

## **Learning About Clients' Needs: Family Planning Field Workers in the Philippines**

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The evolution of population policy in the Philippines reflects the country's political history. In the 1970s, the regime of Ferdinand Marcos (1969–86) provided strong support to a national program centered on fertility reduction and contraceptive distribution. Under President Corazon Aquino (1986–92), population policy was broadened beyond fertility reduction to include the status of women, maternal and child health, and other key health and social issues, such as urbanization. With this broadening came a change in the locus of responsibility for contraceptive service delivery, which shifted from the Population Commission to the Department of Health. A parallel process devolved responsibility for family planning service delivery to local government units, which took the responsibility for decisionmaking out of the hands of central bureaucrats and placed it closer to the communities being served.<sup>1</sup>

The administration of Fidel Ramos (1992–98) broadened policy even further, increasing its emphasis on the reproductive health agenda outlined at the International Conference on Population and Development and the Fourth World Conference on Women. Joseph Estrada's regime (1998–2001) maintained this commitment to reproductive health, although concerns about population growth and its consequences continued to be the main motivations of population policy. Further, the Department of Health continued to strengthen the family planning program with a new focus on natural family planning. Following impeachment hearings that began in late 2000, President Estrada was replaced by Gloria Macapagal-Arroyo in January 2001. The policy of this new administration is marked by a commitment to reproductive health with an additional focus on adolescent health and youth development.

Since 1997 the Department of Health has sought to operationalize the Cairo paradigm by offering family planning as a client-centered reproductive health service.

Whether or not and how this occurs locally, however, is dependent on local leadership, resources, and interests, since the devolution of power has meant that priorities, strategies to achieve these priorities, revenue collection, and budget allocation are now decided locally.

Decentralization, coupled with changing political winds and the influence of the Catholic Church,<sup>2</sup> has led to some confusion regarding program content and provider roles, but has also offered fertile ground for experimentation. In 1997 a project was initiated by the provincial health offices of Davao del Norte and Compostela Valley provinces in collaboration with the Ateneo de Davao University and the Population Council to further the reproductive health agenda. It introduced a model of client-centered service delivery by reorienting both clinic staff and outreach volunteers in the public-sector system. This chapter describes the process of training outreach volunteers in this new model of service delivery and the lessons learned. Work with the volunteers began in mid-1998 and continued until early 2000.

### **SERVICES WITHOUT CLEAR PRIORITIES**

The historical shifts in program emphasis, philosophy, and responsibility described above resulted in fragmented services characterized by uneven quality and unclear priorities. These problems pervade every level of the service-delivery system, which extends from district hospitals at the top to volunteer outreach workers—known as *barangay* health workers (BHWs)—at the periphery.<sup>3</sup> BHWs act as the bridge between health centers and communities (they are assigned to a *barangay* health center and work under the general supervision of a midwife). They are expected to play multiple roles, including those of community organizer; educator; data-gatherer; and provider of both preventive and curative health care, ranging from dental care and first aid to child health care and malaria prevention.<sup>4</sup> They are also expected to offer a range of reproductive health services, including education on available contraceptive methods, prevention of sexually transmitted infections (STIs) and HIV, and antenatal and postpartum care; provide information to contraceptive users and pregnant women about potential warning signs that might require medical attention; and make referrals to health centers, rural clinics, district hospitals, and private doctors for a variety of clinical contraceptive services, management of STIs, and antenatal care (Department of Health and UNFPA 1994).

Because of the immense scope of the volunteers' work and the lack of clear instruction on priorities, reality has diverged substantially from expectations. Insufficient training has compounded the problem. According to a study of four provinces in the Philippines, 33.5 percent of the BHWs had not been trained to perform their

primary outreach functions, such as conducting household visits and organizing community talks, or to function competently in key areas, including family planning (Lacuesta, Sarangani, and Amoyen 1994). BHW training often consists of a supervisor's cursory overview of the workers' role within the health system and the broad spectrum of services she is to offer, with scant attention to providing technical information on each service. Furthermore, the training has rarely focused on client needs or on creating rapport. BHWs are unable to elicit information from clients about their needs because they are not explicitly trained to do so.

The inadequacy of this training is evident from the results of the aforementioned study. BHWs who had participated in the family planning training recalled being taught about the efficacy of particular methods (97 percent) and about side effects and appropriate responses to them (90 percent). Far fewer mentioned interpersonal relations (15 percent). Almost half (45 percent) found the training to be inadequate and claimed not to have a clear understanding of how family planning methods are used or their contraindications. According to the study, BHWs spent about an equal amount of time—one to two days a week—in the clinic and in the field. Assisting midwives in the health center (64 percent), motivating clients to use family planning (40 percent), and conducting surveys to serve general administrative needs (25 percent) were the three most frequently mentioned roles they claimed to play. Far fewer viewed the tasks of disseminating information (10 percent) and resupplying pills (6 percent) as their roles (Lacuesta, Sarangani, and Amoyen 1994). Field visits in Davao del Norte also suggested that BHWs were less likely to provide any type of reproductive health care, including family planning, than to provide information on children's immunization and assist midwives with their immunization work.

It was also clear that BHWs were given little guidance as to which of their multiple tasks they needed to attend to first. Supervisors' evaluation of their reproductive health performance was based on the numbers of women they contacted or motivated to use services, rather than on the extent to which they met individual needs—reflecting the program's emphasis on such macro indicators as contraceptive prevalence and antenatal coverage.

Women who lived in the communities served by the BHWs were asked their perceptions of these volunteers and the services they offered (Lacuesta, Sarangani, and Amoyen 1994). While none of the women described BHWs in explicitly negative terms, one-third said that they were not familiar with the services BHWs offered. About half said that they had consulted with BHWs for family planning services. Only 56 percent of women who had discussed family planning with a BHW had been allowed to choose their method based on information provided on a range of available

choices. Instead, BHWs tended to direct women to particular methods, as typified by the following statement: “You know, there will be scheduled ligation services provided by doctors on Saturday. Why don’t you go and have yourself ligated? You already have five children and you are not getting any younger!” Researchers often overheard BHWs making such statements during field visits.

Fixed clinics exhibit parallel deficiencies in service quality, particularly with regard to contraceptive choice, information provision, and privacy. These deficiencies have been documented in a number of sites across the Philippines (Palma-Sealza 1993; Rood, Raquepo, and Ladia 1993; Zablan et al. 1998). One study of health units and lower-level *barangay* health stations (Zablan et al. 1998) found that in one-third of the observed interactions the provider encouraged one method over others during the consultation.<sup>5</sup> Less than 12 percent of clients were told how to use the method they left with or were informed about the method’s advantages, disadvantages, and side effects. Only 22 percent of family planning clients were asked whether they had a problem or concern about a method, and 9 percent were told that they could change the method they accepted. Only 4 percent of clients discussed in any terms the nature of relations with their sexual partners, information that bears directly on the acceptability and safety of the method selected. Not surprisingly given this context, contraceptive discontinuation in the first year of use is high nationally (41 percent) (National Statistics Office, Philippines Department of Health, and Macro International 1999). Furthermore, nearly a third of the women who discontinued using their contraceptive method reported an accidental pregnancy as the cause, providing further evidence of the substantial scope for improving service quality.

BHWs thus operate within a system that is characterized by serious gaps in quality and does not provide them with the fundamental skills necessary to foster women’s choice. While BHWs are seldom coercive, and the country’s pronatalist societal norms are more supportive of childbearing than of contraception, many BHWs attempt to convince women to limit their fertility and often promote a particular contraceptive method—without inquiring about the client’s health status, reproductive intentions, or needs.

### **DEFINING CLIENTS’ NEEDS WITHOUT THEIR PARTICIPATION**

While outreach work is one of BHWs’ primary activities as originally envisioned by the Department of Health, these workers clearly have not been able to bridge the gap between clinical services and the community. In searching for a solution, the Department of Health adopted a strategy that has been widely used in other parts of the developing world: the high-risk approach. While nominally focused on an individual

woman's situation, the high-risk approach is directed toward all nonusers of contraceptives "who are capable of conceiving, who are exposed to the risk of pregnancy, and who, if they were to become pregnant, would experience an elevated risk of mortality for their expected child, their living child, or themselves" (DeGraff and DeSilva 1996). It does not, however, take into account a woman's own desire to become pregnant or to prevent a pregnancy. It also ignores the needs of users who are having problems with their current method and could potentially switch contraceptives. As in other places, the high-risk approach ultimately proved to be inappropriate in the Philippines, as discussed below.

The Department of Health defined women who belonged to one or more of the following groups as being at "high risk" (Zablan et al. 1998):

1. Married women less than 20 years of age ("too young");
2. Married women over 35 years of age ("too old");
3. Married women of reproductive age with four or more previous pregnancies ("too many");
4. Women with a child younger than 15 months ("too soon");
5. Women with medical conditions such as tuberculosis, hypertension, and anemia.

Under the supervision of clinic personnel, BHWs were instructed to compile an annual survey of all married women of reproductive age. Women who were not using a contraceptive method were classified as either normal or high-risk. Each high-risk woman was then counseled on the possible complications of high-risk pregnancy and encouraged to use contraception. Because the five categories are so inclusive, over 85 percent of married women of reproductive age were classified as high-risk (Zablan et al. 1998).

Proponents of the high-risk approach argue that without such counseling these women cannot make an "informed choice" about whether or not to have another child. They further contend that it is unethical for the program not to provide this information. The approach is problematic, however. First, it uses general predictors of risk derived from rates of maternal and infant mortality and morbidity rather than relying on the client's clinical history, current health status, and reproductive intentions. Thus it has poor predictive value and identifies an enormous number of women as being at high risk who in reality are no more likely than others to have obstetric emergencies (Rooks and Winikoff 1990). Second, the high-risk approach undercuts the spirit of Cairo's client-centered philosophy. The provider elicits information about the client's childbearing history, but not her reproductive intentions. The definition of whether or not she is at risk is determined exogenously by the program, and some women with special needs are ignored. For example, a woman with a history of preg-

nancy complications who wants to become pregnant should not be counseled to avoid pregnancy, but given appropriate support whether her pregnancy is risky or not. Similarly, a woman who might be classified as a perfectly good candidate for pregnancy but who does not want a child should be supported in avoiding pregnancy.

Furthermore, when the provider–client exchange is centered on the high-risk approach the communication skills of the client and the provider are not developed. Accustomed to being told what to do, women rarely express their reproductive health concerns or reproductive intentions, and providers are implicitly (if not explicitly) told that women's concerns and intentions are not relevant. Thus such programs neither increase women's knowledge of reproductive health nor foster their ability to communicate their own health concerns and obtain the services they need.

In sum, while the high-risk approach appears to be an attractive strategy at first glance, it does not help workers prioritize their work or change its nature. More importantly, it obscures rather than supports women's reproductive intentions.

## **GUIDELINES FOR LEARNING ABOUT CLIENTS' NEEDS**

The family planning roles of *barangay* health workers, as originally envisioned and selectively revised, still placed clinical or donor definitions of need over client concerns. There was no clear plan for workers' active engagement with their clientele, and little attention was paid to interpersonal communication or information exchange. An alternative was proposed that would change the operational paradigm of existing workers to one that fostered a much closer and more open relationship with clients (Jain 1996).<sup>6</sup> The key elements of this alternative approach included:

*Eliciting information from clients.* A provider must ascertain basic information about the woman's circumstances to help her select a method or provide other reproductive health services appropriate to her needs. This information ranges from the client's reproductive intentions and prior family planning experience to her contraceptive method preferences and partnership arrangements.

*Involving clients in the selection of the initial method.* As much as possible, the client should select or at least be involved in selecting a method appropriate to her needs and circumstances. Even if a client has a particular method in mind, it is important that the provider discuss at least one alternative. This is particularly true when a permanent method is being discussed.

*Shifting providers' orientation from method to client.* The provider's job should be defined not as motivating women to have small families but as helping women articulate their reproductive intentions and providing support to help them achieve those intentions. Consequently, evaluations of provider performance should be based on

the ability of providers to support clients in meeting their own reproductive intentions, rather than ensuring acceptance and continued use of specific methods.

*Providing adequate information to clients.* There is debate over the level of information that clients should receive. Specifically, the information provided to a client may sometimes be irrelevant to her circumstances or may be so detailed that it becomes too much to absorb (Murphy and Steele 1997). At a minimum, the alternative client-centered approach to family planning posits that the provider must offer information on the following:

- Methods available and their suitability to the client's needs and circumstances (e.g., sterilization is not suitable for clients who want more children or who may not be sure about it, and intrauterine devices (IUDs) are not recommended for clients who have more than one partner or who suspect or know that their partner has multiple partners);
- How to use the method selected, its side effects, and whether or not it protects against sexually transmitted infections;
- The possibility of switching if the method is inconvenient or not suitable given a person's needs, circumstances, or health status; and
- Sources of supply, so that the client feels that s/he is in control and does not have to come back to the same source or to the same provider for resupply.

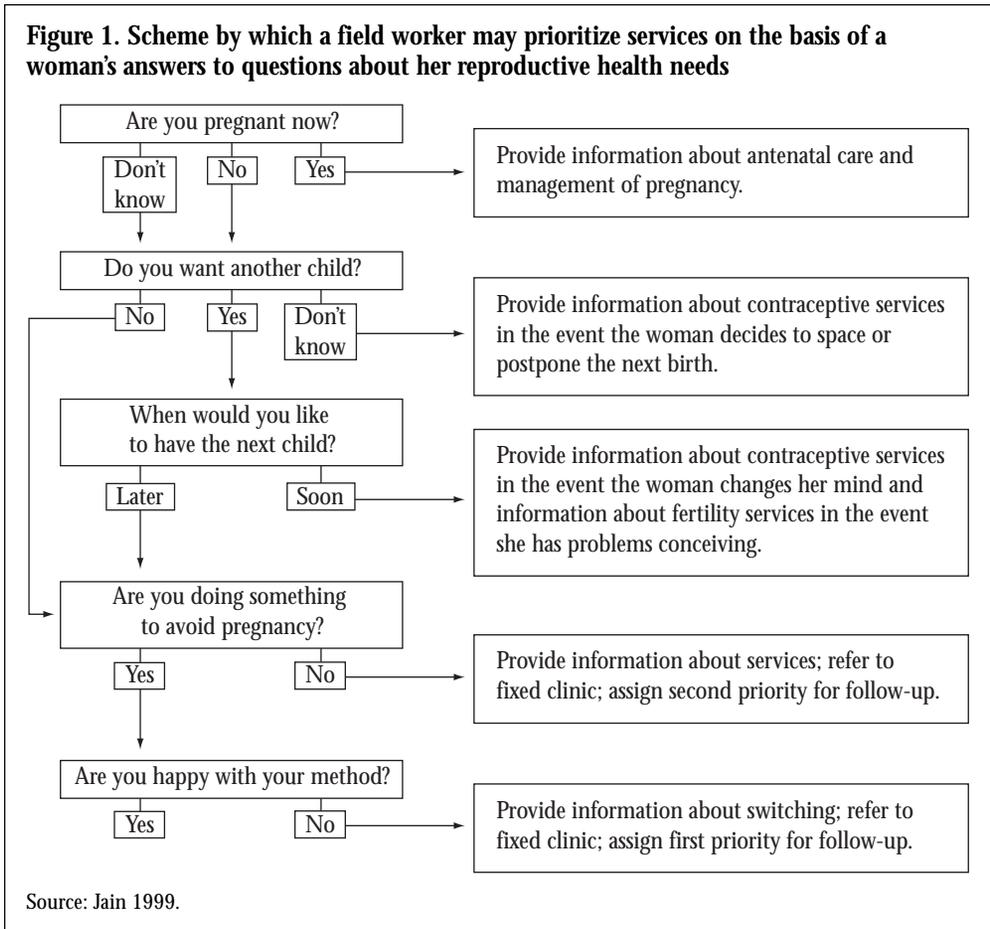
## **AN EXPERIMENT TO CREATE CLIENT-ORIENTED WORKERS**

In search of a more client-oriented approach, the Provincial Health Office of Davao del Norte, the Social Research Office at Ateneo de Davao University, and the Population Council designed an experiment in ten municipalities of Davao del Norte and Compostela Valley provinces in collaboration with EngenderHealth (formerly AVSC International).<sup>7</sup> The component of the project described in this chapter trained BHWs in Panabo municipality in Davao Province and Montevista municipality in Compostela Valley Province<sup>8</sup> in the use of a client-service tool that focuses on helping women achieve their reproductive intentions.

In April 1998, 110 BHWs were trained in the use of a tool that would help them organize their family planning service delivery around client needs.<sup>9</sup> The tool was designed to help BHWs conduct individual interviews with women in the community to learn about their needs and develop a plan for working with each one of them.

The tool consisted of five questions posed to women concerning their current pregnancy status, desire for and timing of an additional child, use of contraception, and satisfaction with the method used (see Figure 1). Responses allowed BHWs to classify women as dissatisfied contraceptive users; women with unmet need for limit-

**Figure 1. Scheme by which a field worker may prioritize services on the basis of a woman's answers to questions about her reproductive health needs**



ing or spacing pregnancies; women who are currently pregnant; and women who are not ready to use contraception because they are uncertain of their reproductive intentions, seek to become pregnant, or have other personal objections. The training emphasized the type of information to be provided to women according to their response and the circumstances under which they should be referred to a fixed clinic, as follows:

- Women who are pregnant are given information about managing the pregnancy safely and told when and where they should go to receive antenatal care, immunizations, and postpartum services, including family planning.
- Nonpregnant women who hope to conceive soon are given information about where to go for infertility services, if necessary, and for contraceptive services, if their intentions change.
- Nonpregnant women who do not want another child soon, are not using contraception, and would like to do so are given information on services avail-

able at the nearest clinic (e.g., injectables and the IUD) and through the BHW directly (e.g., pills and condoms).

- Nonpregnant women who do not want another child soon and who are using contraception but are not happy with the method are given information about alternatives and how they can safely switch to the method to which they are best suited.
- Nonpregnant women who are happy with their current method are resupplied if necessary and/or reminded of when and where they can obtain a re-supply.
- Nonpregnant women unsure of their reproductive intentions are informed of family planning services available in the event they decide to use a contraceptive method.

The project team found that BHWs had trouble accurately classifying some women. This reflected, in part, the intransigence of their earlier approach, which emphasized increasing the numbers of contraceptive users. The project team felt that the number of unhappy or dissatisfied users identified by BHWs was too low, especially given the high national rate of contraceptive discontinuation due to side effects. Some BHWs reported that they were reluctant to record women as dissatisfied users because they feared that doing so would reflect negatively on both themselves and the clinic staff. Presumably, these BHWs had trouble getting used to the notion that listening to and meeting the client's desires were now their primary goals. Some BHWs reported they did not record dissatisfied users as such because they had provided a remedy or referral in response. In addition, given the culture of polite discourse between clients and providers, it is possible that some women were reluctant to disclose their dissatisfaction lest it reflect negatively on the providers. The project team revised the question on method satisfaction to help providers understand its purpose—both to capture the essence of the client's experience with the method and to guide their action. The first version of the question allowed only a straightforward response of satisfied or unsatisfied. It also seemed to focus on the user's perception of the method's ability to protect against pregnancy rather than the totality of her experience with the method. The revised version of the question now encompasses a range of experience from high satisfaction—indicating a sense of ease and comfort with the method—to a minimum level of satisfaction, to explicit dissatisfaction.

The project team also felt that the number of women classified as happy/satisfied was suspiciously high. By design, women who fell into the category of satisfied user were listed as requiring "no action" and did not receive follow-up visits. Also, one-third of these women reported using rhythm, withdrawal, abstinence, or lacta-

tional amenorrhea—methods that require a sound knowledge base for effective use. There was concern that even satisfied users of these methods may require more information, especially because previous studies had documented substantial inaccurate knowledge about fertility cycles and natural family planning.<sup>10</sup> Because natural family planning is a popular choice, and BHWs and midwives were not equipped to provide complete and accurate information, the project team gave these health workers appropriate training. Both the project team and the service providers wanted to treat these methods with the same seriousness as modern methods and felt that doing so was in keeping with the new, client-centered philosophy of care.

Women who had expressed dissatisfaction with their contraceptive method and those who wanted to cease or delay childbearing and to use contraception were referred to the fixed facility. Dissatisfied users were given blue cards, and nonusers in search of a method were given pink cards. They were instructed to hand the cards to the provider to convey the purpose of their visit and to facilitate tracking the performance of the referral system. Qualitative information from the project evaluation suggests that a number of these women took advantage of the referral opportunity; some decided to abandon the method with which they were dissatisfied in favor of natural family planning, rejecting the alternative modern methods available (i.e., condoms, pills, Depo-Provera, and the IUD). The proportion of women with referral cards who subsequently came to the health center is unclear, since it is believed that many clients neglected to bring their cards. Other experiments with referral cards report similar problems, and the project has since stopped using them.

### ***Prioritizing Household Visits Based on Women's Needs***

BHWs also developed a plan for household re-visits based on their interviews with clients. They enumerated eligible women in their areas and grouped them according to self-determined fertility status, reproductive intentions, and contraceptive use/satisfaction. Some BHWs were able to complete enumeration within two months while others needed more time because of the nature of the geographic area they covered. Those working in periurban areas with a clustering of households and a good transportation system were able to compile their lists more easily than those who had to visit far-flung households or traverse mountainous terrain with poor transportation.

A total of 6,173 currently married women of reproductive age were enumerated, and were categorized as follows:

- Pregnant (10 percent)
- Desire more children soon (4 percent)

- Not using contraception but want to cease or delay childbearing (30 percent)
- Dissatisfied users (2 percent)
- Satisfied users (32 percent)
- Satisfied users of sterilization (2 percent)
- Satisfied users of lactational amenorrhea, withdrawal, rhythm, and abstinence (20 percent)

First priority for follow-up was accorded to women who were dissatisfied with their current method and second priority to those who wanted to space or terminate childbearing but were not currently using contraception. BHWs who had a manageable number of households were able to serve all women without prioritizing their visits. BHWs who were not able to serve all the households in their area prioritized their visits and served those with lower priority during subsequent visits to the community.

While some women received relevant services or referrals during the initial visit, some BHWs mistakenly believed that the purpose of the initial visit was to elicit information and enumerate their assigned area only, and additional follow-up was required to provide any information or services clients required. BHWs learned as they went along that they could enumerate and provide information at the same time.

Implementation of the client-oriented strategy was not seamless, and many of the problems encountered are still being resolved. It became clear, for example, that the assigned areas were not clearly delineated because of uncertain or overlapping boundaries between *barangays*. As a result, some women were enumerated by two BHWs. The assigned areas were more clearly demarcated during subsequent meetings between BHWs and supervisors. In addition, despite the time provided for the enumeration and the provision of intensive technical assistance by the project team, only a few BHWs were able to list all of the married women of reproductive age from their area; while many were able to include at least 80 percent, some covered only 50 percent. According to the midwives, this shortcoming was due to the brief canvassing period and to continuing deficiencies in BHWs' skills. In addition, because BHWs are volunteers, the midwives can only encourage them to conduct their activities in a timely and competent manner. Regular meetings to check on the status of BHWs' work helped to improve their performance and was welcomed by the volunteers, who had previously received little supervisory attention, acknowledgment, or recognition. Finally, some BHWs expressed frustration at their inability to effectively address the needs reported by some women in their areas (e.g., the needs of infertile women who wanted to become pregnant).

## CONCLUSION

This pilot project has demonstrated the feasibility and difficulties of reorienting outreach workers to elicit information on women's needs and develop a plan for community visits based on those needs. The *barangay* health workers' family planning role has been more clearly defined, and its outreach component now has a structure. Under the earlier scheme, some BHWs had been asked to cover households that were far from their own residence;<sup>11</sup> in addition, as noted above, there was some overlap between their coverage areas. After the rosters were developed, BHWs were assigned to households near or in their own neighborhoods, and the overlap between coverage areas was eliminated. Each BHW now covers a clear and manageable number of households.

Information gathered during the researchers' field visits suggested that both midwives and BHWs appreciated the value of client-based information in designing their workplans and directing their service efforts. They had originally perceived information collection to be an administrative requirement for reporting purposes; its use as a tool for managing service delivery was entirely new to them. The client-generated database also created an opportunity for midwives and BHWs to communicate more effectively with one another. It thus increased the level of communication at all levels—between supervisors and workers and between workers and their clients.

The project has provided an experiential base for defining a good outreach worker, as follows:

- Committed and concerned about the client;
- Able to engage the client and elicit service needs;
- Able to respond appropriately to these needs; and
- Able to conduct visits based on clients' needs rather than on external criteria.

By extension, a good supervisor provides appropriate support to BHWs and encourages open exchange—both on problems that have been solved and on those for which a solution is still being sought. BHWs and midwives talk about women who are referred to the clinic, with a focus on their service needs. Increased flow of information between supervisors and BHWs has meant that their work is now effectively interdependent. When a midwife learns about the needs of BHWs' clients, she is able to provide better services when these clients are referred, and can have a more productive exchange with BHWs about the clients' status; in turn, BHWs can provide better care during follow-up visits.

This project was pilot-tested in a limited area—one municipality in each of two provinces. The provincial health officer of Davao del Norte found the experiment to be innovative and useful as it built on the resources already available within the public

system. He is thus using provincial government resources to expand the project provincewide, increasing the population covered from 131,000 to over 700,000. Furthermore, he has integrated an expanded version of the project's client-based record form into the provincial health program.

Using this expanded tool, BHWs also elicit information on clients' needs for tetanus toxoid immunization for women, vitamin A supplementation for children, and child immunization, in addition to family planning. Services in all these areas are prioritized based on what the BHWs learn in their exchanges with clients. All services provided by BHWs are now recorded on a newly developed client-based form, and both BHWs and midwives have been trained to use the form.

The fact that the public system in Davao del Norte was able to scale up the pilot project, expand it to include a broader range of services, and institutionalize the new approach is a notable achievement. Other projects—particularly one being undertaken by Management Sciences for Health—are also using the lessons learned from this pilot effort to improve the client orientation of family planning services. The project demonstrates that community-based health workers can be reoriented to provide services based on client needs. Further progress and sustainability hinge on commitment to a client orientation among both decisionmakers and service providers. Translating the concept of client-centered care into practice is a key post-Cairo mandate. While this pilot experiment with outreach workers in the Philippines is not without remaining challenges, it provides a simple tool to help workers learn about—and respect—the fertility needs, concerns, and uncertainties of the client.

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### **Notes**

- 1 The central office of the Department of Health retains responsibility for contraceptive supplies and logistics, standard setting, and accreditation.
- 2 The Catholic Church is an important participant in issues related to population policy and fertility regulation in the Philippines. Differences between the government and the Church have created an environment inimical to a strong program, and changes in policy can often be traced to the Church–state relationship.

- 3 A *barangay* is the smallest unit of government in the Philippines.
- 4 An illustrated Department of Health manual exceeding 350 pages provides *barangay* health workers with information about a broad range of health issues (from malnutrition to drowning).
- 5 While there is no systematic bias favoring specific methods, anecdotal evidence suggests that some methods may not be offered to women depending on their age or parity.
- 6 A full description is available in Costello et al. 2001.
- 7 The project goal was to improve the quality of family planning services by training clinic providers, with an emphasis on information exchange practices; by training supervisors in supportive supervision techniques; and by training outreach volunteers. (See Chapter 6 for more information on EngenderHealth's supportive supervision strategies.)
- 8 Panabo municipality has a population of around 131,000; Montevista municipality has a population of around 32,000.
- 9 Initially, project staff trained 49 BHWs. Immediately after this training, 61 other BHWs were trained by midwives and selected BHWs who had participated in the initial training exercise.
- 10 Natural family planning methods, also known as fertility awareness methods, include rhythm/keeping a calendar, monitoring cervical mucus, and tracking basal body temperature.
- 11 This occurred whenever the households of a BHW who had stopped volunteering were distributed among those who were still in service.

## References

- Costello, Marilou, Marlina Lacuesta, Saumya RamaRao, and Anrudh Jain. 2001. "A client-centered approach to family planning: The Davao Project," *Studies in Family Planning* 32(4): 302–314.
- DeGraff, Deborah and Victor DeSilva. 1996. "A new perspective on the definition and measurement of unmet need for contraception," *International Family Planning Perspectives* 22(4): 140–147.
- Department of Health (DOH) and UNFPA. 1994. *Health Work Is Team Work! An Operations Manual for Community Volunteer Health Workers (CVHW)*. Government of the Philippines: The CVHW Program, Community Health Service, DOH.
- Jain, Anrudh. 1996. "Items on information exchange to be emphasized in training of providers," internal memo. New York: Population Council.
- . 1999. "Should eliminating unmet need for contraception continue to be a program priority?" *International Family Planning Perspectives* 25(suppl): S39–S43, S49.
- Lacuesta, Marlina, Segundina Sarangani, and Napoleon Amoyen. 1994. "A diagnostic study of the implementation of the DOH Health Volunteer Workers Program," final report, Asia and Near East Operations Research and Technical Assistance Project. Manila: Population Council.
- Murphy, Elaine and Cynthia Steele. 1997. *Client–Provider Interactions in Family Planning Services: Guidance from Research and Program Experience: Recommendations for Updating Selected Practices in Contraceptive Use*, vol. II. Chapel Hill, NC: INTRAH.
- National Statistics Office (NSO), Philippines Department of Health and Macro International, Inc. (MI). 1999. *National Demographic and Health Survey 1998*. Manila: NSO and MI.
- Palma-Sealza, Lita. 1993. "Quality of care and family planning dropouts in Bukidnon Province: A survey study," *Philippine Population Journal* 9(1–4): 1–11.
- Rood, Steven, Marcelo Raquepo, and Mary Ann Ladia. 1993. "A diagnostic study of Department of Health training courses for family planning providers," *Philippine Population Journal* 9(1–4): 37–48.

- Rooks, Judith and Beverly Winikoff. 1990. "Chapter 12: Conclusions" and "Chapter 13: Recommendations," in *A Reassessment of the Concept of Reproductive Risk in Maternity Care and Family Planning Services*, proceedings of a seminar presented by the Population Council's Robert H. Ebert Program on Critical Issues in Reproductive Health and Population, New York, 12-13 February.
- Zablan, Zelda, Josefina Cabigon, Luzviminda Muego, Marilou Costello, and Chona Echavez. 1998. "Improving the quality of care in family planning/reproductive health services of selected communities of Pangasinan Province: An intervention study," final report, Asia and Near East Operations Research and Technical Assistance Project. Manila: Population Council.

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