. One reported having already extended such services for 23 years.

Training courses attended by these providers include:

	No. who have attended
Skills Training in FP	2
Pill Dispensing	3
Clinical Service Provider Training	4
Management/Planning Training	2
Supervision/Evaluation Training	2
Motivation & Outreach Services Training	3
IEC Skills Training	8
MIS Training	3
Information, Communication Services & Family Planning	7
None	3

Most respondents (80 percent) had both theoretical and practical training in providing pill and condom, as compared to 40 percent on IUD insertion/removal, and 50 percent on natural family planning.

The respondents were also asked what methods of family planning they have actually provided to clients in the last three months. A strong majority had provided pills (19 providers) and condoms (17 providers). Six providers claimed to have inserted an IUD during the last 3 months and another 6 said they had taught natural family planning to clients.

Among the methods they said they recommended for delaying and spacing pregnancy were pills (by 18 providers), IUD (14), condom (11) and NFP (10). One provider claimed to have recommended all the FP methods to her clients. Others gave their recommendation depending on the condition of client or how suitable the method would be for her (3) as well as depending on what client wants (4). For stopping, they usually recommended female and male sterilization and the IUD.

Respondents were asked their knowledge about two specific FP methods, specifically the pill and the IUD (two of the methods they provide to their clients). The service providers were found to be knowledgeable about contraceptive pills. For example, most of them (18) indicated the fifth day of the cycle as the time the client should start taking the pill. One, however, said the woman should start taking it on the third week of the month while another said it should be taken at the start of the menstrual cycle. They were unanimous in saying that the woman should take one pill everyday, and should she forget to take the pill for a day, she should take the forgotten one immediately and then continue. They noted several minor problems that a client may experience after taking the pill. These included mild headache (mentioned by 19 respondents); nausea (13 respondents); spotting/bleeding (8 respondents); epigastric pain (6 respondents); and small weight gain (5 respondents). Other minor problems mentioned were infertility and feeling hungry.

Apart from the regular return visit for resupply, the respondents said they remind their pill clients to come back to the clinic if they experience major problems like severe headache (13 respondents), severe abdominal pain (6), severe chest pain/shortage of breath (5), blurred vision (4) and other major problems like epigastric pain, dizziness, nausea and vomiting.

The respondents were also found to possess a very good grasp of the mechanics of providing IUD services. Ten clinics or fifty percent of the clinics sampled offer IUD insertion and removal services. Ten service providers from these clinics knew that, for a client to check if the IUD is in place, she must touch the threads regularly. They also knew that the client may experience heavy bleeding (6), cramps (5), increased discharge (3), backache, spotting (2) and may also experience infection (PID) or infertility. Only three respondents were unable to mention any problem associated with this method.

INVENTORY OF FACILITIES AND SERVICES OF THE HEALTH CLINICS/SERVICE DELIVERY POINTS

An inventory of facilities and services available at the twenty centers/service delivery points (SDPs) were also made for this study.

Accessibility. Field supervisors were given instructions to come to the clinic early in the morning to be able to determine the actual opening time of the different clinics. It was found that the official opening time was not uniform in the twenty clinics. While most (18 clinics) open at 8:00 o'clock, one opens at 7:30 a.m. and another at 8:30 a.m. Fourteen (70 percent) clinics provide service as soon as the SDP has officially opened, but three could only do this after a 30-minute wait while two more were only able to offer services an hour later.

Eight clinics provide FP services for all five working days that they are open. Others, however, have a scheduled day or days for FP. Five clinics, for example, allot 3 days for FP, three clinics 2 days for FP, one has FP services for four days, and three clinics devote only one day of the week for family planning.

Seven of the clinics do not have any sign announcing availability of FP services either outside or inside the clinic building. Nine have signs inside the building while two have a sign outside the building. Two clinics have put up signs both inside and outside their buildings.

Infrastructure. On the day of the visit, eleven SDPs did not have piped running water while seven did not have electricity connections yet. A majority of the clinics (18 SDPs) have a waiting room/area for clients. Three clinics did not have working toilets/latrines available for clients.

IEC Materials and Activities. FP posters were seen posted on walls of nineteen clinics during the survey. Other materials like samples of contraceptives, FP information sheet, FP brochure/pamphlet, flip charts, promotional materials and anatomical models were also found to be present in most clinics.

During the visit, group lecture or discussion with clients ("health talks") were held in seven of the clinics. In six of these clinics family planning was one of the topics discussed.

Medical Examination Facilities. Sixteen of the clinics visited by the study team had a separate room/area for examination. Twelve of these areas were rated "clean" (with fresh linen at the start of the day, floors swept and mopped, no dust on window sills and table). Eleven clinics had adequate light while only seven had an adequate water supply. Visual privacy was upheld in ten of the examination areas, while auditory privacy was observed in nine examination areas.

Equipment and Commodities. The most common equipment which was available for family planning services in the clinics were the scale, blood pressure apparatus, stethoscopes, examination table/bed, and thermometers. Seventeen clinics were found to have these equipments for FP services. It was learned, however, that these equipments were also used for non-family planning services. Table 28 shows a listing of equipments available.

Table 28. Equipments Available in Clinics.

Type of Equipment	No. of Clinics
Blood Pressure Apparatus	17
Scale	17
Stethoscopes	17
Examination Table/Bed	17
Gloves (pair)	17
Thermometer	16
Scissors	8
Specula	7
Sterilizer	7
Uterine Sound	6
Tenacula	5
Flashlight or Angle Poise Lamp	4
Sterilizing Lotion	4
Microscope	3

All twenty clinics provide services for pills and condom users while only ten provide IUD insertion and removal services. Seven clinics indicated they also provide services for "natural" family planning. All of the twenty clinics also had available supplies of pills and condoms at the time of the visit. In comparison, however, only five clinics had available IUD devices. Four clinics admitted having run out of stock of condoms during the last six months, one clinic ran out of its stock of pills and another clinic ran out of its stock of IUDs. This also supports the complaints of some clients that supplies were not always available at their local clinic.

A record system for keeping track of FP commodities received and dispersed was present in 19 clinics. It was also found that FP commodities were stored according to their expiration date in all the twenty clinics. Storage facilities for contraceptives were generally found to be adequate.

Recording and Reporting. Most clinics (18) kept a multiple visit card for each client. Ten of these were found to be well-ordered and eight were partially ordered but still usable. On the other hand, only twelve clinics maintained a daily family planning activity register. Preparation of statistical reports about FP activity were regularly done in 17 clinics. They also submit these reports to a supervisor on a monthly basis. Seven of these clinics claimed they usually get feedback on these submitted reports.

The staff of three clinics reported they have never been visited by their supervisor, 12 were visited within the last three months, 4 four to six months ago, and one was visited more than six months ago.

Services. The following non-family planning services were also available in the twenty clinics studied:

<u>Non-Family Planning Services</u>	<u>No. of Clinics</u>
Consultation for Infertility	11
Consultation for STDs	3
Deliveries	20
Immunization	20
Nutrition & Growth Monitoring	20
Antenatal Care	20
Postnatal Care	20
Oral Rehydration Therapy	19
Information/Counselling on Aids	6
Curative Services	15
Environmental Sanitation	19
Malaria Prevention & Treatment	17

Services at the twenty clinics are given free. Ten clinics, however, admitted that they sometimes ask the clients to give minimal cash donations.

HEALTH PROVIDER-CLIENT INTERACTION: AN OBSERVATION

An observation of actual client-provider interaction was also made to help validate the responses of both the clients and the service providers. There were two types of clients who were served in the different clinics during the visit. These were, first, the new acceptors and, secondly, clients who came for resupply or regular follow-up. Interactions were observed in only 17 clinics because staff of the other three clinics were out on training during the scheduled observation day.

The New Family Planning Clients. In the seventeen clinics observed, six clients were noted to have visited the FP clinics to become new acceptors. It was observed that all the providers were very friendly to the clients who were greeted immediately upon entering the clinics. This observation concurs with the clients' description of the clinic staff as "friendly and approachable."

During the consultation, the providers talked about the pill (in 3 clinics), condom (4), IUD (4), female sterilization (1), vasectomy (1) and natural methods (1). Details of the topics discussed are given below.

	Mentioned	How to use	Advantages	Side Effects
Pill	3	2	2	1
Condom	4	4	3	1
IUD	4	4	3	2
Female Sterilization	1	1	-	-
Vasectomy	1	1	-	-
Natural Methods	1	-	1	-

Discussions of possible side effects were rarely held during their interactions. This supports an earlier contention of the clients to this effect.

It was also observed that in three of the six consultations, one method was particularly overemphasized like the IUD and condom. The most common IEC materials used during the consultation were samples of contraceptives, flipcharts and posters.

Four new clients had an IUD insertion. It was observed that in each of these cases the providers conducted the following examination and insertion procedures: a) performed

a pelvic exam using sterile speculums, b) washing of hands by the provider before the exam as well as using clean gloves, c) informing the client of what would happen before the exam, and d) informing the client about the outcome after the exam. During the IUD insertion, the clients were also given emotional support and the IUDs were handled using sterile procedures.

The only other health issue discussed during the clients' visit was child immunization.

Returning Family Planning Clients. Interactions with twelve returning FP clients were also observed. In eight cases the provider was heard and seen greeting the clients in a friendly manner. Three other clients were also greeted but in this case with a less friendly demeanor. One client, unfortunately, was not greeted by the provider in one clinic. Nine of the clients were pill users, two were IUD users and one was a condom user.

During the consultation, topics like supplies and whether the client had any problem with the method were mentioned and discussed. Three clients were asked whether they still wanted to space or limit pregnancy while two clients were asked whether they wanted to change methods or to stop using family planning.

Blood pressure and weights of seven clients were determined during the visit while five clients were asked about their menstrual cycle. Most of the other medical examinations which were supposed to be done by the provider were not carried out or were done in a sporadic fashion. Examples of this are asking the client about unusual vaginal bleeding, unusual discharge or performing physical exam, breast exam, pelvic exam, and the like.

Two of the returning clients had their FP methods discontinued, while ten continued using their pre-existing method.

THE RESEARCH UTILIZATION CONFERENCE/WORKSHOP

A research utilization conference/workshop was held on May 6, 1994 where this principal investigator and the DOH Regional Family Planning Manager together presented their preliminary findings of the study along with some initial plans for the program in the region.

Thirty three service providers from DOH Region X and from Bukidnon (including the Provincial Health Officer) were in attendance during the conference/workshop. A number of local government executives were also invited. Only one mayor, however, was able to make it to the session. Other participants were from the academe, from other government agencies like POPCOM, or were representatives from other research units or funding agencies like the Population Council and US-AID.

Aside from the presentation of the study results, the FP Program Manager also discussed the implications of the study results for the family planning program of the region. She specifically noted some aspects of the program that can be improved and/or sustained.

Time for open forum was also allotted to clarify certain issues which stem from the findings or which pertain to the FP program itself.

The following topics were discussed by three separate work groups: (1) issues regarding "quality of care," (2) issues concerning the FP program methods as well as on devolution, and (3) issues concerning the FP acceptors. Towards the end of the workshop, problems on these three broad topics were discussed. Other problems (including some not identified by the study) were also identified and solutions or interventions were suggested by the participants.

The workshop outputs were also presented to the participants. Individual group outputs are presented in Tables 29 to 31.

Table 29. Issues/Problems and Suggested Interventions on Quality of Care.

Issues/Problems	Suggested Interventions
Supply mechanism	<ul style="list-style-type: none"> -Follow strictly manual operation -All RHUs & BHS should be provided copies of manual
Overloading of RHMs (IEC often overlooked)	<ul style="list-style-type: none"> -Re-train & utilize services of BSPOs, BHWs, & Hilots in the follow-up and distribution of FP supplies
Untrained Personnel in FP	<ul style="list-style-type: none"> -Continue training of RHMs on Basic Comprehensive Family Planning
High drop-out rate of various categories of mothers	<ul style="list-style-type: none"> -Focus on high risk groups
Charges for FP services in Hospitals	<ul style="list-style-type: none"> -Tap the services of NGOs -Tap the services of the German doctors
Clients' fear of side effects	<ul style="list-style-type: none"> -Clients should be assured of the availability of service in case of complications during IEC
Lack/Inadequate supervision due to budgetary constraints (LGU concerns)	<ul style="list-style-type: none"> -Provision of TEV for program supervisor (A memo of agreement should be forged at the provincial and municipal level)

Table 30. Issues/Problems and Suggested Interventions Concerning the FP Acceptors.

Issues/Problems	Suggested Interventions
<p>Clients' perception Causes: Poor counselling Inadequate KAS/motivation Some IEC materials are inappropriate Negative attitude of clients which also influence others/past experiences (among ethnic groups)</p>	<ul style="list-style-type: none"> -Recommend training on Basic FP and ICS -Adding cultural specific dimensions to respond to the needs of ethnic groups -On motivation : sustain support for trials as well as continuing use -Reinforcement of volunteers for motivation -Strengthen linkages with BSPOs to also utilize them as motivators -Orientation of lay/church leaders -Strengthen motivation campaign at the grass root level.
<p>Lower level of educational attainment Causes: Low economic status Inappropriate IEC materials for their level</p>	<ul style="list-style-type: none"> -Better communication skills value of practice in FP -Use of visual IEC materials rather than textual -Radio programs focusing on misconceptions about FP
<p>Lack of husband/male participation Causes: Chauvinistic attitude Negative attitude</p>	<ul style="list-style-type: none"> -Tapping members of credit cooperatives & other male associations for FP motivation and advocacy -Review/revitalize the contents of PMC sessions (both church and govt.) making them gender sensitive
<p>Low income - Clients do not return for follow-up visit due to charges on oral contraceptives</p>	<ul style="list-style-type: none"> -Conduct dialogue with LGU for free FP services -Require volunteers to give re-supply to FP clients -LGU must mobilize more volunteers -Tap other community-based workers
<p>Too many pregnancies</p>	<ul style="list-style-type: none"> -Recommend permanent FP method for those who have completed their family size -Pre/Post natal counselling
<p>Unemployment</p>	<ul style="list-style-type: none"> -Encourage women to organize cooperatives for livelihood projects

Table 31. Issues/Problems and Suggested Interventions Concerning the FP Program Methods and Devolution.

Issues/Problems	Suggested Interventions
<p>Condom: High drop-out rate among condom users -usually used as a temporary method -use can be stopped at patient's choice</p>	<p>-Motivate for more effective and acceptable method -Improve recording system</p>
<p>Pills: Rumors about pills' side effects No choice of pill brand</p>	<p>-Intensify IEC campaign -Assign health workers who will provide FP services only</p>
<p>IUD: Infections Surgical complications</p>	<p>-Conduct a study of IUD related infections -Provide funds for surgical intervention of complications -Conduct periodic evaluation of personnel trained to give IUD insertions</p>
<p>Devolution: Mobility problems -Lack of TEV -Misuse/lack of service vehicles</p>	<p>-LGU should allocate funds for workers' TEV -Provide service vehicles, issue memorandum to officials misusing vehicles</p>
<p>Lack of LGU support for family planning</p>	<p>-Conduct meetings with LGU executives who are not supportive of the program</p>

SUMMARY AND POLICY IMPLICATIONS

Background. This study has involved interviews with a randomly selected sample of 389 family planning (FP) acceptors from twenty barangays in Bukidnon province. The respondents were currently married women who had either continued to use family planning since their initial acceptance (current users) or who had stopped using FP altogether (drop-outs). Findings from the present study may be expected to shed light on several aspects of the drop-out problem namely:

1. How extensive is this problem and how accurate are the DOH records in this regard?
2. How do FP acceptors view their local FP clinic and the services offered therein?
3. What reasons are given by the drop-outs for their decision to stop using FP?
4. What are the factors associated with dropping out?

The Extent of the Drop-out Problem. The study found that 30.8 percent of the women who had adopted FP at some time in 1992 had dropped out of the program as of the survey date (September to October, 1993). This is somewhat lower than the 60 percent drop-out rate which had earlier been reported for Bukidnon and may therefore indicate that the dropping out phenomenon has become somewhat less pervasive in that province.

Clinic records about current FP users were found to be fairly accurate. Actual interviews showed few inconsistencies with the DOH categorization of the respondents. The categories were current users, drop-outs and switchers. The DOH classification was found to be correct in 73.4 percent of all cases.

Views and Experiences Regarding the Local FP Clinic. As FP acceptors, the respondents were in a good position to assess their local program. In all only 9 percent said that they were dissatisfied with their visits to the clinic. Another 53 percent said they were "satisfied" while 38 percent claimed to be "very satisfied." Clients who were "dissatisfied" reported inavailability of supplies as their reason. These respondents also tended to be critical of the local midwife for various reasons, e.g. that she is "not available", too "strict", or "unfair" in giving out medicines and supplies.

A little less than ten percent had never been given any lecture about FP. Another 61 percent had received a lecture about only one method. These statistics do not show the FP

clients as being given a wide variety of choices. Even so, 98 percent of all respondents said they were allowed the freedom to adopt whatever FP method they desired.

Most respondents (83 percent) felt that their FP trainer had been "friendly and approachable." They also gave favorable assessments with regard the trainers' ability to "clearly explain" the method, to show how to use it, and to explain its advantages. There was, however, less agreement with the idea that the trainers had dealt adequately with the method's disadvantages and potential side effects.

Exposure to IEC materials on FP was relatively high (only 24 percent said that they had never been so exposed). Home visits by FP providers, however, were rare, with 76 percent of the respondents not experiencing these.

Respondents gave several suggestions as to ways in which the program could be improved. The most commonly cited themes included the following:

1. There should be a permanent supply of contraceptives on hand.
2. There is a need for an intensive FP information campaign (e.g. seminars, house-to-house visits).
3. The midwives and motivators should develop friendly relations with local residents.
4. FP acceptors could be mobilized to teach/motivate other potential clients.
5. Free medicines should be provided by the local clinic.
6. Midwives/motivators should follow up the FP acceptors to monitor their progress.

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

Other reasons given were much less common. These included the desire to have another child (5.0 percent), objections on the part of the husband (5.0 percent), poor health status (4.2 percent) and "too old now" (3.3 percent). As for method or clinic related reasons, six

women said that their clinic lacked either a midwife or regular FP supplies, two said the clinic was too far away, and four found the method to be either ineffective (i.e. they became pregnant while using it) or inconvenient to use.

Factors Related to Dropping Out. Factors associated with the decision to terminate FP use may be seen as falling within three major categories, i.e. those relating to (1) the individual acceptor (2) the method accepted and (3) the quality of services provided by the local clinic. Each of these dimensions was explored by the study.

Client Factors. When drop-outs were compared to current users they were found to be significantly more likely to possess the following characteristics:

1. A lower level of educational attainment,
2. A lower rating on a scale of household economic status (ownership of consumer items),
3. A smaller likelihood of having been employed during the past year,
4. A greater number of previous pregnancies, and
5. Less favorable attitudes toward FP.

For the attitudinal factor it is interesting to note that the attitudes of the husband were a better predictor of current use than those held by the respondent herself.

Various other factors (e.g. age, religion, ethnicity) were not found to be significantly related to current user status.

FP Method. Dropping out was highest among those respondents who had accepted condoms (37.8 percent), followed by pill users (with a 34.3 percent drop-out rate) and IUD acceptors (every one of whom was still using some FP method as of the survey date). It is also interesting to note that the clients who were expected to return to the clinic every month for a new supply of contraceptives were less likely to stay with the program than were those who were required to return on a less frequent basis.

Program Factors. In general, provision of improved services ("quality of care") was found to be associated with lower levels of dropping out. Among those respondents who said that their FP trainer was "friendly and approachable", drop-out rates were significantly lower than for those who did not feel that way. Similarly, those who reported themselves as "satisfied" or "very satisfied" with local services were found to be less likely to drop out. A

summary index of client-provider interaction was formed from various items. Current users gave significantly higher scores to their trainers on this scale than did the drop outs. Particularly important in this regard was the experience of having been told the advantages of the method in question (thereby strengthening client motivation for continued use) and its potential side effects (thereby helping the client to become less alarmed about these experiences when they did happen). Clients who were only given an orientation on one method were found to be less likely to continue using FP than those exposed to a wider variety of choices.

Interviews with FP Service Providers. Service providers were found to be well experienced. A good number of them had both theoretical and practical training in providing contraceptive pills and condoms. However, only 40 percent had been trained for IUD insertion and removal. They were found to be knowledgeable in providing the pill including those who were authorized to provide IUD insertion and removal services.

Facilities and Services of the Health Clinics. Most clinics (18) observed the official opening time. The number of days allotted for family planning were not uniform. While some (8 clinics) have FP services for five days, others offer this on only one day.

Infrastructure facilities of the clinics were far from ideal. Eleven SDPs, for example, did not have piped running water at the time of the visit.

IEC materials were found to be available in almost all clinics. Most clinics were also "clean". Equipment in all clinics was often being used for non-family planning services. Six clinics experienced running out of stock of FP supplies.

Commodities were stored according to their expiration date in all 20 clinics. Storage facilities for contraceptives were also found to be adequate.

Visits by supervisors were not regular in some clinics. Services in all twenty clinics were provided free, although some (ten clinics) would at times ask for a minimal donation.

Health Provider-Client Interaction. Most health providers were observed to be friendly and approachable. Discussion of possible side effects was rarely done

during the consultation. This supported the earlier contention of the clients concerning the infrequent discussion of side effects.

It was observed that in some consultations some methods were overemphasized to the exclusion of others. This was particularly true for the IUD, condom and pills.

Program Implications. Some of the major implications of the study for the current FP program are listed below:

1. The FP drop-out phenomenon continues to be pervasive in Bukidnon, although levels are perhaps not quite as high as is sometimes believed. The major problem in this regard appears to be the wide-spread belief that the various FP methods (especially pills) cause harmful or disturbing side effects.
2. A large majority of FP acceptors claim to be satisfied with the current program. Most also perceive the FP personnel as competent and friendly. Sustaining proficiency and favorable attitudes of personnel towards work would prove advantageous to the program.
3. Some programmatic weaknesses were also uncovered, however. Acceptors were generally not given an orientation on a wide variety of FP methods. Discussions of the side effects issue were often missing. Home visits by program personnel are rare.
4. Respondents gave several suggestions for improving the program, focusing in particular upon improvements in the logistics system and a more intensive educational/motivational campaign.
5. The drop-out problem appears to be most prevalent among poorer and less educated women, housewives (i.e. those not gainfully employed), those with many previous pregnancies and with less favorable attitudes toward FP. Strengthened efforts to reach out to these groups will be needed.
6. Campaigns to bring about more favorable opinions toward FP should focus on husbands as well as on the wife.
7. Increased use of the IUD should help to bring about declines in the drop-out problem. However, efforts to convince more women to use this method should not run counter to the goal of free and informed choice of method by the client.
8. Greater emphasis on high quality FP services (quality of care) will help to reduce FP drop-out rates. Providers should be both competent and friendly, and concerned as well with fulfilling client expectations. They should offer as much as possible, a wide variety of FP choices, bringing out in a clear and objective fashion the advantages, disadvantages and possible side effects of each method.
9. A number of local government executives are not supportive of the FP program. Convincing them of the importance of the program should be given priority.

10. Some FP clinics are not well equipped. An effort to upgrade these facilities will help improve the delivery of services.
11. Some FP services providers have not been trained yet. For example, about fifty percent of the clinics in Bukidnon are not prepared to provide IUD insertion and removal services. Providing the staff with the appropriate training will be a help.

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