

CICRED'S SEMINAR

**Improving the quality of care in FP/RH Services,
in the context of an integrated FP/MCH program**

Zelda C. Zablan

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Background

In line with the Philippine commitment to the Program of Action of the 1994 ICPD, the Philippine Population Management Program has adopted the Reproductive Health Approach in the provision of family planning services. This led to a shift in the conceptual paradigm of family planning service provision, from a focus on the achievement of demographic goals, to a concern for the client's reproductive, sexual and health needs. The paradigm shift requires a change in focus from that of contraceptive service delivery to an emphasis on quality health care and has generated doubts about the ability of the existing devolved health systems to provide a wide array of services in the reproductive health package.² Many take the view that the reorientation to a reproductive health approach and the investments in improving quality of care might water down family planning promotion efforts and thus delay the attainment of desired population growth levels. There is much debate on what constitutes a client-centered reproductive health program, and on how “good” quality health should be operationalized and measured. Others argue that strengthening the quality of care will improve client satisfaction, which could consequently encourage family planning practice/contraceptive use. In fact, evidence exists that quality of care increases contraceptive use and reduces unintended pregnancy (Koenig et al., 1997; Magnani et al., 1999; Mensch et al., 1997; Mensch et al., 1996). Humanitarian concerns also argue for the provision of good quality services to all.

Objectives of the Paper

This paper shares the experiences gained in the operationalization of a client-centered approach to the provision of RH/FP services in one province of Northern Philippines, Pangasinan. Moreover, the paper attempts to draw lessons from the experiences of the health clinics of the study that have reoriented their service delivery schemes from FP to RH and to bring out some of the major challenges and constraints that these clinics encountered in the process of reorientation. Data for this paper come from the operations research study conducted in Pangasinan from June 1997 to July 1998, an operations research project funded by the Population Council, Asia and Near East O-R and TA, Manila office in collaboration with the Department of Health.

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² In 1998, the Philippine Department of Health issued Administrative Order No. 1-A where 10 elements were officially identified as important in the provision of a reproductive health package. This includes: family planning; maternal and child nutrition; prevention and management of abortion complications; prevention and treatment of reproductive tract infections (RTIs), covering STDs, and HIV/AIDS; education and counseling on sexuality and sexual health; breast and reproductive health concerns and other gynecological conditions; prevention and treatment of infertility and other sexual disorders; adolescent reproductive health; prevention of violence against women (VAW); and male reproductive health.

In particular, the paper will

1. Assess the extent to which the algorithm to identify women with unmet need has influenced the prioritization of outreach volunteer activities and increased the demand for and use of family planning services.
2. Assess the effects of three study interventions, namely, training on FP counseling, supportive supervision, and the identification of women with unmet need on the quality of FP services provided, client satisfaction, acceptance and continued use.

Conceptual Framework and Hypotheses

An assessment of the impact that the interventions have upon the quality of care is the objective of this study. This objective is attained through an experimental research design discussed in the following section on Methodology. The hypotheses tested were formulated around comparisons between the experimental and control areas utilized in this design and include the following:

1a. **Knowledge about health risks, unmet need and appropriate counseling messages** will be higher among outreach workers (OWs) and service providers (SPs) after the intervention in the experimental areas than in the control areas.

1b. There will be an increase in the above knowledge levels among SPs from the experimental areas **after they have been trained and supervised** in these subjects.

2a. Client-provider interactions in the experimental areas will show greater evidence of good quality service provision after the intervention (e.g. provision of privacy for counseling and examination, attitude toward clients exhibited by the SPs, utilization of proper procedures for soliciting and sharing FP-related information, use of proper screening procedures and of aseptic examination techniques) than will be the case in the control areas.

2b. There will be a positive improvement in the above-noted practices among SPs from the experimental communities **after they have been trained and supervised** in these matters.

3. FP clients from experimental areas will report a significantly higher level of **satisfaction** with the services they have received from the program than will clients from the control areas.

Two community-level surveys were carried out during this study. It will be possible to collect information and to test several other hypotheses related to the conceptual framework's medium-range and long-term objectives. However, the study was funded only for one year and a Phase II did not materialize.

4. There will be a **higher proportion of new users** of RH/FP services among women in the experimental than in the control areas.

5. The proportion of FP acceptors who become **dropouts** will be lower in the experimental than in the control areas.

6. The level of unintended pregnancies in the experimental areas will be lower than in the control areas.

7. The level of reproductive morbidity will be lower among women in the experimental areas than in the control areas.

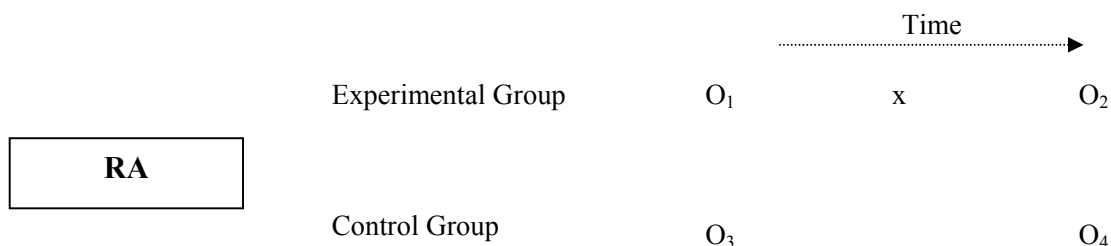
The short study time frame did not allow for a definitive test of hypotheses 6 & 7.

Refer to Figure I for the graphical presentation of the framework.

Methodology

The study design used was the pre-post test control group design conducted in four municipalities of Pangasinan. These four study areas were randomly assigned to the experimental and control groups from the 47 municipalities of the entire province.

The experimental group received three project interventions (X) while the control group did not receive such interventions. Approximately four months after the last intervention, the same measurement observation of two types, situation analysis and community survey (posttest and post-baselines O₂ and O₄) were undertaken. The experimental design is shown in the following diagram:



The Client-Oriented Model: The Interventions Tested

Very briefly, a client-centered approach for providing care consists of the following:

- Providing clients and would-be clients with better and accurate information that will empower them to regulate their fertility in a healthy manner.
- Paying attention to the content of information provided to clients
- Undertaking information exchange rather than counseling
- Helping clients avoid an unintended pregnancy
- Helping them avoid transmission of disease, and cope with adverse social and family conditions

The client-centered approach therefore requires a shift in providers' orientation from methods to clients: the providers' job is not to motivate clients to have small families but to help them achieve their reproductive intentions. The providers should focus on the clients' well-being than on the performance of particular method. While it is tempting for health professionals to provide "advice" as experts in the field, they are challenged in this approach to first ascertain from clients their particular needs, preferences and circumstances, and then to facilitate the clients' choice of method, if they desire to adopt family planning. It is important that clients are actively involved in the selection of the method so that they will own this decision and not feel that this has been imposed on them. Equally important is the need to provide clients with adequate information about the method adopted, its advantages and disadvantages, how it should be used and what are the likely side effects. Clients also should be informed of signs and symptoms which will require medical attention, and where and when they should seek this.

The client-centered model implemented in Pangasinan is one that ascertains individual's needs first and then addresses them in an appropriate manner. Recognizing that potential clients interface with the service delivery system at different venues (i.e., in the clinics or in their homes), the model has both a fixed clinic and an outreach component. This combination of fixed clinic and outreach components provides better services to clinic attendees while reaching out to clinic non-users in the community at large.

- (1) **The Fixed Clinic Intervention.** Interventions at the fixed clinic component comprise of (1) training family planning service providers on **information exchange** with clients and (2) training their supervisors in facilitative (supportive) supervision. The contention is that service delivery is better institutionalized if it is bolstered by **supportive supervision**. Supervisors undertake supervision beyond routine inquiries of supplies, checking of records, by reviewing achievement of targets and provide feedback. They give support to service providers if the latter encounter problems conducting a successful Client Provider Interaction (CPI).
- (2) **The Volunteer Outreach Intervention.** The outreach component consists of training outreach volunteers attached to fixed clinics in the use of a flowchart or algorithm (Figure 2), which specifies information to be given to clients and actions to be taken by the volunteer worker depending on responses of clients to questions. The purpose is to help volunteers prioritize their work routines, identify clients with unmet need and enhance efficiency while providing services (Jain, 1999). Outreach work in the Philippines is often hampered by the inability of workers to visit all the households assigned to them. One reason for such poor outreach is the high number of households to be covered per worker. While it is encouraged that the ideal ratio be about 1 outreach worker to 50 households, it is not uncommon to find one worker serving 500 households.

Besides helping to prioritize household visits, and thereby reducing the load on the outreach worker, the algorithm helps the outreach worker to categorize women according to their stated needs as: dissatisfied contraceptive users, those with unmet need for limiting or spacing, currently pregnant, and those who are not ready to contracept either because they are uncertain of their reproductive intentions or because they desire a pregnancy. Dissatisfied users and those with an unmet need are considered priority for referral to a fixed clinic and for follow-up. Referral forms are then given to these women. In order to make the approach client-centered and comply with ICPD recommendations, the outreach worker is instructed not to motivate those who want an additional child soon (see Jain 1999 for further discussion of this point); instead, the basic message imparted is that “services are available in the clinic to help them and that the volunteer will help to facilitate her access to a clinic provider.” Those who are currently pregnant are given information about the available maternal and child health (MCH) services while those who do not wish to contracept are given information about methods and sources of supply should they require them in the future. (See Figure 2 for Jain’s flowchart)

The Implementation of the Fixed Clinic Intervention

The intervention at the clinic level consisted of training of family planning service providers in information exchange and the training of supervisors in facilitative supervision. A five-day training program was conducted by AVSC International using the GATHER Approach. It was attended by eight doctors, 11 nurses and 38 midwives from 10 rural health units and 30 Barangay Health Stations. These service providers were trained in information exchange so that they could listen to their clients, and respond with relevant, accurate, and complete information. Specifically, their training stressed imparting information on the following topics:

- Information about alternative methods
- Procedures for dealing with clients who want to switch to another method
- Information about other sources of family planning supplies
- Procedure for using the method selected
- Possible side effects of method selected
- Instructions on what to do in case a problem arises
- Duration and level of effectiveness of the method selected in preventing pregnancy
- Information on follow-up and/or resupply visit

One of the unanticipated results of the training assessment was the finding that service providers scored rather low in the topic on contraceptive technology. This was explained by the fact that it has been some time since service providers had undergone basic comprehensive training for FP provision. This finding underscored the need for refresher training for providers on contraceptive technology.

The other component of the clinic intervention is supportive supervision training. The purpose of this was to train supervisors to undertake supervision beyond simple

monitoring and reviewing achievement of targets. The training provided a brief review of GATHER and contraceptive technologies. Supervisors were trained to create an enabling environment for providers to ensure that their work related problems are resolved during their visits.

Implementation of the High Risk Approach

Pangasinan is the biggest province in the Philippines with a population of 2,434,086 as of the 2000 census. It has 46 municipalities and 2 cities. The project was installed in two municipalities, with two selected comparison municipalities. Selection was based on population size, socio-economic characteristics and access to the highway to Manila. Historically, this province has adopted the high-risk approach to service delivery, where women are **motivated** to use family planning if they possess any one of the following conditions:

- Married women below 20 years of age (“too young”)
- Married women over 35 years of age (“too old”)
- Married women of reproductive age with four or more previous pregnancies (“too many”)
- Pregnant women with a child younger than 15 months (“too soon”);
- Women with medical conditions such as TB, hypertension, and anemia.

While this approach provides information on the individual woman’s context, the high risk approach exogenously determines its parameters. There is no room or scope for the individual’s self-expressed reproductive health interests, primarily because she is not asked about these. Such service delivery strategy leads clients to be unexpressive about their interests as they are accustomed to being told rather than being invited to participate.

Adopting the “high-risk” approach to service delivery presented a challenge to the implementation of the client-oriented model. The service providers had to unlearn the old ways and be reoriented to use the “unmet need algorithm”. This had implications on the length and level of difficulty of the training of service providers and outreach workers. The old master listing forms had to be modified. Unfortunately, due to political sensitivities and management reasons, all program managers did not share the introduction of the new approach with their staff. As a result, a mixed type of data collection was adopted in the province. This, however, turned out to be a good learning experience as it provided the study team an opportunity to compare the results of the two approaches.

The Results

Implementing the client-centered FP service delivery have yielded the following major outcomes:

- The **service provider (SP) counseling** training was effective in upgrading the knowledge of SPs on contraceptive technology. The average score per provider was significantly higher in the experimental (30.1) than the control group (23.5). As shown in Table 1, those who underwent training on FP counseling (experimental group) reveal statistically and significantly higher average scores than those who were not trained (control group). The areas in which training plays an important role are on contraceptive technology, their advantages and disadvantages (particularly side effects), and FP counseling skill and quality of care. The training did not have a significant effect on the monitoring and supervision topic which focused on the nature and use of CBMIS and the UNA.

Table 1: Significance of the Difference in the Average Scores of the Experimental Group (O₂) and Control Group (O₃): Training on FP Counseling

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

- **Supportive supervision** had a limited impact in view of the training on local governments' lack of resources to allow supervisors to conduct field monitoring and supervision, especially after the devolution. In Table 2, the average overall scores of the experimental group is significantly higher than the control groups. The training increased knowledge and skill in counseling and supervision, but did not make a significant change on knowledge of contraceptive technology.

Table 2: Significance of the Difference in the Average Scores of the Experimental Group (O₂) and Control Group (O₃): Training on Supportive Supervision

	Number of Cases	Mean	Standard Error	t Value	Significance level
1. On Counseling					
Experimental	10	10.3	.62	4.88	.00
Control	9	6.4	.48		
2. On Contraceptive Technology					
Experimental	10	9.7	.58	1.7	.10
Control	9	8.4	.41		
3. On Supervision					
Experimental	10	4.2	.33	3.1	.01
Control	9	2.7	.37		
4. Overall Scores					
Experimental	10	24.2	1.37	4.49	.00
Control	9	17.6	.56		

- Overall, it was shown that respondents who had used the experimental clinics reported to have **better care** than those who visited the comparison clinics. Table 3 shows the comparison of quality of care indicators before and after the interventions (SA1 vs. SA2).

Interpersonal Relations. Nearly all of the observed provider-client interactions portray a very friendly atmosphere in both experimental and control areas in both SAs (Table 3).

Choice of Methods. Almost all clients in the experimental SDPs were told about various methods of contraception such as the pill, condom, IUD, injectable and NFP in both SAs. Far fewer new FP clients in the control area were told about various methods in both SAs although the differences were not statistically significant. More service providers in experimental than control SDPs tended to promote one method over another at SA1, but this practice was greatly reduced in the experimental SDPs and remained the same in the control SDPs at SA2. The differences were, however, not statistically significant.

Information Exchange. After the interventions, a pattern of improvement towards more comprehensive information about a particular method being accepted is evident. A significant improvement is observed regarding information on side effects. Since the control area behaves in the same way in SA2 as in SA1, it may be inferred that the training intervention has generated some improvement in information exchange in the experimental areas.

Appropriateness and Acceptability of Services. There was a high level of client satisfaction of services received in both experimental and control areas. Almost all FP clients were generally satisfied with their visit to the SDP and generally felt that they received the information they wanted. Almost everyone found the clinic opening hours convenient; has never been turned away from the clinic during official hours; feel their waiting time to be reasonable and feel that the service provider was friendly and approachable.

Table 3. Selected indicators related to quality of services

Selected Indicator	SA1		SA2	
	Experimental	Control	Experimental	Control
Interpersonal Relations				
N	39	39	37	29
%	100.0	100.0	100.0	100.0
1. Percent of FP clients who received a friendly greeting (Obs)	100.0	82.0	97.3	96.6
2. Percent of FP clients who feel that the provider listened to her concerns (N)				
N	36	35	36	27
%	100.0	100.0	100.0	100.0
(Exit)	55.6	40.0	47.2	37.0
Choice of Methods				
1. Percent of new FP clients who were told about various methods: (observation) (N) %				
N	5	6	15	7
%	100.0	100.0	100.0	100.0
a. Pill	100.0	66.7	86.7	71.4
b. Condom	100.0	33.3	66.7	28.6
c. IUD	80.0	33.3	66.7	28.6
d. Injectable	100.0	66.7	66.7	71.4
e. Female Sterilization	40.0	33.3	13.3	28.6
f. Vasectomy	40.0	16.7	6.7	-
g. NFP	100.0	16.7	6.7	-
Information Exchange				
1. How to use the method	12.8	10.3	43.2	20.7
2. Advantages	12.8	10.3	24.3	10.3
3. Disadvantages	10.3	10.3	27.0	10.3
4. Side Effects	12.8	12.8	43.2	13.8*
5. What to do if problems occurs	10.3	10.3	21.6	10.3
6. Possibility of changing method	7.7	10.3	24.3	10.3
7. Possible sources of supply other than this SDP	7.7	7.7	5.4	-

- For purposes of prioritizing clients for services, the **Unmet Need Algorithm** is more efficient and acknowledged by midwives to be useful since it helped to

focus their work priorities on a smaller number of clients. A subsequent population survey showed a significant increase in the contraceptive prevalence when compared to the survey conducted before the intervention.

A total of 5,926 women of reproductive ages (15-49 years old) were masterlisted between January 1 and April 1998 and classified either as high risk (HR) or with unmet need (UN) using the HR-UN algorithm (Refer to Figure 2). It can be noted from the results in Table 4 that 84.5 percent of the WRAs were considered as high risk, of which 42.1 percent were currently using a method. Meanwhile, 22.9 percent are classified both as high risk and having unmet need. Of the 15.5 percent non-high risk women, only 4.7 percent have unmet need, giving a total of 27.6 percent WRAs with unmet need. It can be observed that of the 27.6 percent WRAs with unmet need, 83 percent are high risk ($22.9\% \div 27.6\%$). Thus, the use of Unmet Need as basis for prioritizing women for family planning and other health services has greater appeal because:

1. it identifies far fewer women who may be more predisposed to use contraceptive methods and therefore promotes the efficient use of resources,
2. the large overlap between unmet need and high risk justifies the use of unmet need criterion for prioritizing reproductive health services, and
3. the unmet need classification supports the quality of care approach since it is based on women's own fertility preferences and the need for services is not imposed by the service provider to the client.

Table 4. Results of the Masterlisting Activity in Two Municipalities of Pangasinan Using the Unmet Need Algorithm, January – April 1998

	Number	%
1. High Risk women who want to delay or stop childbearing and are dissatisfied with the current method	1360	22.9
2. High Risk women who want more children	813	13.7
3. High Risk women who are currently using a contraceptive method, and	2492	42.1
4. High Risk women who are currently pregnant	343	5.8
Sub-total: HR	5008	84.5
5. Non-High Risk women who want to delay or stop childbearing and are dissatisfied with the current method	276	4.7
6. Non-High Risk women who want more children	333	5.6
7. Non-High Risk women who are currently using a contraceptive method	83	1.4
8. Non-High Risk women who are currently pregnant	226	3.8
Sub-total: NHR	918	15.5
Grand Total	5926	100.0

Major Issues in Implementing a Client-oriented Model

- The role of the different administrative officials in the Philippine FP/RH program has undergone some changes in the devolved context of the Philippine system of governance. Apart from the PHOs, who are still in charge of provincial and district hospitals, the governors and mayors of provinces and municipalities are important stakeholders that any interventions of this nature will have to involve. The role of the PHO is limited to providing technical assistance to program staff and he/she has no administrative link with staff working in the health centers. The political support of the governor to the PHO is necessary as this official has the authority to allocate budgets for various developmental projects. Health should be perceived as priority concern of governors, to ensure success of any health initiatives, especially family planning.
- It takes some “gestation time” for frontline service providers to comprehend a new model of service delivery. For example, it was noted that the outreach workers in Pangasinan had difficulty in learning the new concept of the unmet need algorithm, thus requiring a longer for of training.

It is a well recognized fact that technical capacity and financial resources vary greatly among the local government units in the country. The formulation and implementation of an RH program require major reorientation from decades of practice where the demographic goal was a main driving force behind family planning program (despite the health rationale being promoted by DOH as its justification for promoting family planning since 1987).

- Another issue is the general lack of clarity in the distinction between facility readiness to provide quality health services (QHS) and quality of care (QOC) as exemplified in the client-oriented model followed in the study. This often leads decision makers of family planning to prioritize efforts and limited resources toward upgrading infrastructure. While the provision of basic equipment and infrastructure are needed to provide the enabling environment for the delivery of quality care service, it is equally important to be able to understand women's perspectives in health service provision and utilization. Focus group discussions conducted among women in nine regions of the country³ revealed that the women's basis for assessing whether services were adequate, complete or comprehensive was the competence and attitude of the health service provider, especially in terms of their ability to treat clients with dignity and respect. Equally important as health infrastructure, facility or equipment is the good interpersonal relations of the health service provider with the client, in determining women's use of the health services.
- Aside from financial constraints on travel funds for supervision, one of the major issues that surfaced relates to the supervision and authority of health officials particularly from the province. Under the decentralized and devolved set-up, municipal mayors and health officers are autonomous from the regional or provincial level and this extends to health concerns. The Provincial health officials' role vis-à-vis the municipal health officials is thus fuzzy and unclear. Provincial and municipal coordination on health matters depends largely on personal relationships between the PHO and Municipal Health Officers (MHOs). Devolution has weakened the links between the province and the municipalities and this has affected the level of supervision.

Conclusions

In fulfillment of the commitment made in the ICPD in Cairo for adopting a client-oriented FP/RH services, this model tested in Pangasinan illustrates the many operational problems confronting efforts to implement the paradigm shift. The devolution of health services to the local government units has great implications for the operationalization of the paradigm shift, since priorities are now highly dependent on the interest, commitment

³ Woman Health Philippines. "National Advocacy Campaign on Advancing Women's Health Through Quality of Health Services and Participatory Governance". Report presented at the National Assembly and Launching of the National Advocacy Campaign, Rembrant Hotel, Quezon City, 27 February 2002. (Dr. Z. C. Zablan is the research consultant of the Project).

and resources of local leadership. Hence the implementation of these initiatives vary in many parts of the country.

The model for prioritizing services for women with identified unmet needs and improved system of information giving at fixed facilities yielded some positive results. Clients in the experimental areas are likely to report receiving better quality of care. The unmet need flowchart has served to systematize the information system at the community level, has been easily adopted by local government units, and appreciated by service providers and outreach workers. As a result, it is now being up scaled nationwide under the auspices of the matching grant program of the Department of Health. The usefulness of the unmet need approach in prioritizing clients and rationalizing the provision of services has been clearly demonstrated not only in Pangasinan province where it was piloted but also in the areas where the matching grant program has introduced the strategy. Plans for using this mechanism as a tool for assessing program performance is being studied.

In conclusion, the model of a client-centered approach has promising potential in the Philippines. An important issue is the need to find a strategy to keep the intervention sustainable. There are indications in Pangasinan that the updating of the masterlist was not being done on a regular basis. Much of this work depend on the outreach workers. A system for rewarding good providers and volunteer workers must be devised to maintain their motivation, particularly since supportive supervision was found to be a weak intervention within the devolved setting. In successfully replicating the intervention, the major implementation issues mentioned in this paper have to be addressed.

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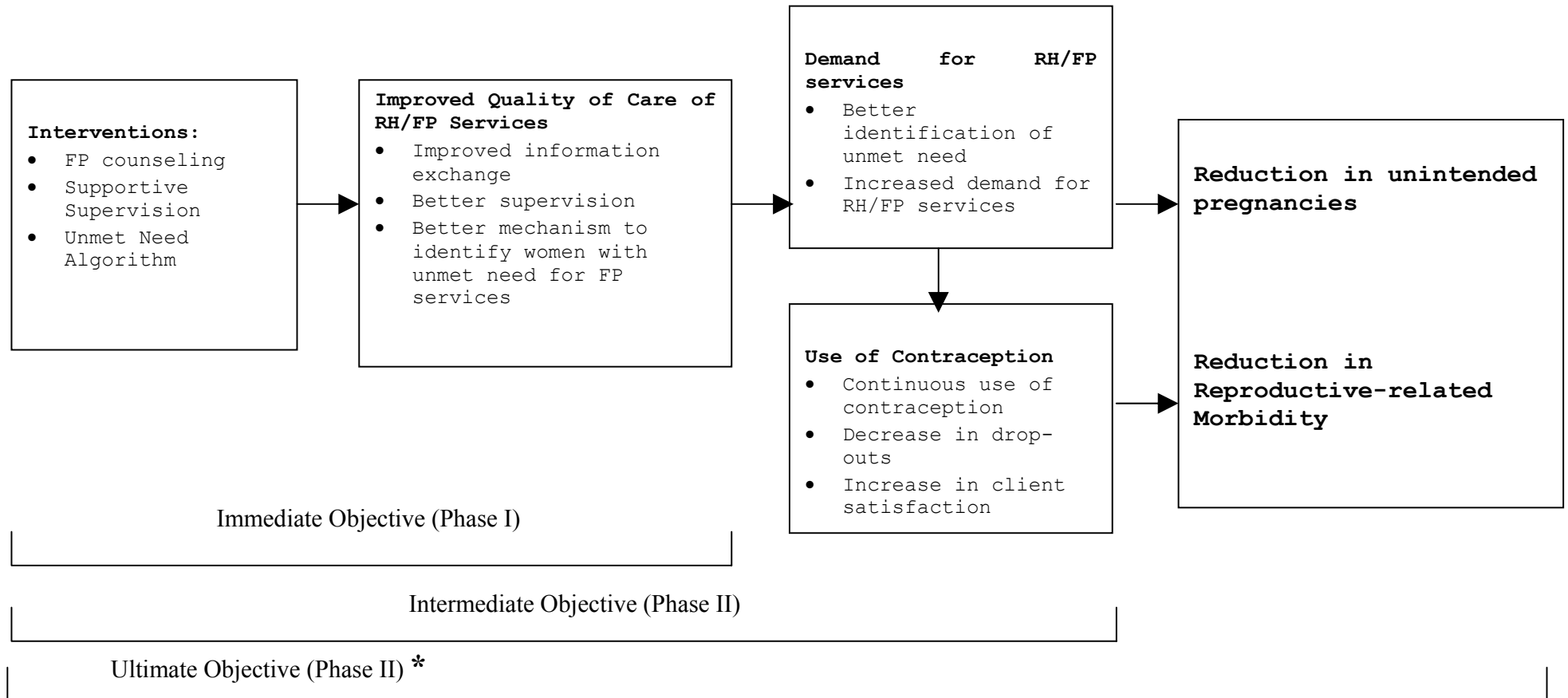
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Figure 1: Conceptual Framework of the Relationships between Quality of Care Interventions and Women’s Reproductive Behavior



* The study was not able to test this objective

FIGURE 2. Scheme by which a field worker may prioritize services on the basis of a woman's answers to questions about her reproductive health needs.

