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Male involvement through reproductive health awareness in Bukidnon Province, the Philippines: An intervention study

Lita Palma-Sealza

Marilou P. Costello
Population Council

Chona R. Echavez

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LIST OF ACRONYMS USED

AVSC	Access to Voluntary and Safe Contraception
BHS	Barangay (village) Health Station
BCG	Bacille Calmett Gourain
BHW	Volunteer Barangay Health Worker
CDD	Control of Diarrheal Diseases
CPR	Contraceptive Prevalence Rate
CAs	Cooperating Agencies
DHS	Demographic Health Survey
DMPA	Depo Medroxy Progesterone Acetate
FGD	Focus Group Discussion
FP	Family Planning
HIV/AIDS	Human Immuno-Deficiency Virus/Auto Immune Deficiency Syndrome
ICPD	International Conference on Population and Development
IEC	Information, Education, Communication
IRH	Institute for Reproductive Health of Georgetown University
IUD	Intra Uterine Device
KFI	KAANIB Foundation, Incorporated
LGU	Local Government Unit
NDS	National Demographic Survey (1993)
NGO	Non-Governmental Organization
PHILDHRRA	Philippine Partnership for the Development of Human Resources in Rural Areas
PO	People's (base) Organization
RH	Reproductive Health
RHA	Reproductive Health Awareness
RHU	Rural Health Unit
RIMCU	Research Institute for Mindanao Culture
RTIs	Reproductive Tract Infections
SDP	Service Delivery Point
STDs	Sexually Transmitted Diseases
UNFPA	United Nations Fund for Population Activities
USAID	United States Agency for International Development

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Prof. Lita Palma-Sealza
Principal Investigator

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EXECUTIVE SUMMARY

Introduction

Recent years have been characterized by an increasing consensus that, in order to support women's goals and aspirations, health programs directed to the improvement of women's and children's health must consider men's perspectives, intra-couple roles and decision making power. This makes sense, given the social and cultural reality that men play a dominant role in families' decisions about resource allocation (including determining when to use resources for health related activities) and fertility in many if not most developing countries. Although family planning (FP) is often viewed by both men and women as solely the woman's responsibility, men have an important role in decisions of whether family planning will be practiced, and if so, which method will be used. In addition, the widespread unwillingness of husbands to practice family planning, even in cases where their wives would like to do so, is a major explanation for the high levels of unmet need found in the nations of Africa, Asia and Latin America (Bongaarts and Bruce, 1995).

According to the Philippines 1997 Family Planning Survey, the CPR for currently married women of reproductive age at the national level was 47.0%, a decrease from 1996 (CPR=48.1%). The decrease was largely accounted for by a decline in the use of traditional methods. Simultaneously, there was a more modest increase in the use of modern methods from 30.2% to 30.9%. In the latest survey, 2 percent of males used a modern family planning method (1.7 percent condoms, 0.2 percent vasectomy, and 0.1 percent Billings). However, 16.1% of married couples practiced the use of traditional methods including 5.9 percent withdrawal and 9.7 percent calendar/rhythm. According to Bongaarts and Bruce (1996), in the developing world countries they studied, the use of male to female modern methods of contraception is about 1:4; in the 1997 Philippines Survey, this ratio was 1:15.

Even though gender relations in the Philippines are often characterized as being relatively egalitarian, there are several reasons for believing that the question of male involvement in family planning is highly relevant for this country. Diagnostic studies indicate that not only are Filipino husbands accorded a disproportionate share of power in

conjugal decision-making about matters pertaining to sexuality, fertility and family planning (Yu and Liu, 1980), but also that their reluctance to use FP is a contributory factor underlying the country's significant unmet need (Perez, Casterline, Biddlecom and Arguillas, 1995).

Project Objectives

The overall objectives of the project are to design, implement and test a Reproductive Health Awareness (RHA) training, education and organizational development intervention with the KAANIB Foundation, and their largely male member beneficiaries, in selected barangays (villages) of three municipalities (Impasug-ong, Malaybalay and Valencia) in Bukidnon Province, Mindanao. KAANIB Foundation, Inc. (KFI), a rural-based NGO, works with 35 farmers' associations giving technical assistance on agriculture, management and marketing.

The long-term goal of this project is to evaluate the effectiveness of involving men as partners in the RHA intervention on the basis of indicators such as degree of support for FP use, use of male oriented methods, more couple communication on family formation matters, etc. The study addresses the following questions:

1. Does the RHA pilot program result in the incorporation of an RHA perspective within the Foundation's educational activities and materials, and in the support services provided to its members? More generally, will this perspective be fully institutionalized within KFI by the end of the pilot program and will KFI develop plans to replicate it in other areas where it works?

2. Will the RHA pilot program increase RH/FP knowledge and skills among KFI members and their families and result in more positive RH attitudes and improved health seeking behaviors (particularly in the areas of family planning, use of male oriented methods, etc.)?

3. Will the RHA pilot program have an impact on the health services being offered by the LGUs in the barangays where the intervention will be implemented?

The specific objectives of Phase I were to:

1. Collect baseline information on the three study communities (health facilities and services, community institutions);

2. Gather information on the activities, structure and group processes associated with KAANIB;

3. Study the knowledge, attitudes and practice of KFI members and their wives (or husbands) regarding reproductive health-related issues and other relevant household and individual level information (e.g., gender relations, male involvement in fertility and FP matters, health-related behaviors, etc.); and

4. Develop an intervention plan using educational modules that have been adapted to suit the needs of the community through a systematic analysis of the baseline data.

Experimental Design and Activities Completed under Phase I:

Four major activities have been completed during the course of Phase I:

(1) Husband-wife study of all KFI members in the selected barangays (both experimental and control groups);

(2) Descriptive analysis of the roles, functions and activities of KFI extension workers, and the structure and operations of the KFI;

(3) Community-level analysis of locally-based institutions, organizations and services found within the study areas; and

(4) Development of a proposed RHA intervention strategy based upon a review of the results of the Phase I analysis and a joint planning process involving all of the collaborating organizations.

The overall research design selected for this study is a pretest, post-test control group design. Baseline data were collected in both the study areas and a corresponding group of matched control areas. The intervention will be introduced during Phase II of the project. Post-tests will also be carried out during Phase II with the same project beneficiaries who were interviewed during the pre-test round, in order to assess any changes which occurred during the course of the project. Post-tests will also be conducted in the control areas so that a comparative analysis of changes that occurred on selected indicators between the experimental and control communities can be assessed.

The Phase I diagnostic study on which this report is based, gathered data from over 200 couples living in eleven intervention barangays in Bukidnon Province, Mindanao. Information was also gathered from 250 couples in control barangays. Husbands and wives were interviewed separately, and only couples with wives in the reproductive age were selected for the study. Intervention area families have a member in one of the 35 farmer organizations which work with and receive technical assistance from KAANIB Foundation, Inc. (KFI). In addition, a health service inventory was performed. Interviews and discussions with KFI staff, KFI members and key informants were also conducted.

Based on the findings of the diagnostic study, the Phase II intervention project will be couple focused. It will train couples using the RHA methodology developed by the Institute for Reproductive Health of Georgetown University (IRH) and adapt it to local needs. Its general objective is to develop, implement and test cost-effective and sustainable strategies to increase male participation in reproductive health matters and family planning. The focus on couples was decided on because it was felt that working exclusively with men had the potential to increase their power through increased exclusive knowledge; and, because of the finding from the first phase of a need to improve communication between spouses in reproductive health matters. Phase II will be implemented by KAANIB, IRH and the Research Institute for Mindanao Culture (RIMCU).

Findings

1. Community survey

Respondents: The KFI members' survey included 220 husbands and 226 wives under 49 years of age. The majority of both sexes had at least an elementary school education, however, the wives were found to be more educated. Over 95% of the wives had one or more births and 7.8% were pregnant at the time of the survey. Twenty-one percent had experienced one or more child deaths. A third of the respondents had 5 or more children, and another third had 3 or 4 children. A fifth of the wives had more than their stated ideal number of children. Over 85% of both husbands and wives either wished to postpone or prevent another pregnancy. Approximately 60% of respondents stated they were using a family planning method, with 1/3 using traditional and 2/3 using modern methods. Condom use was reported by only 3.7% of users and no man had had a vasectomy. Of the wives who were not pregnant and wanted to avoid a pregnancy, 31% were not using a family planning method. Thirty eight to 50% of respondents said they had been unprepared for some of the pregnancies they experienced.

Knowledge: Although almost all respondents were able to mention several family planning methods, basic knowledge of reproductive anatomy and physiology was found to very low. None of the respondents, including those who claimed they were using periodic abstinence based methods (rhythm and natural family planning, NFP) were able to identify correctly the time of the cycle when a woman is most likely to be fertile. Additionally, most respondents were able to identify advanced age as a reproductive risk but few were aware of young age, closely spaced births, and more than 4 children as risks for women and children.

In spite of government IEC campaigns about STDs, only 20% of respondents appeared to know that there were such diseases and even fewer knew any of the common signs and symptoms. On the other hand, most respondents had heard of HIV/AIDS. Nevertheless, there was a significant lack of knowledge about how it is transmitted and of preventive measures. Most significantly, only 2.2% of women and less than 5% of men knew that condoms protect against AIDS.

Communication and decision making power: In this report, data is presented for all husbands and wives, as well as matched couple responses that point to a lack of communication between spouses on reproductive issues. This includes the number and timing of children, whether or not their last pregnancy was jointly planned, whether to use family planning and which method to use.

Although the wife appears to have significant decision making power in the family, there are some issues which are the husbands' territory, mostly where economic decisions are involved. When there a difference in opinion between spouses, the husbands' opinion most often prevails. In addition, interviewers noted that both men and women are uncomfortable discussing sexual topics.

Gender: Gender roles were examined. Although there are culturally determined primary responsibilities, the husband appears to be quite helpful performing chores that are primarily considered to be his wife's, especially if she is pregnant.

Many women stated that they sometimes refuse to have intercourse when their husband wants it, but only 20% stated that they request it from their husbands. On the issue of pain during intercourse, 26 women stated that they "always" or "usually" had pain. Of this group, only one husband said he thought his wife "sometimes" had pain; all other husbands claimed to have no knowledge about this.

Domestic violence: More than one fifth of both husbands and wives admitted that the man had hit the woman at least once. When we looked at matched couple responses there was considerable mismatching, prompting the conclusion that there may be very significant under reporting on this issue. Husbands tended to think that domestic violence was none of the community's business; wives thought it was.

2. Inventory of health services

Nine of the eleven barangays included in the intervention have health services available in the community. The two without services are visited by a rural midwife once or twice monthly, and people avail themselves of services in neighboring barangays. The two largest communities, Malaybalay and Valencia, have Rural Health Units (RHUs) staffed by doctors, nurses, midwives, sanitary inspectors, a dentist and a lab technician. In

the five smaller communities, Barangay Health Stations (BHSs) are staffed by one midwife. Services available in all SDPs include: pre-natal exams, family planning, well child monitoring and immunization, CDD, EPI, micronutrients and essential services for children and adults. Family planning methods available are pills, condoms and DMPA; some midwives have been trained in NFP, but very few clients request this method from the health services. In the RHUs, IUD services are also available. No stock-outs for family planning commodities were reported in the last six months (although there have been some child vaccine stockouts). Female voluntary sterilization is available in several provincial hospitals. Vasectomy is not presently available in the provincial hospital at present.

Several essential elements were reported to be missing or not acceptable in several of the clinics, which included privacy, cleanliness and a water supply. The two RHUs that were visited were found to have all the necessary elements except for one which lacked water.

3. Interviews with KAANIB staff

Sixteen of the 28 KFI staff members were interviewed. KAANIB's vision, objectives, achievements and work methodology are described in this report. The staff appears enthusiastic about incorporating the RHA intervention into their, up to now, exclusively agricultural and organizational assistance work. They also expressed the need to be trained in reproductive health, to have reference materials, to have access to transportation and training funds, as well as to have a health technician added to their staff.

4. Focus Group Discussions (FGDs) with KAANIB members

A total of 9 FGDs were held with mostly male KFI members. The prevailing opinion is high appreciation for KAANIB and its assistance and support for KAANIB to incorporate reproductive health interventions into their program. FGD participants feel that there will be great interest in this intervention, and that most members will want to attend training sessions.

5. Interviews with Key Informants

Descriptions of participating community populations, including their infrastructure and services, language, occupation, religion, after work entertainment, etc., are presented in this report. Most inhabitants are involved in farming activities (with the exception of one of the large communities, Valencia), are Catholic and speak one or two common languages. All communities have electricity and transportation but other services are only to be found in Malaybalay and Valencia. Most inhabitants participate in community organizations.

6. Results Utilization and Dissemination

An intervention plan was developed during a four day workshop based on the Phase I findings. Participants included representatives from KAANIB, The Institute for Reproductive Health of Georgetown University (IRH), the Population Council, the Research Institute of Mindanao Culture (RIMCU), regional and national Departments of Health, the Provincial Health Office and other NGOs. The proposed intervention and a preliminary activity schedule were presented and approved by the KAANIB Board of Directors.

The priority issues identified during the workshop and incorporated into the intervention plan include: gender inequality, low levels of reproductive health and family planning knowledge, poor intra-couple communication, low use of existing health services, low use of male family planning methods, unintended pregnancies, pre-natal and postpartum complications and high levels of domestic violence.

Dissemination activities that were completed include seminars in three communities in March 1998, and a National Research Dissemination Conference held in Manila in May 1998.

The intervention project, scheduled to start in August 1998, will be implemented by KAANIB, with assistance from the IRH and RIMCU. The Population Council may provide technical assistance to RIMCU for the evaluation component as part of the FRONTIERS project.

The recommendations for the implementation of Phase II are as follows:

- The selection of couple-educators should primarily be the member agency's (POs) responsibility, with input and selection criteria clearly spelled out by KAANIB. This will contribute to the member organizations' sense of ownership of the intervention and will allow them to monitor couple educators' contribution and insist on the fulfilment of their commitments.

- KAANIB should carefully consider what incentives it can offer couple-educators in return for their considerable time investment.. No direct financial incentives will need to be considered, since this would jeopardize the institutionalization of the intervention, assuming it is evaluated as successful, useful and cost-effective. KAANIB has had experience in providing rewards for outstanding work which includes indirect financial incentives such as small reductions in loan interest rates and acquisition of produce at a better price, etc.

- KAANIB, the project's health technician, and the member organization's directors need to consider what strategies they will use to obtain 100% participation from their member-couples, and how to sustain their participation over time. These strategies may include the incorporation of RHA activities into existing agricultural and organizational activities. Incorporating a small sport or other entertainment activity into every couple-meeting in order to increase the enjoyment and appreciation of meeting participants should also be considered, while it is important that these extras do not become the principal activities.

- Project managers should foresee the possibility that men may decrease attendance to meetings and delegate their wives as their representatives due to agricultural demands. To forestall this from occurring, men, as well as their wives', should be given choices of times for their meetings and then insist that they both attend.

- KAANIB should consider what it will do to replace possible drop-out couple educators.

- During meetings, consideration should be given to assist couple participants to develop communication skills on topics relating to sexuality, not just between spouses, but also with their adolescent sons and daughters.

  Health service providers from the member organization's barangay should be encouraged to attend the couple meetings, as well as the couple educator training. This will assure that health messages will remain consistent and that the same non-technical language will be used by the providers when they are with clients. This may also help sensitize providers on men's particular needs and to make services more male friendly.

- A referral system for accessing health services and other resources should be established. Referrals, although primarily to LGU services, should also include other existing services in the area, including the church for couple education in NFP, NGO health services, etc. Couple-educators need to be provided with this information which too can complement it with their knowledge of available services.

- In order to offer vasectomy services in strategic SDPs, providers need to be trained. Training and equipment assistance may be requested from AVSC.

- The health technician's job description should include the responsibility for assuring cultural appropriateness of all intervention contents, activities, methodologies and used.

- A detailed cost analysis of the intervention should be performed so that its cost-effectiveness can be determined. This may be a principal factor for decisions on institutionalization and replication.

- Careful process monitoring and lessons learned documentation should be an important part of this intervention to facilitate project replication.

- The husband and wife interview instruments and the Georgetown IRH project proposal are included as Annex I, II and III respectively.

INTRODUCTION

Background

Recent years have been characterized by an increasing consensus that, in order to support women's goals and aspirations, health programs directed to the improvement of women's and children's health must consider men's perspectives, intra-couple roles and decision making power. This makes sense, given the social and cultural reality that men play a dominant role in families' decisions about resource allocation (including determining when to use resources for health related activities) and fertility in many if not most developing countries. Indeed, although family planning is often viewed by both men and women as solely a woman's responsibility, men have an important role in decisions as to whether or not family planning will be practiced, and if so, which method will be used. In addition, the widespread unwillingness of husbands to practice family planning, even in cases where their wives would like to do so, is a major explanation for the high levels of unmet need found in the nations of Africa, Asia and Latin America (Bongaarts and Bruce, 1995).

The 1993 Philippines DHS and the National Demographic Survey (NDS) found that 28% of 9,817 pregnancies over the last five years were reported by women interviewed as wanted, but at a later time, and 16% were reported as unwanted. The unmet need was 26.2% (12.4% for spacing and 13.8% for limiting).

According to the Philippines 1997 Family Planning Survey, the CPR for currently married women of reproductive age at the national level was 47.0%, a decrease from 1996 (CPR=48.1%). The decrease was largely accounted for by a decrease in the use of traditional methods. Simultaneously, there was a modest increase in the use of modern methods from 30.2% to 30.9%. In the latest survey, 2 percent of males used a modern family planning method (1.7 percent condoms, 0.2 percent vasectomy, and 0.1 percent Billings). However, 16.1% of married couples practiced the use of traditional methods including 5.9 percent withdrawal and 9.7 percent calendar/rhythm. According to Bongaarts and Bruce (1996), in the developing world countries they studied, the use of male to female modern methods of contraception is about 1:4; in the 1997 Philippine Survey, this ratio was 1:15.

Even though gender relations in the Philippines are often characterized as being relatively

egalitarian, there are several reasons for believing that the issue of male involvement is highly relevant for this country. Diagnostic studies indicate that not only are Filipino husbands accorded a disproportionate share of power in conjugal decision-making about matters pertaining to sexuality, fertility and family planning (Yu and Liu, 1980), but also that their reluctance to use FP is a contributory factor underlying the country's significant unmet need (Perez, Casterline, Biddlecom and Arguillas, 1995).

The issue of gender relations is by no means simple. According to the 1993 NDS, less than one percent of women reported that their husbands disapproved of their current family planning method use. Less than 4 percent of women reported their husband's disapproval as the primary reason for method discontinuation. On the other hand, spousal disapproval has been linked to the FP drop-out problem by several studies (e.g., IPPF, 1984; Palma-Sealza, 1993; Arenas, Cabigon and Palabrica-Costello, 1996). Finally, gender relations are relevant to the large proportion of Filipino couples (16%, according to the 1997 Family Planning Survey) who use traditional methods such as calendar/rhythm and withdrawal. Failure rates for traditional methods is inherently high and was the major reason given for method discontinuation recorded by the 1993 NDS. It is evident that contraceptive failure rates for these methods will be higher in cases where the husband and wife do not hold the same reproductive goals, where the husband is not strongly committed to consistently applying the method or where inter-spousal communication patterns are weak. Clearly, engaging men's interest and support could be a big factor in reducing unwanted fertility (Bongaarts and Bruce, 1996).

2. The intervention project with KAANIB Foundation, Inc (KFI).

The present couple-focused intervention study addresses the issue of male participation in reproductive health by working with KFI. The general objective of this study is to develop and test cost-effective and sustainable strategies to increase male participation in reproductive health activities. The study aims to provide training in Reproductive Health Awareness (RHA) to KFI staff members involved in outreach and community organization activities and to enable them to carry out RHA activities in three contiguous municipalities of northern Bukidnon Province, Mindanao. The project proposes to train all the couples in 12 KFI member organizations in three municipalities in RHA; training modules and other informational materials have been or will be adapted to the Philippine context using the Phase I data. The intervention will also assist KFI to explore the potential for incorporation of RHA concepts and activities into the existing programs directed to its 2,000 members in Bukidnon and Agusan del Sur provinces. It is expected that this intervention study will serve to stimulate men's involvement in, and support for, family planning

(FP) use and other reproductive health (RH) efforts. If this is determined to be a cost-effective strategy for stimulating male interest and participation in the family's reproductive health while also increasing intra-couple communication and egalitarian decision making power, it could serve as a model for other institutions working primarily with men nationally and internationally.

In general, family planning research has focused on women. The male perspective, attitudes and practices have not been considered. Reproductive health programs and research are now increasingly devoting attention to the male partner. It has become clear that women's and couples' reproductive behavior are often determined by the husband. Some of the reasons given for the divergent views of the marital partners include, differing reproductive and family size goals and aspirations (with the husband most often becoming the decider), and absent or poor communication about sexual topics between spouses. The programmatic initiative which this project focuses on is to increase both the husbands' and wives' reproductive health knowledge and to create a process to facilitate their communication about reproductive goals and how to best achieve them. This focus aims to increase men's and women's equal participation and responsibility in determining FP use.

Delivering culturally appropriate couple and male-oriented reproductive health messages and providing more male-friendly services should help increase the demand for family planning services. Greater male willingness to accept responsibility for matters pertaining to reproductive health might also stimulate more demand for male FP methods (condoms and vasectomy). In this context, a cautionary note is appropriate: increasing men's willingness to become an equally responsible family planning user may drive some couples to switch from a more effective female method such as oral contraception, the IUD or DMPA to the less effective condom or abstinence based methods. This in turn may result in an increase in unwanted fertility. Because comparative method effectiveness is one of the principal reasons for users to select their method, it is imperative that the RHA education include clear information about the differing use-effectiveness of all the methods discussed.

The project goal is to use the couple and not only men as their target population. The latter option was considered and discarded because of the possibility that giving men increased knowledge in isolation of women might increase male intra-couple power.

This intervention study has been conceptualized in two phases:

Phase I activities include diagnostic investigations at four levels: (1) community, (2)

service delivery points, (3) KFI organization and staff, and, (4) KFI members and their wives. It also includes the preparation of a detailed intervention strategy and prototype training materials based on data obtained in the diagnostic study.

Phase II includes the implementation of the intervention and the assessment of its effect by means of several follow-up data gathering activities.

The present report is limited to Phase I.

3. The Project Site: Bukidnon Province, Mindanao

Bukidnon is a landlocked province in north central Mindanao. Its economy is dominated by small scale subsistence farming, many farms in poorly accessible upland areas. The standard of living in the study sites, according to the 1990 Census, is quite low. Less than 1/3 of households had electricity, piped water or a water sealed toilet. In contrast, the literacy rate is over 90%. The study sites are all accessible to project workers.

4. The KAANIB Foundation, Inc.

KFI is an NGO established in 1980 that works in Bukidnon and Agusan del Sur provinces of Northern Mindanao. It is well known and respected by residents in general, and members in particular. The Foundation provides technical and production assistance to subsistence farmers and agrarian reform beneficiaries to enable them to establish sustainable diversified farms. Its only health- related activity involves the reduction of dependence on the use of pesticides and safe pesticide management.

KFI is a federation of over 35 independent cooperatives, irrigation associations, marketing groups and agrarian reform beneficiary groups organized at the local level (barangay). The Foundation has 28 staff, mostly male, and a current membership of 2,000, also mostly men, with approximately 40% of them active in one of KFI's programs. In addition to its traditional programs (production, commercialization, organization building and management, etc.), KFI has more recently established a Gender and Development Program funded by Lutheran World Relief focusing on the incorporation of a gender sensitive orientation into all of their services.

KFI's institutional objectives include the following, which have a direct bearing on the RHA project: 1) To help members improve conditions of life and obtain better access to basic

social services; and, 2) To see holistic human development taking place among the members.

5. The Institute for Reproductive Health of Georgetown University (IRH) and the Reproductive Health Awareness (RHA) Approach

In the last two decades the IRH has developed and tested a series of training modules on Fertility Awareness with the objective of helping men, women and couples to practice family planning, including NFP, more effectively. It is of note, that in the 1993 NDS, only 24% of all women interviewed knew the correct timing of fertility in the menstrual cycle and among women using abstinence base methods, only 34% could identify the fertile period correctly.

The IRH works with in-country groups, adapting the generic RHA materials to local needs. Since the Cairo International Conference on Population and Development (ICPD), the IRH has expanded its mandate and incorporates additional reproductive health elements in its modules. Therefore, it has now piloted modules on women's and men's reproductive life cycle stages, reproductive anatomy and physiology, sexuality, gender relations, violence toward women, couple communication, and reproductive morbidities including STDs, etc.

The IRH defines RHA as an educational tool designed to help people learn to observe their own bodies, understand normal changes and know what is healthy and typical for them. It also helps them to think and understand socio-cultural factors that influence reproductive health, communicate appropriately with partners and service providers and make decisions that can have a positive effect on their reproductive health.

6. The Research Institute for Mindanao Culture (RIMCU), Xavier University

The Research Institute for Mindanao Culture was founded in 1957. It is the social science research arm of Xavier University and has conducted 400 locally, nationally and internationally-funded studies. RIMCU has a well-equipped computer laboratory and a field research unit composed of highly trained and experienced field research staff. The Institute has a core of nine research associates, all of whom have considerable experience in research and a long list of publications.

RIMCU was responsible for the development of all research instruments, the collection of data, data analysis and preparation of the final report in consultation with Population Council and

IRH.

Project Objectives

The overall objectives of the project are to design, implement and test an RHA training, education and organizational development intervention with the KAANIB Foundation and their largely male member beneficiaries in selected barangays (villages) of the three municipalities (Impasug-ong, Malaybalay and Valencia) in Bukidnon Province, Mindanao.

The long-term goal of this project is to address the effectiveness of involving men as partners in the Reproductive Health Awareness (RHA) intervention. The study will assess impact on the KFI organization and its members on the basis of indicators such as degree of support for FP use, use of male oriented methods, increased couple communication on family formation matters, etc. The study will address the following questions:

1. Does the RHA pilot program result in the incorporation of an RHA perspective within the Foundation's educational activities and materials, and in the support services provided to its members? More generally, will this perspective be fully institutionalized within the KFI . By the end of the pilot period, will KFI develop plans to replicate this program in other areas where it works?

2. Will the RHA pilot program increase RH/FP knowledge and skills among KFI members and their families, resulting in more positive RH attitudes and improved health seeking behaviors (particularly in the areas of family planning, use of male oriented methods, etc.)?

3. Will the RHA pilot program have an impact on the health services being offered by the LGUs in the villages where the intervention will be implemented?

The specific objectives of Phase I were to:

1. Collect baseline information on the three study communities (health facilities and services, and community institutions);

2. Gather information on the activities, structure and group processes associated with KAANIB;

3. Study the knowledge, attitudes and practice of KFI members and their wives (or husbands) regarding reproductive health-related issues and other relevant household and individual level information (e.g., gender relations, male involvement in fertility and FP matters, health-related behaviors, etc.); and

4. Develop an intervention plan using educational modules that have been adapted to suit the needs of the community through a systematic analysis of the baseline data.

OVERALL PROJECT DESIGN

This study consists of two phases: Phase I (May 1997 to January 1998) consists of a diagnostic operations research (OR) study intended to be the baseline for the development of a culturally sensitive RHA intervention design, and the design itself. The intervention focuses on educational and promotional activities using RHA modules based on the findings and recommendations resulting from analysis of the baseline data. Baseline information was collected on the health services available in the three study communities; the activities, structure and processes associated with KAANIB; and relevant household and individual level information (e.g., knowledge, attitudes and practices, gender relations and male involvement in fertility and FP matters, health-related behaviors, etc.).

Phase II will consist of the training intervention. The subjects for the training will include KAANIB members and their spouses, KAANIB administrative and technical staff and service providers in the area. Comparative panel-type data on all of the above levels of analysis (i.e., study communities, KAANIB, households and individuals) will be collected to identify the changes brought about by the intervention.

Phase I was funded by the Population Council through its ANE OR/TA Project. Phase II funding has been guaranteed by IRH, with possible funding from the Population Council (FRONTIERS Project) for the evaluation component.

In all, four major activities were completed during Phase I:

(1) a husband-wife study of all KFI members in the selected barangays (both experimental and control groups);

(2) a descriptive analysis of the roles, functions and activities of KFI extension workers, and the structure and operations of the KAANIB Foundation;

(3) a community level analysis of locally-based institutions, organizations and services found within the study areas; and

(4) the development of a proposed RHA intervention strategy based upon the results of the Phase I analysis and a joint planning process involving all of the collaborating organizations.

The overall research design selected for this study is a pretest-post-test, control group design. During Phase I, baseline data were first collected in both of the study areas and a corresponding group of matched control areas. The intervention will be introduced during Phase II of the project. Post-tests will also be carried out during Phase II with the same project beneficiaries who were interviewed during the pretest in order to assess changes, if any, which occurred during the course of the project. Post-tests will also be conducted in the control areas so that comparative analysis of changes on selected indicators in the experimental and control communities can be accounted for by the intervention.

Control barangays were selected from three municipalities: Malaybalay, Maramag and Valencia. These areas were matched with the study areas for at least three major criteria: barangay population size, farming system type and income classification. A one hundred percent sample of all beneficiary couples belonging to four KAANIB affiliates in the nine experimental barangays was selected for interviews. A total of 220 couples and 226 wives were interviewed. A total of 250 couples from the control barangays were interviewed using the same set of questions for interviewing couples from the experimental areas.

METHODOLOGY (PHASE I)

The diagnostic study was carried out in three selected municipalities of northern Bukidnon: Malaybalay, Impasug-ong and Valencia. Malaybalay is the largest town in Bukidnon and also serves as the provincial capital. It also contains several very large barangays (villages) which are basically rural in character.

The following series of data collection activities were undertaken during Phase I of the study (interview instruments are submitted in this report as Annex I and Annex II):

1) A **descriptive institutional survey** of the three municipalities was developed. The survey was conducted by means of semi-structured interviews of key informants living in Malaybalay, Valencia and Impasug-ong.

2) An **inventory of maternal and child health and reproductive health services** offered in the pilot LGUs was assembled. It also documented the physical structure, equipment, specific services offered and hours of operation. To gather this information, a special set of questionnaires designed, developed and tested by the Population Council were used.

3) A **descriptive study of KFI**. The purpose of this study was to collect information about KFI workers' roles, functions and activities. This information was used to design the intervention so that it could be incorporated by KFI into its ongoing activities. An English questionnaire was developed and pre-tested for this purpose and sixteen KFI employees were interviewed.

4) A **community survey**. All married couples, (wherein the wives were between 15 to 49 years of age) member-beneficiaries of KFI in the communities covered by the study, were interviewed. Husbands and wives were interviewed separately. A total of 220 couples were interviewed, all of whom are presently enrolled as active member-beneficiaries in KFI sub-associations operating in Impasug-ong, Malaybalay and Valencia.

5) Three **focus group discussions** (FGDs) were arranged with member beneficiaries in the three sample municipalities on issues pertaining to the proposed intervention. The facilitators used a standard set of FGD guides for each group of participants. The FGDs were conducted in the local language, Bisayan. Transcripts of the discussions were subsequently translated into English.

To conduct the community survey, two separate structured interview instruments were developed in English, one for the husbands and another for the wives. These were translated into Bisayan and pre-tested in the field after which the interview schedule was revised and finalized. A listing of KAANIB-assisted cooperative members was obtained from the KAANIB office. From the listing, the names of currently married members were culled out. They constitute the survey respondents for this study. The respondents are married couples currently living together in which the wives are between 15 to 49 years of age. The husbands and wives were interviewed separately. To prevent one partner influencing the other partner's responses, no one was allowed to listen in on their partner's interview. Interviewers were hired and trained for this purpose. Most of the husbands were interviewed by two male nurses and the wives were interviewed by female nurses. The data collection was supervised by two female supervisors of the Research Institute for Mindanao Culture.

Husbands and wives were asked questions about their knowledge, attitudes and practices relating to FP and reproductive health; male and female fertility as well as about RTIs and HIV/AIDS; awareness about the relationship between reproductive patterns and overall levels of maternal and child health; local views on human reproduction; methods of family planning; reproductive goals; child care beliefs and activities; family health problems and needs; health services utilized and general health-seeking behavior; domestic violence; husband-wife communication and perceived appropriate sex roles. Similar questions were also asked to the wife so that her answers could be compared to those given by her husband.

The completed interviews were edited in the field before submission to RIMCU for processing. The forms were reviewed and errors corrected in the field by revisiting the respondent. Corrections were made directly on the forms whenever necessary based on the verification and revisit interviews. The responses were coded at RIMCU using a coding manual developed specifically for this study. Data processing was done using the computer facilities of RIMCU. Data analysis was accomplished using the SPSS package.

FINDINGS

1. Community Survey: Husbands' and Wives' Interviews

A total of 226 couple members were identified for interviews in the intervention barangays and 250 in the control barangays. In the intervention group, 220 interviews were completed for husbands and 226 for wives. The data presented here reflects these interviews. Data from the control group couples' interviews were also processed and analyzed but are not shown in this report. Basic socio-demographic and health variables show great similarity between the two groups. This is also true for the results of the survey.

A. *Respondents' profiles:*

Age: As expected, wives were younger as a group than their husbands. In the reproductive risk age groups; there were 6 wives (2.7%) and only one husband under 20 years old and 94 (41.6%) wives between the ages of 36 and 49. These women, together with those with children under 24 months of age need to have special attention and information about the importance, for them and their children, of avoiding high risk pregnancies.

Table 1. Age of Respondents

Age Groups	Husband (%)	Wife (%)
Less than 20 years	0.4	2.7
20 - 35 years	46.0	55.8
36 -49 years	47.8	41.6
50 and over	5.8	-

Education: In Philippine agricultural populations women are usually more educated than men, which is also the case in this study. In this group, however, 8.8% of the wives and 16.8% of the husbands have less than five years of basic education; this group may need special attention as they may be found to have low functional literacy levels.

Table 2. Highest Grade Completed by Respondents

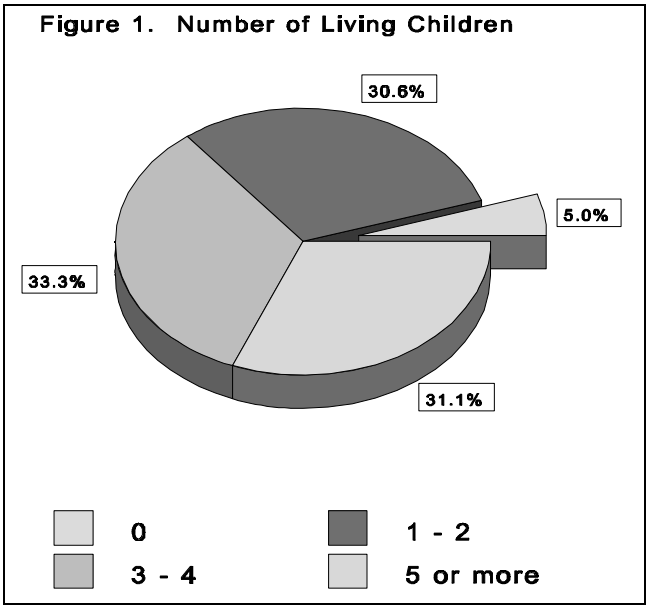
Educational Attainment	Husband (%)	Wife (%)
Less than five years	16.8	8.8
5 - 6 years	34.5	37.2
High School	38.1	40.3
College	10.6	13.7

Income generation: As expected from the profile of the typical KFI member, most of the husbands (83.2%) are engaged in income generating work, generally farming occupations: farm owners, part owners and managers. Half the wives (54%) are also involved in family income generation, mostly working as farm laborers and/or in backyard gardening production.

B. *Reproductive history-wives*:

Among the wives interviewed:

- Five (2.3%) have never been pregnant
- Seventeen (7.8%) were pregnant at the time of the survey, with 3 (1.4%) who were pregnant for the first time
- Two hundred eleven (96.3%) have had one or more completed pregnancies
- Forty-six (21%) have experienced one or more child deaths



As expected, a very high proportion of couples have children. It also appears, from

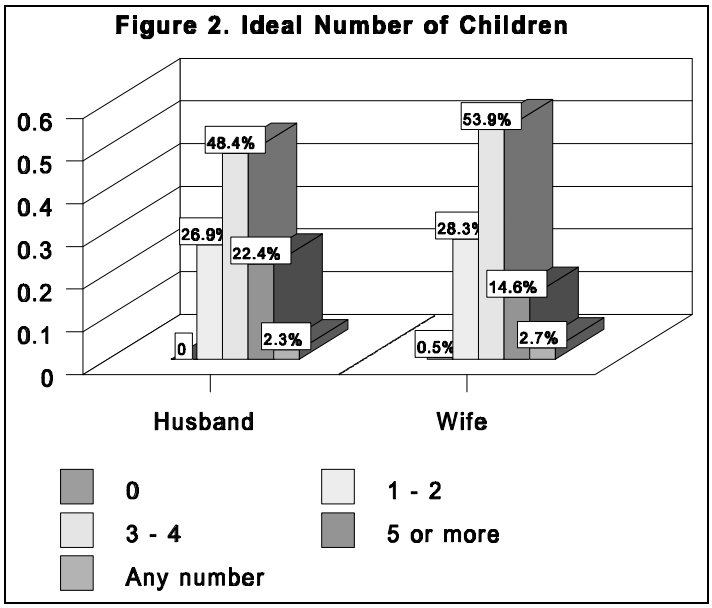
these data, that the child mortality experience in this group of farming families is quite high.

When we looked at the number of living children in the group of wives, 68 (31.1%) of them had 5 or more living children and 73 (33.3%) had 3 or four. Again, as in the discussion on the ages of the wives, this group of women are at varied levels of reproductive risk, and those at risk need special attention.

C. Reproductive intentions and contraceptive practices:

In this section we report on husbands and wives:

1. Stated ideal family size and actual family size,
2. Reproductive intentions: whether to have another child and if so when,
3. How many more children are wanted and,
4. If they could choose, what sex they would prefer their next child to be.



For those who wished to delay or prevent future pregnancies, we examined:

1. Contraceptive status as an indirect approximation of family planning need;
2. Method used at present (both modern and traditional); and,
3. Reasons for non-use of a method.

Ideal family size and actual family size:

When asked about their ideal family size, three out of four respondents, both husbands and

wives, said that 4 was their ideal number of children. However, 22.4% of husbands and 14.6% of wives said that 5 or more children were ideal.

The number of respondents who said they had more children than their stated ideal included 18.7% of the husbands and 23.7% of the wives. These figures are likely to represent an under-reporting as some people may not admit that some of their existing children were not wanted. The higher percentage among wives than husbands may be a reflection of this sensibility. These figures give us a hint that there is, within KFI members, significant unmet need for family planning.

Reproductive goals: to have more children soon, have them later or not to have more children:

When we asked about reproductive intentions (to have a child soon, to delay the next pregnancy or to have no more children), two thirds (66.4%) of wives and 57.7% of husbands interviewed said they desire no more children. In addition, 28.3% of husbands and 19.2% of wives stated that they wish to delay the next pregnancy. These two groups together amount to 85% of both husbands and wives who do not wish to become pregnant.

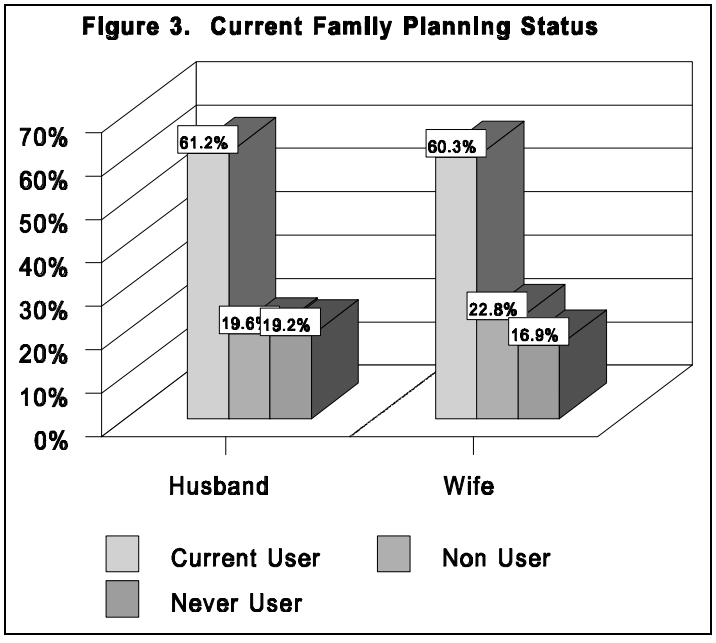
Of the wives who wish not to become pregnant and were not pregnant at the time of the interview, 69.1% said they were using a family planning method and 30.9% said they were not. These findings, wives not wishing to get pregnant but not using a method, are an indicator of unmet need.

Table 3. Desire for Further Pregnancies by Family Planning Status

	Percentage	FP Status
Reported by Husband:		
Wants child soon	14.2	
Wants to delay	28.3	Current user : 67.6% Non-user : 32.4%
Wants no more	57.5	
Reported by Wife:		
Wants child soon	14.2	
Wants to delay	19.2	Current user : 69.1% Non-user : 30.9
Wants no more	66.7	

Family planning status: using now, used in past but not using now, never used

Almost two thirds of respondents (60.3% of wives and 61.2% of husbands) stated they were using a family planning method at the time of the survey. Of the wives, 18.2% were using traditional methods (rhythm and withdrawal) and 42% modern methods.



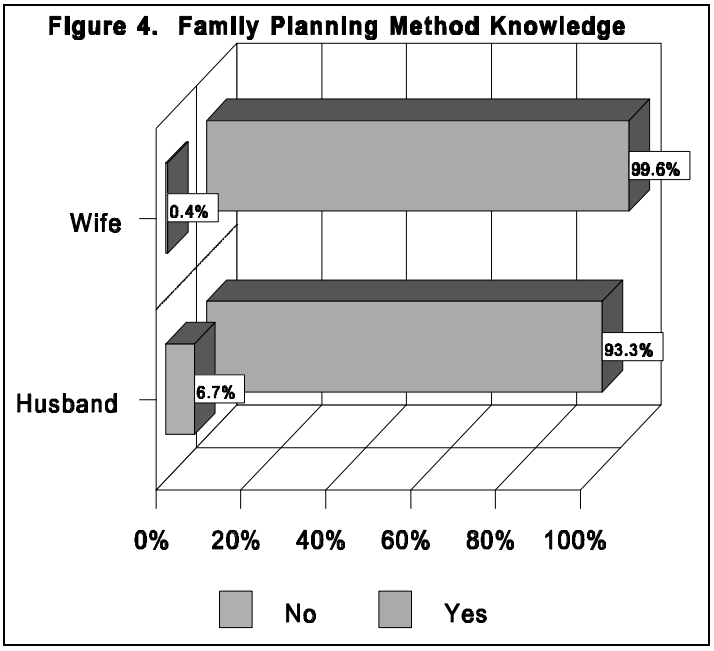
The contraceptive prevalence in this group of farming couples is higher than that recorded in the 1997 National Family Planning Survey (CPR= 47% with 30.9% use of modern methods and 16.1% traditional methods). In Northern Mindanao, (where Bukidnon Province is located) the proportion of users was higher than the country as a whole

(59.8%) with 40.7% modern method users and 19.1% traditional method users. In the present survey, the use of modern methods among KFI farmer beneficiaries in Bukidnon is slightly higher than the figure reported in the 1997 National Survey for Northern Mindanao (42% vs. 40.7%). The same is true for traditional methods (19.1% vs. 16.1%). The higher figures derived by the study could be explained by the fact that Bukidnon is a largely rural and agricultural province compared to the other provinces in Region X (Northern Mindanao).

One fifth of the respondents (19.6% of the husbands and 22.8% of the wives) stated that they had used a method in the past but were not presently using any method and 19.2% of husbands and 16.9% wives said they had never used a method.

Knowledge of family planning methods

Over 90% of respondents, both husbands and wives, stated they know about family planning methods. This figure agrees with national statistics which show that a very high proportion of women surveyed are able to mention several methods. The husbands were more likely to mention pills, IUDs and condoms; the wives were more likely to mention pills, IUDs, injectables, rhythm and condoms. Fewer respondents identified permanent methods.



When we asked if they knew how to use the methods mentioned, more than 3/4 of respondents said yes.

For users: Family planning method used

There is little disagreement between the number of husbands and wives reporting individual method use, except in the case of withdrawal in which 9.6% of husbands said they were

using this method while only 5.2% of wives reported its use. The use of male modern methods is remarkably low (3.7% condoms and 0% vasectomy) as it is in the 1997 national statistics (condom 1.7% and vasectomy less than 1%).

When we matched couples' responses on methods used, we obtained the results shown below. There is a good, even if not perfect, match between what method was reported by the wives and their husbands for IUD, condoms, withdrawal, DMPA and female sterilization. There were 41 women who said they were using pills but only 36 of their husbands appear to have known this. Is this a case of covert use of contraception or merely lack of communication? The most disturbing finding on this matter was the case of rhythm and of NFP: only 13 husbands of the 30 wives who stated they were using the former and 2 husbands of the 5 women who reported using NFP said they were using the method reported by the wife. Since these methods depend on perfect understanding between spouses to be effective, these findings can be taken as predictors of future unplanned and unwanted pregnancies.

Table 4. Husbands and Wives' Reported Method Use and Matched Couple Responses

FP Method	Wife's Report	Percent of their husbands who reported use of same method	Husband's Report
Pill	41 (29.9)	36 (87.8)	38 (27.1)
IUD	25 (18.2)	25 (100.0)	26 (18.6)
Condom	5 (3.6)	3 (60.0)	5 (3.6)
Withdrawal	7 (5.1)	5 (71.4)	15 (10.7)
Abstinence	2 (1.5)	0 (0)	0 (0)
DMPA	6 (4.4)	6 (100.0)	7 (5.0)
Rhythm	30 (21.9)	13 (43.3)	27 (19.3)
NFP	5 (3.6)	2 (40.0)	6 (4.3)
Ligation	15 (10.9)	15 (100.0)	15 (10.7)
Others	1 (0.7)	0 (0)	1 (0.7)
Total	137 (100.0)		140 (100.0)

For users: Percent of modern methods vs. traditional methods used

Among users, 72% of wives and 70.5% of husbands reported using a modern method (pills, IUD, DMPA, condoms, modern NFP, and female sterilization). Rhythm or calendar method accounted for approximately 2/3 of traditional method use.

For non users, reasons for non-use:

The most common reason given by husbands for not using contraception was the desire for a pregnancy soon (42.4%) . However, only 15% of wives said that was the reason for not using family planning. Again, we see large differences in the spouses as to their reproductive intention. The second most frequent reason given, is one classified under: "no more need to practice". This category included such explanations as: *already old when I got married, I do not get pregnant easily, just had a miscarriage, just had an operation for an ectopic pregnancy, just gave birth, postpartum amenorrhea/currently breastfeeding, no sexual contact due to husband's accident, seldom menstruate/menstruation is irregular, before I can get pregnant I have to see a hilot (a traditional birth attendant) or a doctor and previous method failed.* Some of these reasons, including having had a recent miscarriage or operation for an ectopic pregnancy, having irregular menstruations and previous method failed, are not technically valid reasons for not using contraception. It is not known if the 2 women who stated they were breast-feeding and amenorrheic were breast-feeding exclusively and were earlier than 6 months postpartum; if one of these conditions was not fulfilled, they were at risk for pregnancy.

Twenty percent of wives stated that the reason for not using FP is that it is too expensive. Most of them were never users who know that contraceptives are quite expensive in pharmacies and may not know they are available free of charge in the Health Centers. The implication of this finding is that there needs to be more information given to the community regarding availability of services and family planning supplies in the Health Centers. Another implied cost of contraception may be related to the cost of transportation, of time away from economically productive work, etc.

Another frequent reason, accounting for between 20 and 30% of non users, was health related concerns: either having experienced side-effects or fearing untoward health consequences if a method is used. The question of health related concerns is a known cause for discontinuation and non use of contraception in the face of need. This must be explicitly addressed in Phase II of

the project: not minimizing the occurrence of side- effects and how they may affect women's daily lives, but explaining their significance and how they may be managed, their low level health consequences and putting them in perspective in comparison with an unwanted or risky pregnancy.

Table 5.-- Reasons for Not Using Family Planning

Reasons for not using family planning	Husband	Wife
Irregularity/unavailability of supplies	1.2	
Learning Difficulty	2.4	
Wants another child	42.4	14.9
Too much trouble to practice	1.2	1.2
Spouse/I felt side effects	9.4	12.6
Afraid of side effects	3.5	6.9
Sterile		1.2
No more need to practice	25.9	26.4
I/spouse have some other objections	9.4	10.3
Too expensive		20.7
Religious reason	3.5	1.2
Other health reasons	1.2	4.6
Total	N = 85	N = 87

"*Unprepared*" *for a pregnancy in the past; attitudes and practices when this occurs:*

One half of the wives and fewer husbands stated they had not been ready for one of their previous pregnancies.

Table 6. Did couple Ever Experience Not Being Ready for Wife's Pregnancy

Ready for wife's pregnancy?	Husband (%)	Wife (%)
Yes	37.7	48.7
No	62.3	51.3
Total	100.0	100.0

When asked what a couple should do in the face of a pregnancy which they were not prepared for, almost all respondents said that they should continue the pregnancy and prepare for delivery.

Table 7. Best Thing To Do When couples are Not Ready for the Pregnancy

Best thing to do when not ready for pregnancy	Husband %	Wife %
Continue pregnancy/prepare for delivery	97.3	97.3
Abort baby/consult doctor on ways of discontinuing pregnancy	0.9	0.9
Don't know	1.4	
Blame husband	0.4	
No response		1.8
Total	100.0	100.0

When asked directly if they had ever attempted to stop a pregnancy, 4% of husbands and 7% of wives said they had.

D. Reproductive health knowledge:

Knowledge of female and male reproductive organs and their functions:

Both husbands and wives lacked knowledge about reproductive organs. In addition, the interviewers noted discomfort on the part of the responders with questions on reproductive anatomy. Some "just kept silent" and refused to discuss these despite assurances that their replies would be kept strictly confidential. There were also respondents who referred to the vagina and penis by their popular names: Flower, Toy and Bird.

When asked to name female reproductive organs 3/4 of the husbands and wives were able to identify the vagina but only 50% of wives and 40% of husbands named the uterus. "Stomach" was mentioned by 10% of men and 18% of women; perhaps, for some respondents, this term is a surrogate for uterus, as technical names tended to be avoided. Interestingly, 20% of both men and women identified the breast as a reproductive organ. The Fallopian tubes were only identified by 2.3% of men and 5.3% of women.

Table 8. Female reproductive organs named by respondents

Reproductive organs named	Husband	Wife
Uterus	40.5	50.0
Vagina	73.6	77.5
Egg cells	7.8	6.2
Ovary	6.4	10.6
Stomach	9.6	18.1
Breast	20.5	23.1
Fallopian tube	2.3	5.3
No response	7.7	3.1
	N=220	N=226

Over 90% of both husbands and wives said they knew the function of the female

reproductive organs; functions mentioned reflect both correct and incorrect knowledge:

A. Uterus

* Organ where the fetus develops
* Depository of the egg cells
* Organ that produces the egg cells

B. Vagina

* For sexual intercourse
* Where the sperm passes
* Passage for the baby

C. Egg cells

* will develop into a fetus
* will be fertilized by the sperm
* produces the egg cells

D. Ovary

* where the fetus develops
* where the fetus stays until delivery
* develops the egg cells/allows the egg cells to mature

E. Stomach

* resting place of the baby
* place for food
* where the fetus develops

F. Breast

* to feed the baby/provides food
* sexual function

G. Fallopian Tube

* meeting place of the sperm and egg cells
* where the fetus develops

When asked about male reproductive organs, the penis was the only organ mentioned by a great majority of respondents. Both males and females mentioned the sperm cells and testes, but in much smaller numbers.

Table 9. Male Reproductive Organs Identified by Respondents

Reproductive Organs named	Husband	Wife
Penis	84.6	83.1
Sperm Cells	24.9	34.4
Testes	11.4	8.4
Scrotum		0.4
No response	6.4	3.1
	N=220	N=226

Table 10. Self-reported Knowledge of the Functions of Male Reproductive Organs

Self-reported knowledge	Husband	Wife
Yes, all of them	93.6	96.5
Yes, some of them		
No		0.4
NA	6.4	3.1
Total	100.0	100.0

The functions of the male reproductive organs that were mentioned, include:

A. Penis
    * for sexual intercourse
    * to ejaculate the sperm
    * produces the sperm cells

B. Sperm Cells
    * will develop into a fetus
    * will fertilize the egg cells

C. Testes
    * factory of sperm cells
    * for urinating

D. Scrotum
    * depository of the sperm cells

These findings: low knowledge levels on reproductive anatomy and physiology, need to be addressed in educational interventions, as included in Phase II of this project. Improving knowledge on where and how pregnancy occurs, how to prevent it when one wishes to, and the site and mechanism of action of the various contraceptive methods will assist them in making truly informed choices on whether to use contraception and, if so, which method to use.

Knowledge of when young women initiate fertility:

Although there was fairly high levels of confidence expressed by both men and women about their knowledge of when a woman first becomes fertile (68% of men and 82% of women stated they knew when this occurred) only 21.8% of the men and 29.7% of the women mentioned the first menstruation as that time. The rest of the respondents mentioned a specific age.

Recognition of fertility period within the menstrual cycle:

It is important to note that 22.3% of men and 25% of women claimed they are using a

fertility awareness based method, including NFP and rhythm. Of the respondents who said they use these methods, 74.3% of the wives and 68.6% of the husbands claimed they know how to determine fertility time within the cycle. In fact, none of this group identified the fertile times correctly. Therefore, it is likely that they are using their method incorrectly as were most of the Philippine couples using these methods during the 1993 NDS. The extremely high failure rates consistently reported for periodic abstinence dependent methods (47% of users in the 1993 NDS discontinued due to pregnancy) are a result of lack of knowledge and a false sense of security that users have in their ability to use their method accurately.

When all respondents are taken into account, 59% of wives and 49% of husbands claimed they know when, in the menstrual cycle, a woman is more likely to conceive. However, when asked to identify when the woman is fertile, not a single respondent mentioned a time between menstruations. Most of them, 74% of men and 56% of women, identified just after menstruation as the time of fertility. Many simply replied "fertile period".

It is the couples who used periodic abstinence methods who most need to know how to determine when a woman is fertile; we note that although a large percentage of them claim this knowledge, in reality they do not have it.

Table 11. Distribution of What Respondents Know About a Woman's Fertile Period

Knowledge about woman's fertile period	Husband	Wife
After menstruation	74.0	56.0
Fertile period	19.3	34.0
Before menstruation	2.9	1.8
During menstruation	2.9	1.8
Presence of white blood in the vulva	1.0	6.4
Total	100.0	100.0

When asked how to count the duration of the menstrual cycle, there were many answers, mostly incorrect. In addition, most respondents did not know the length of their own cycles. Some probably interpreted cycle length as the duration of menstruation as they reported their cycle was 2 to 9 days long.

Table 12. Method of counting a Woman's Menstrual Cycle

Method of counting menstrual cycle	Husband %	Wife %
Start counting from the onset of menstruation up to the last day before the next menstruation	43.9	41.7
Every month the woman must have her menstruation, there is no fixed date	2.4	2.2
Start counting from the onset of menstruation and count 21-28 days more depending on the woman's experience	9.8	6.5
Start counting after the last day of menstruation and count 15-21 days more depending on the woman's experience	1.2	2.2
Start counting from the onset of menstruation up to the last day of menstruation	22.0	41.0
Every month, the date of the next menstruation will always be earlier than the previous	4.9	4.3
Woman must menstruate two weeks after the end of the previous menstruation		1.4
Other answers	15.9	0.7
Total	100.0	100.0
	n=82	n=139

Source of information on fertility:

Most respondents reported that they learned about a woman's fertility from seminars and lectures. Asked about the source of their information, 15% of husbands and 29% of wives reported they received it from health providers: either midwives, BHWs or doctors. Health providers may not know and/or may not give complete information about the menstrual cycle, how to count its days and indicators of fertility within it. It is important to insure their knowledge about fertility and fertility awareness based methods before they can teach these topics to couples. Also, adult education methodology instead of lectures and seminars, ought to be used for training.

It is of note that 23% of husbands said they obtained fertility information from their wives; but what if the wife has the wrong information? In any event, these data show that for some couples, communication on sexual matters does take place, even if the wrong information is

passed from one spouse to the other.

Table 13. Reported Source of Knowledge Regarding a Woman's Fertile Days

Source of knowledge	Husband %	Wife %
Wife	23.4	0.7
Midwife/BHW/Doctor	15.0	29.1
Myself/from own observation	7.5	14.9
Seminar/school/lectures/church	37.4	35.8
Pamphlets	1.9	
Friends/relatives/neighbors	13.1	17.9
Radio/books	1.9	1.5
Total	100.0	100.0
	n=107	n=134

Knowledge and attitudes regarding obstetric care:

Husbands and wives were asked to rate the importance of a series of pregnancy care items on a list. Both husbands and wives rated having a medical check-up with a midwife during pregnancy as "Very important" and delivering in a hospital or medical clinic as "Important". Filipino practices in this regard are somewhat contradictory. The respondents were not asked whether they had prenatal care and who assisted them in their last delivery. But the Philippines National Safe Motherhood Survey (1993) reported that a large proportion of pregnant women attend clinics for prenatal care but approximately 50% of births are attended by a hilot (traditional birth attendant)**.** Another item asked in the present survey was about the importance of postpartum exams: both husband and wife stated that this is "important"; however, only 40% of women seek postpartum exams, according to the 1993 Philippines National Safe Motherhood Survey.

Table 14. Degree of importance of doing certain activities and reminders during pregnancy by group of respondents

Reminders	Husband	Wife
Have a medical checkup with a midwife while she is still pregnant	Very important	Very important
Be massaged by a hilot to straighten the uterus	Very important	Important
Be told not to eat salty foods	Important	Important
Get some exercise by taking a walk in the morning with her husband	Important	Important
Have the baby delivered by a modern practitioner like a doctor, nurse or midwife	Important	Important
Have the baby delivered in a hospital or medical clinic	Important	Important
Have a medical checkup soon after the birth with a doctor or midwife	Important	Important
Be accompanied by her husband whenever she has a medical consultation about her pregnancy	Important	Important
Stop doing difficult work in the house or on the farm	Important	Important
Stop having sexual relations with her husband two months before and one month after birth	Important	Important

Knowledge of reproductive risk factors:

The respondents had low levels of knowledge of reproductive risks for women, except for advanced maternal age. This risk was correctly identified by 57.5% of husbands and 58.3% of wives.

Table 15. Period when it is not healthy for a woman to have a baby (multiple answers)

Period when it is not healthy to have a baby	Husband %	Wife %
She has just had a baby	3.8	2.6
Too young/less than 20 years old	0.9	7.1
Too old/more than 35 years old	54.7	57.7
More than four children	16.0	17.3
She had undergone a caesarian operation	17.0	12.8
She is sickly	12.3	17.9
She has problems with her reproductive organs especially the uterus	10.4	3.8
	N=106	N=156

This information is important especially in the case where a risk factor is modifiable by time, as in the case of too closely spaced births. Too young maternal age, also modifiable by time, being a tradition-determined behavior, may be much more difficult to address. Nonetheless, it should not be avoided in community education interventions.

Knowledge of STDs: symptoms, transmission, prevention:

A nationwide information campaign has been executed by the government of the Philippines and other concerned groups on Sexually Transmitted Disease (STDs) and HIV/AIDS prevention. We found there are still couples not reached by the campaign. Twenty percent of the husbands and 12% of the wives stated they did not know that there are diseases which can be transmitted and acquired by sexual intercourse. A larger number denied knowing any common STD symptoms.

Table 16. Ever Heard or Read About Some Common Signs and Symptoms of Sexually Transmitted Diseases

	Husband %	Wife %
Yes	65.5	62.1
No	34.5	37.9
Total	100.0	100.0
	n=177	n=198

When asked to mention some common signs and symptoms and whether they had experienced any of these, most respondents were not able to do so.

Table 17. Common Signs and Symptoms of Sexually Transmitted Diseases known and experienced

Common signs and symptoms of STDs known and experienced	Husband		Wife	
	Symptoms Known	Symptoms Experienced	Symptoms Known	Symptoms Experienced
Abnormal vaginal discharge	1.7		2.5	
Abnormal vaginal bleeding	5.1		3.5	
Genital itching	16.4	1.1	21.2	1.5
Lesions/sores in the genital area	15.3		15.7	
Lower abdominal pain	11.9	0.6	7.6	
Pain during intercourse	1.1		1.5	1.0
Painful urination	14.7		13.6	
Abnormal growth in the genital area(warts)	2.8	1.1	4.0	
Urethral discharge	9.0	0.6	2.5	0.5
Diarrhea of long duration	0.6			
Urinary disorders	1.1		3.5	
Swelling of the testes	1.7		0.5	
Fever of long duration	1.1		3.0	0.5
Cough/asthma	0.6		1.5	
Pain in the genital area	1.1		1.0	
Dry skin	1.7	1.7	3.0	1.0
Yellowish/reddish eyes and skin	2.3		1.5	
Skin diseases/skin irritations	3.4		2.0	
Pain in the prostate			1.0	
Crab lice	1.7	0.6		
Person becomes aggressive			1.5	
Person is irritable	1.1		0.5	
Weakness	6.2		6.6	

Paleness	7.3		6.6	
Loss of weight	18.1		16.2	
	n=177		n=198	

On the question of whether they had ever experienced any of the symptoms and signs they mentioned, a minimal number of respondents asserted they had. This is not surprising considering how few respondents, unprompted, had actually identified these symptoms.

Knowledge of HIV/AIDS: how transmitted, how prevented:

Respondents' level of awareness is much higher for HIV/AIDS than that for STDs. Only 3% of the husbands and 1% of the wives stated they had never heard about HIV/AIDS.

When asked if they could name some transmission modes, 13% of both husbands and wives, could not identify any. The responses of the remaining 87% are presented in the following table. Although over 80% of respondents identified sexual intercourse and only 9% identified blood transfusion as modes of transmission, it's apparent there is significant misinformation about this topic, particularly with regards to behaviors such as sharing utensils, using the same furniture, etc.

Table 18. Ways People Get Infected with HIV/AIDS

Ways HIV/AIDS get transmitted	Husband %	Wife %
Sexual intercourse	84.1	83.4
Sharing of personal items	4.2	6.3
Blood transfusion	8.9	9.9
Sharing utensils with an infected person	0.9	
Use of same furniture like chairs	7.0	8.5
Wearing used clothing (ukay-ukay)	0.9	1.8
Getting it from public places like restaurants	1.4	0.9
Mosquito bites	0.5	0.5
Getting near infected persons	0.5	0.9
Mother to baby	0.9	0.5
No response	13.6	13.5
	n=214	n=223

When asked if they knew how to prevent getting AIDS, 77% of husbands and 80% of wives stated they knew this. Although many were able to identify certain behaviors correctly, condom use was only mentioned by 1.2% of husbands and 4.4% of wives. Also, about 1 out of 5 respondents of both sexes said that to prevent getting AIDS one should "avoid person with AIDS or infected persons". It is not clear if what they meant was avoid sexual intercourse or avoid socialization.

Table 19. Ways of Protecting Oneself from Sexually Transmitted Diseases including HIV/AIDS

Ways to protect oneself from contracting STDs	Husband %	Wife %
Stay faithful to your spouse/partner	71.8	58.0
Encourage spouse/partner to remain faithful	7.1	20.4
Use condoms	1.2	4.4
Avoid sharing needles, etc.	4.1	8.8
Have husband checked regularly	1.2	1.7
Be sure ukay-ukay is very clean	0.6	
Have the woman checked before sexual intercourse	0.6	0.6
Properly screen blood donors		1.7
Use own kitchen utensils	0.6	
Avoid person with AIDS/infected persons	21.8	18.8
Avoid sex with commercial sex workers	21.2	16.6
Put commercial sex workers to prison		0.6
Cleanliness	2.9	3.3
	n=170	n=181

We conclude that there is still ample room for IEC activities to address the prevalent misinformation and absence of information about STDs and HIV/AIDS: what these diseases are, their modes of transmission, signs and symptoms, their prevention, the use of condoms, and the importance of seeking services if they occur, etc.

E. Husband-wife communication and decision making power

Communication on reproductive intentions:

When we matched couples for the same reproductive intentions, we noted a significant discordance between what the husbands and wives wished. For example, among the 31 husbands who said they wish to have a child soon, only 18 (58.1%)of their wives were of the same opinion and 6 wives wished no more children. Of the 126 husbands who want no more children, 112 (88.9%) of their wives had the same desire. This finding points to either lack of communication between spouses, or, if communication on this subject took place, that no consensus was reached. We shall see in the section on Communication and Decision Making Power (below), that when there is disagreement between spouses, it is the husband's opinion which prevails most often.

Table 20. Matched Responses of Couples by Reproductive Intentions

Husband	**Wife**			**Total**
	Wants child soon	**Wants to delay**	**Wants no more**	
Wants child soon	**18 (58.1%)**	8	5	31
Wants to delay	7	**26 (41.9%)**	29	62
Wants no more	6	8	**112 (88.9%)**	126
Total	31	42	146	219

Communication on fertility matters: sex preference for the next child:

When asked if they wished the next child to be a boy or a girl, there were minor discrepancies between the percentage of husbands and of wives who wished for a boy, but more wives than husbands tended to want a girl. More husbands on the other hand said the sex of the next child did not matter to them.

Table 21. Preferred Sex of Next Child

Sex of child preferred	Husband		Wife	
	Husband's reply	As reported by wife	Wife's reply	As reported by husband
Boy	40.9	40.4	36.8	37.2
Girl	23.7	31.9	38.2	32.6
Doesn't matter	35.5	27.7	25.0	30.2
Total	100.0	100.0	100.0	100.0
	n=93	n=94	n=76	n=86

Communication on fertility matters: Was the last pregnancy planned?

When asked if the last pregnancy was planned, 175 (80%) husbands and 144 (65.5%) wives stated their last pregnancy was planned. When couples were matched for this question, of the 175 husbands, 132 wives said they had and 43 said they had not planned the pregnancy. On the other hand, 132 husbands of 144 wives who stated the pregnancy was planned, agreed with their wives and 12 did not.

Table 22. Did Couple Plan Last Pregnancy? Matched Couple Responses

	Husband response	His wife's reply	Wife response	Her husband's reply
Planned last pregnancy?				
Yes	175	Yes: 132 No : 43	144	Yes: 132 No : 12
No	31		62	
Did couple actually talked about having a baby even before wife became pregnant?				
Yes	175		144	
Were the two of you in agreement?				
Yes, both wanted	174	Yes: 129	142	Yes :129
Husband wanted, wife did not	1		2	

Communication on fertility matters: Husband-wife actually talked about having another child:

The same respondents who said they had planned their last pregnancy (see above) said they had

Communication on fertility matters: Husband-wife agreement on next pregnancy:

When asked if the two spouses had agreed on having or not having the next pregnancy, 174 of the 175 husbands said they had talked about this with their wives and said there was agreement; 142 out of 144 wives also said there was agreement. However, when the couples were matched, only 129 of them matched for agreement.

From these findings we may conclude that most couples may be planning their families and discussing this before pregnancy occurs. However, this apparent openess appears to be voiced more by husbands than by wives. This may point to some communication gaps even among couples where the husband appears to be open to discussing fertility matters with his wife.

Communication about pain with intercourse:

When wives were asked if they experienced pain during intercourse and if so, how often, 8 replied they “always” did and 18 that they “usually” did. More wives said they had pain "sometimes" or did not have pain. One of the husbands of the 8 women who stated that they “always” have pain during intercourse said he thought his wife had pain, but only “sometimes”; the other 7 denied knowing about their wife’s pain. Of the 18 women who stated they “usually” had pain, the husbands all denied knowing about this. This finding may indicate that many women believe pain during intercourse is normal and therefore do not communicate this problem to their husband. Another possibility is that this group of women do not wish to have intercourse but they are afraid of their husband, and they are unable to tell him that intercourse is painful. A third possible explanation is that for some women, intercourse takes place exclusively under the husband’s initiative, with little foreplay, giving the wife no chance to become lubricated.

Communication on family matters: Topics discussed at home according to husbands and wives:

Husbands and wives were asked if they discussed specific issues of importance for the family (see Table 23) and how often they did so. The frequencies reported by husbands and wives were not always the same. Furthermore, some issues that were said to be frequently discussed by half or fewer of the respondents (depending on whether the respondents were the husbands or the wives) were subjects of such clear family importance as whether to use family planning and which method to use, whether the wife should have a job outside the home and whether to punish children for misbehaving. In general, however, there were similar percentages of the husbands and wives who stated that they discussed each of the topics frequently.

Table 23. Distribution of Topics Discussed by Husbands and Wives by Frequency of Discussion

Topics	Husband			Wife		
	Frequently	Occasionally	Do not talk	Frequently	Occasionally	Do not talk
Family matters	84.5	15.5	-	81.0	18.6	0.4
Number of children	67.3	28.2	4.5	68.6	25.2	6.2
What to do if the child is sick	60.9	35.5	3.6	66.8	27.4	5.7
What food to buy for family meals	73.2	26.4	0.4	76.5	21.7	1.8
Whether to buy or sell animals	38.6	56.4	5.0	32.7	59.7	7.5
Whether to buy or sell an important item in the household	37.3	57.3	5.4	35.0	56.2	8.8
Whether or not the wife should have a job outside the home	32.7	56.8	10.5	32.7	54.4	12.4
Whether to use or not use FP	43.6	40.5	15.9	50.4	35.0	14.6
Which FP method to adopt	45.9	36.4	17.7	53.1	31.9	15.0
What to do with extra money	53.6	37.7	8.6	60.2	31.1	8.9
Religion	43.2	43.6	13.2	42.0	42.5	15.5
Membership in cooperatives and NGOs	42.7	48.2	9.1	50.4	39.4	10.0
Education of the children	77.3	18.2	4.5	78.3	15.5	6.2
Future plans for the family	85.0	14.1	0.9	84.1	14.6	1.3
Important decisions regarding the farm	85.9	12.7	1.4	81.9	15.5	2.7
Recreation & entertainment	16.8	60.0	23.2	13.3	50.9	35.8
Whether to punish children for misbehaving	46.4	44.1	9.5	46.5	42.4	11.5
Health needs of the wife	53.6	44.5	1.8	62.0	33.6	4.4
Health needs of the husband	56.8	40.4	2.7	62.8	32.7	4.4
Health needs of the children	73.6	20.4	5.9	74.8	17.7	7.5

Decision making: Who makes most household decisions:

The respondents were also asked who is primarily responsible for making most of the decisions regarding the different issues or topics they discuss. The following table shows that there are some topics that the husbands and wives responded to differently. These topics were who makes most of the decisions on what food to buy for the family, whether to buy or sell animals and on health needs of the wife.

Regarding other topics, there was agreement between perceptions of decision making power within the couple. For example, what to do with extra money was said to be decided by both, whether the wife should have a job outside the home was said to be decided by the wife by both the men and the women interviewed. Family planning issues, though frequently discussed by barely more that 50% was said to be a joint decision by both sexes.

Table 24. Distribution of Topics Discussed by Husbands and Wives by Person Responsible for Making Most of the Decisions

Topics	Who Decides	
	Husband	Wife
Number of children	both husband and wife	both husband and wife
What to do if the child is sick	both husband and wife	both husband and wife
What food to buy for family meals	both husband and wife	wife
Whether to buy or sell animals	both husband and wife	husband
Whether to buy or sell an important item in the household	both husband and wife	both husband and wife
Whether or not the wife should have a job outside the home	wife	wife
Whether to use or not use FP	both husband and wife	both husband and wife
Which FP method to adopt	both husband and wife	both husband and wife
What to do with extra money	both husband and wife	both husband and wife
Religion	both husband and wife	both husband and wife
Membership in cooperatives and NGOs	husband	husband
Education of the children	both husband and wife	both husband and wife
Future plans for the family	both husband and wife	both husband and wife
Important decisions regarding the farm	husband	husband
Recreation & entertainment	both husband and wife	both husband and wife
Whether to punish children for misbehaving	both husband and wife	both husband and wife
Health needs of the wife	wife	both husband and wife
Health needs of the husband	both husband and wife	both husband and wife
Health needs of the children	both husband and wife	both husband and wife

Decision making: When there is disagreement, who decides:

The findings show that when there is disagreement on a topic discussed between spouses, it was reported (by both men and women) that the husband prevails on decisions of economic importance like whether to buy or sell animals, whether to buy or sell an important item in the household and on important decisions regarding the farm. Also, on number of children, on whether to punish children for misbehaving, and on the husband's own health needs.

Table 25. Distribution of Topics Discussed by Husbands and Wives by Person Whose View Prevails Whenever There is Disagreement

Topics	When there is disagreement whose view prevails?	
	Husband	Wife
Number of children	husband	husband
What to do if the child is sick	husband	wife
What food to buy for family meals	wife	wife
Whether to buy or sell animals	husband	husband
Whether to buy or sell an important item in the household	husband	husband
Whether or not the wife should have a job outside the home	wife	wife
Whether to use or not use FP	both husband and wife	both husband and wife
Which FP method to adopt	wife	wife
What to do with extra money	both husband and wife	both husband and wife
Religion	both husband and wife	both husband and wife
Membership in cooperatives and NGOs	husband	husband
Education of the children	both husband and wife	both husband and wife
Future plans for the family	husband	both husband and wife
Important decisions regarding the farm	husband	husband
Recreation & entertainment	both husband and wife	both husband and wife
Whether to punish children for misbehaving	husband	husband
Health needs of the wife	wife	wife
Health needs of the husband	husband	husband
Health needs of the children	both husband and wife	both husband and wife

On the other hand, both husbands and wives agreed that the wife's decision would prevail on the face of disagreement on matters such as whether to seek a job outside the home, on the food to be bought for family consumption, on which family planning method to be used and on her own health needs. For many of the remaining topics, when the spouses disagree, the decision

appears to be made by consensus as the respondents of both sexes agreed that both spouses would prevail.

It appears that there is significant decision making power vested in the wife in the group of couples interviewed, but certain matters, principally of economic importance, are the husbands' territory. Also, the decisions about the number of children the couple will have appears to be mostly the husbands'. Decisions on which FP method is to be used, appears to be the wives'. The latter fits in with the finding that when the couple uses modern contraceptive methods, these are almost exclusively female methods. This finding also points to the importance of educating couples about taking joint responsibility for family planning and encouraging husbands to participate by using male methods.

F. Gender roles:

The findings on gender roles are not very different from expected, as roles are highly culture dependent. However, there are some findings that don't conform to preconceived expectations, such as husbands' level of involvement in typically female chores in the home and the wife's ability to refuse sexual intercourse with the husband**.**

Male involvement in day to day family chores:

When a list of family responsibilities was read to the respondents there was almost total agreement between wives and husbands as to which spouse had the primary responsibility. As expected, financial responsibility and household repair is vested mainly in the husband and managing the home is the responsibility of the wife.

Table 26. Person Responsible for Certain Tasks in the Household

Tasks	Husband	Wife
	Person responsible	Person responsible
Earning income	husband	husband
Managing the daily expenses of the household	wife	wife
Cooking meals	wife	wife
Cleaning up after meals	wife	wife
Going to market/buying the groceries	wife	wife
Handling the household budget	wife	wife
Cleaning the house	wife	wife
Washing/ironing the clothes	wife	wife
Watching the young children	wife	wife
Taking the children to the doctor when they are sick	both	wife
Caring for the children when they are sick	both	both
Bringing the children to school	wife	wife
Doing house repairs	husband	husband
Gathering cooking fuel	husband	husband
Fetching water	husband	husband

However, when asked how often the husband assists in household chores, it appears that the man is quite active in assisting his wife in what is perceived are her tasks. Both spouses agree on this.

Table 27. Involvement of Husband in Housework

Involvement of husband	Husband	Wife
Everyday	73.2	61.1
Sometimes	26.4	37.6
On special occasions/on week-ends/whenever vacant	0.4	0.9
Never		0.4
Total	100.0	100.0

Male involvement when wife is pregnant:

Over 90% of both husbands and wives stated that the husband helped his wife during pregnancy, taking over some of her regular chores and almost the same proportion said that the husband was with his wife when she gave birth.

On the other hand, less than half the husbands accompanied their wives for prenatal care visits and of those who did, one half joined their wives during the consultation with the doctor or midwife. The latter finding may be more of an indication of providers' attitudes and perceived gender roles; maybe the man is not invited to join in the consultation.

Perceived appropriate gender roles:

To better understand the perception of appropriate gender roles, husbands and wives were asked if they agreed or disagreed with a series of assertions**.** The responses from the two groups were similar in most cases. The following table confirms some of the previously presented data and includes additional information on sexual matters and gender roles.

Table 28. Perceived Appropriate Sex Roles

Perceived sex roles	Husband	Wife
Men should share the work around the house with women such as cooking, and so forth.	agree	agree
In the case of men who have outside jobs, they should refuse to work under a woman.	disagree	disagree
Sex exists mainly for the man's pleasure.	disagree	disagree
The woman has the sole responsibility for planning the family.	disagree	disagree
Men are not good housekeepers.	disagree	disagree
Men should share in the responsibility of assuring the good health of the family.	agree	agree
Family planning is for women only.	disagree	disagree
It is much better for everyone if the man is the achiever outside the home and the woman takes care of the home and family.	agree	agree
Most of the important decisions in the family should be made by the man.	agree	agree
If the husband would like to have sex, the wife should never refuse him.	disagree	disagree
Outsiders should not get involved in a family quarrel, even if the husband will hit his wife, because that is no concern of theirs.	agree	disagree
Even though a wife holds an outside job, it is still her responsibility to take care of cooking, keeping the house clean, and taking care of the children.	disagree	agree
A woman who tells her husband that she wants to have sex with him is not acting in a modest way.	disagree	disagree
It's alright for a married man to have a querida, as long as he can earn enough money to support both families.	strongly disagree	strongly disagree
It's alright for a married man to go to a CSW (boring) as long as he doesn't do this too often.	strongly disagree	strongly disagree

Gender roles: can women refuse to have or ask for sex from their husbands?

When wives were asked if they had ever refused intercourse when their husband wanted it, 92.7% replied in the affirmative. Of the husbands, 85.8% said they had been refused. Conversely, when wives were asked if they ever let their husband know they wished to have sex with them, only 25.1% said they had.

G. Domestic violence

Husbands who have hit wives and wives who report being hit:

Domestic violence is considered a reproductive and public health problem. Of the respondents, 50 (22.8%) of the wives stated that they had been hit at least once by their husband and 59 (26.9%) of the husbands said they had hit their wife. When we matched the husband/wife pairs for this response, we noted that of the 59 wives whose husbands said they had hit them, only 34 asserted they had been hit and 24 said they had not. Conversely, of the 50 wives who stated they had been hit, only 35 husbands said they had hit their wives and 15 said they had not. These figures indicate that both some wives and some husbands may be reluctant to report domestic violence and that the percentages obtained with this questioning may in fact be an underreporting of the real figures.

Table 29. Incidence of Domestic Violence

Reply	Reported by Husband	% which matched with wife's reply	Reported by Wife	% which matched with husband's reply
Yes	26.9%	70%	22.8%	59.3%
No	73.1%		77.2%	

Does the community have a role in cases of domestic violence?

When asked if they agreed that the community had a responsibility in cases of domestic violence, a majority of husbands said yes. Wives had the opposite opinion. These findings, together with the high incidence of violence toward wives, suggest a reluctance of husbands to discuss domestic violence; another interpretation is that husbands (and also some wives) think that violence is a normal occurrence in marriage and that it is only the spouses' business and nobody else's.

Wives who are afraid to disagree with spouse

When the wives were asked if they were afraid to disagree with their husbands because the husband would be angry, 42% said yes. When the husbands were asked the same question, 32.7% stated they thought that their wives feared disagreeing with them because they might become angry.

Conflict resolution:

Although most of the respondents (77% of husbands and 69% of wives) said the spouses compromise to resolve disagreements, 14% of husbands and 17% of wives stated it was more likely that the husband would get his way when there was disagreement.

H. Morbidity

Signs and symptoms of gynecological problems

When asked about specific signs and symptoms of gynecological problems, a significant percentage of wives stated that they had experienced these at some time. For example, over 30% reported having experienced menstrual problems and excessive vaginal discharge. We did not couple match the information but it appears that husbands, in many cases, appear to be aware of their wives problems. This does not confirm the previously reported data in which both spouses said that wives' health matters are the responsibility of only the wife.

Table 30. Problems in Connection with the Woman's Reproductive Organs Experienced During the Past Year or Two

Problems	Wife		Husband		
	Yes	No	Yes	No	Don't know
Problems with menstrual cycle	31.0	69.0	36.4	57.3	6.4
Excessive vaginal discharge	32.3	67.7	25.9	65.5	8.6
Pains in her lower abdomen	69.5	30.5	67.3	30.5	2.3
Burning sensations during urination	45.1	54.8	23.6	51.4	15.0
Itchiness in or around her vaginal area	29.2	70.8	15.5	74.1	10.5
Pain during intercourse	36.3	63.7	15.9	81.4	2.7
Other problem in the vaginal or genital area	1.3	98.2		92.7	7.3

STD signs and symptoms:

It is not possible from the responses obtained to get a clear history of STD symptoms from either wives or husbands. (See Table 17-Knowledge section on STDs). Since most couples did not know what the STD symptoms were, they could not possibly know if they had experienced them.

Obstetric complications:

When asked about obstetric complications, 15% of both husbands and wives stated there had been prenatal complications and 29% of husbands and wives stated the woman had experienced birth and/or postpartum complications.

I. Knowledge and use of health services

Only one person, a husband, said he was not aware of the existence of a Barangay Health Center in his community. The following table shows respondents' knowledge of services provided by health centers (when these were named by the interviewer) and of their reported use in the past. Traditional services offered in the centers that are the best known and most often availed of are family planning, immunization, prenatal care, child health monitoring and CDD, nutrition, and dental services. Some services appeared not to be widely known, such as STD and HIV/AIDS counseling, diagnosis and treatment of STDs, infertility services, post abortion services and services directed to domestic violence.

Table 31. Health Services Respondents Are Aware Of and Have Availed Of

Service	Husband		Wife	
	Aware	Availed	Aware	Availed
Family Planning	95.9	76.4	98.7	75.2
Prenatal & postnatal care	97.3	83.2	98.7	83.6
Maternity care	89.6	55.9	85.1	52.2
Maternal & child health	92.3	78.6	88.5	77.9
HIV/AIDS Counseling/IEC	27.7	17.7	25.7	16.4
HIV/AIDS testing	8.6	3.6	8.0	3.5
STD counseling/IEC	23.6	16.8	16.8	9.7
STD diagnosis/treatment	12.7	4.1	10.2	4.0
Children under five	81.8	71.8	69.9	62.0
Immunization	97.3	89.1	99.1	90.7
Control of diarrheal diseases	86.8	72.7	91.6	79.6
Consultation regarding infertility	27.7	9.1	31.9	10.7
Post abortion	34.6	10.9	34.5	8.0
Nutrition	92.3	82.7	85.0	72.6
National Tuberculosis Program	64.1	20.5	64.6	18.6
Malaria control	56.8	27.3	55.8	21.2
Pre-marriage counseling	51.8	39.1	48.2	31.4
Managing of cases involving VAW/VAM	22.3	10.0	16.8	7.5
Cancer	13.6	4.1	12.4	3.5
Schistosomiasis control	63.2	49.6	58.8	42.5
Dental service	61.4	41.4	55.3	43.8
Environmental sanitation	85.5	80.9	91.2	87.2
Leprosy control	25.5	6.4	22.6	5.8
Public information & health education	74.1	70.9	71.2	66.8
Food and drugs	76.4	70.4	71.2	63.3
Library services	36.4	31.4	37.2	31.4
Breastfeeding counseling	84.1	72.3	89.4	83.2

Respondents who knew of the existing services but did not use them gave the following service related reasons for this:

1. Waiting time was too long (providers did not attend to the clients immediately)
2. The midwife is not always available
3. The clinic schedule is not known
4. Medicines are not always available
5. Services are expensive

They also expressed client-related reasons, such as nobody in the household needed services, they were shy in consulting health personnel, and that they preferred to go to a hospital or a hilot (traditional birth attendant).

2. Inventory of Facilities Available and Services Provided

All health services in the intervention area were visited including two Rural Health Units (RHU) in Malaybalay and Valencia and seven Barangay Health Stations (BHS) in Impalutao, Apo Macote, San martin, Simaya, Kahaponan, Tongan-Tongan and Vintar. There are two Barangays in the study area (Kawayan and Sinanglanan) which do not have a health station. People living in these barangays avail themselves of services in adjoining communities which are no further than ten kilometers from their community. In addition, a midwife visits these barangays once or twice a month. The following information was obtained from midwives and/or doctors available during the time of the field interviewers' visit.

Services offered and accessibility:

All nine clinics offer family planning, prenatal care, immunizations, growth monitoring, oral rehydration therapy, nutrition and breast feeding counseling and curative services for children and adults. Postnatal care services are not available in Impalutao, Simaya and Kahaponan. Other services, as noted in the following table, are variably accessible.

Table 32. Services Available in Facility

	Impa-lutao	Malay-balay	Apo Macote	San Martin	Simaya	Valen-cia	Kaha-pona n	Tongan-tongan	Vintar
Family Planning	x	x	x	x	x	x	x	x	x
Prenatal care	x	x	x	x	x	x	x	x	x
Maternity care/delivery services			x	x		x			
Postnatal care			x	x		x		x	x
HIV/AIDS counseling			x	x			x	x	x
HIV/AIDS testing									
Other STD counsel/IEC			x	x		x	x	x	
Other STD diagnosis		x							
Other STD treatment		x	x			x			
Child immunization	x	x	x	x	x	x	x	x	x
Child growth monitoring	x	x	x	x	x	x	x	x	x
Infertility consultation	x		x	x		x			
Oral rehydration therapy	x	x	x	x	x	x	x	x	x
Treatment of complication of post abortion									
Nutrition counseling	x	x	x	x	x	x	x	x	x
Curative services -client	x	x	x	x	x	x	x	x	x
Curative services -child	x	x	x	x	x	x	x	x	x
Pre marriage counseling		x	x						x
Management of domestic violence			x			x	x	x	x
Cancer screening			x					x	
Breastfeeding counseling	x	x	x	x	x	x	x	x	x

Clinics are scheduled to be open from 8:00 a.m. to 5:00 p.m. Except in one case, the providers were on site early or at the official opening time. Seven of the clinics offer family planning services 5 days a week; two clinics offer them 3 days a week. Only 3 clinics had signs outside announcing the availability of services; the remainder only had signs inside. Most family planning clients arrive between eight and ten a.m. Waiting time varied from 10 minutes to 2 and 3/4 hours.

Table 33. Accessibility of Health Providers and Services

Accesibility indicators	Impal utao	Malay-balay	Apo Macote	San Martin	Simaya	Valencia	Kaha-ponan	Tongan-tongan	Vintar
Official opening time	8:00	8:00	8:00	8:00	8:00	8:00	8:00	8:00	8:00
Actual arrival of health worker (time)	8:00	7:01	6:15	6:00	99	7:30	7:45	8:30	7:30
Time first FP client arrived	7:00	8:00	8:15	9:00	99	8:30	9:00	9:00	10:00
Time first FP client was seen	9:45	99	99	99	99	10:40	99	9:10	99
Time last FP client was seen	2:45	4:00	99	99	99	12:00	99	11:50	99
Official closing time	5:00	5:00	5:00	5:00	5:00	5:00	5:00	5:00	5:00
No. of days per week FP services are offered	3	5	5	5	3	5	5	5	5
Sign regarding FP services available (Location of announcement)	2*	3*	3	2	2	3	2	2	2

2* Inside building

3* Both inside and outside building

99 Not observed/not seen

Infrastructure

The following table shows the need to improve certain aspects (visual privacy, cleanliness, water supply and working toilets) in a number of clinics. Only one of the facilities, the RHU in Malaybalay fulfilled all preselected infrastructure criteria. Valencia only an lacked adequate water supply at the time of the study.

Table 34. Description of Medical Examination Facilities

	Impa-lutao	Malay-balay	Apo Macote	San Martin	Simaya	Valencia	Kahapo-nan	Tongan-tongan	Vintar
Auditory Privacy	x	x	x	x	x	x	x	x	x
Visual Privacy		x				x			
Cleanliness		x		x		x		x	x
Adequate light	x	x	x	x	x	x	x	x	x
Adequate water		x			x				x
Adequate space	6 x 5m	2.5 x 4m	4 x 4m	2 x 2m	4 x 4.5m	4 x 4m	4 x 5m	4 x 4m	3 x 3.5m
Pipe Water	X	X		X	X	X			X
Electricity	X	X	X	X	X	X	X	X	X
Sufficient seating for clients	X	X	X	X	X	X	X	X	X
Working toilets		X	X	X	S	X			X

Equipment and commodities:

The two larger Rural Health Units (Malaybalay and Valencia) had all items (21) of equipment and commodities being looked for. The Barangay Health Units need varying degrees of upgrading. Several clinics do not have sterilizing equipment, refrigerators for the EPI, IUD kits and in three cases, microscopes.

Table 35. Equipment and Commodities Inventory

Equipment/commodities	Impa-lutao	Malay-balay	Apo Macote	San Martin	Simaya	Valencia	Kaha-ponan	Tongan-tongan	Vintar
Sterilizing equipment (MCH/FP)	x	x	x	x	x	x		x	
Sterilizing equipment (outside MCH/FP)		x				x			
Goose neck lamp		x	x	x	x	x			
Blood pressure apparatus	x	x	x	x	x	x	x	x	x
Regular weighing scale	x	x	x	x	x	x	x	x	x
Infant weighing scale	x	x	x	x	x	x	x	x	
Scissors	x	x	x	x	x	x	x	x	x
Antiseptic solutions	x	x	x	x	x	x	x	x	x
Stethoscope	x	x	x	x	x	x	x	x	x
Refrigerator for EPI		x	x			x			
Examination table	x	x	x	x	x	x	x	x	x
Thermometer	x	x	x	x	x	x	x	x	x
Needles	x	x	x	x	x	x	x	x	x
Syringes	x	x	x	x	x	x	x	x	x
Microscope		x		x	x	x		x	x
Cotton	x	x	x	x	x	x	x	x	x
Gauze	x	x	x	x	x	x	x	x	x
Alcohol	x	x	x	x	x	x	x	x	x
Slides	x	x	x	x	x	x	x	x	x
IUD kit		x		x	x	x			
Ovum forceps		x	x	x	x	x			
	15	21	18	19	19	21	14	16	14

The absence of certain equipment and supplies for gynecological exams were noted in the clinics visited. Disposable gloves were lacking in all of the clinics, specula, tenacula and sounds in 5 of the clinics, and forceps in 4 clinics. There were varying numbers of instruments in different clinics; for example there were only 2 and 3 pairs of non-disposable gloves in two clinics and one speculum, one tenaculum and one sound in another clinic. Having so few instruments would make it almost impossible to offer gynecological exams and IUD services without putting infection prevention practices at risk: that is, if the only existing instrument is used or contaminated and there is need for it again in a short time, providers may cut short sterilization or disinfection time.

Table 36. Number and Type of Equipment Available and Functional in the Facility

equipment	Impa-lutao	Malay-balay	Apo Macote	San Martin	Simaya	Valencia	Kaha-ponan	Tongan-tongan	Vintar
Forceps		12	3	7	1	7			
Uterine sound		10		3	1	2			
Vaginal speculum		20		7	2	15			
Tennaculum		5		1	1	3			
Nondisposable globes (pairs)	8	251	5	8	50	60	3	2	10
Disposable globes (pairs)									

Contraceptive methods offered:

Pills and condoms are offered and were available in all 9 service delivery points on the daythey were visited. IUDs were only offered in 4 clinics and DMPA in 8. All informers stated that they had not had stock-outs in the last six months.

Table 37. Available Family Planning Methods

FP method	Impalu-tao		Malay-balay		Simaya		Apo Macote		San Martin		Valencia		Kahapo-nan		Tongan-tongan		Vintar	
	1*	2*	1*	2	1	2	1	2	1	2	1	2	1	2	1	2	1	2
Pills	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x
IUD			x	x	x	x			x	x	x	x						
DMPA			x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x
Condom	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x
Diaphragm							x											
Spermicide																		
Others																		
	2	2	4	4	4	4	4	3	4	4	4	4	3	3	3	3	3	3

* Column 1 - Does the facility provide each of the following contraception methods?

** Column 2 - Are commodities available today?

Family planning counseling services:

The two RHUs offered counseling in five areas in addition to counseling on pills, condoms, DMPA and IUDs. These five areas included natural family planning, LAM, dual method use, emergency contraception, and referrals for further evaluation in reproductive health. None of the clinics offered counseling on surgical sterilization methods. All of the clinics claimed they counsel on reversible methods including exclusive breast-feeding and all but one on natural methods.

Table 38. Services for Counseling

Services	Impa-lutao	Malay-balay	Apo Macote	San Martin	Simaya	Valencia	Kahaponan	Tongan-tongan	Vintar
Female sterilization									
Vasectomy									
Natural FP counseling	X	X	X	X	X	X	X	X	
Exclusive breastfeeding counseling	X	X	X	X	X	X	X	X	X
Dual Method counseling	X	X		X		X	X		
Referrals for further evaluation & management of reproductive health cases	X	X	X	X	X	X	X	X	X
	4	5	3	4	3	5	4	3	2

Immunization services

The following table presents immunizations which are offered in each of the clinics, and whether there were any stock-outs during the last six months. It will be noted that 3 clinics do not offer TT for non-pregnant women, and that 4 out of the 7 clinics that offer Hep B vaccine, and one of the nine clinics offering BCG have had stock-outs.

Table 39. Immunization Services Provided by Type of Antigens by Clinic.

Immunization Services	Impalutao		Malaybalay		Apo Macote		San Martin		Simaya		Valencia		Kahaponan		Tongan-tongan		Vintar	
	Provide 1*	Out of Stock 2*	Provide	Out of Stock	Provide	Out of Stock	Provide	Out of Stock	Provide	Out of Stock	Provide	Out of Stock	Provide	Out of Stock	Provide	Out of Stock	Provide	Out of Stock
BCG	x	x	x		x		x		x		x		x		x		x	
Polio	x		x		x		x		x		x		x		x		x	
DPT	x		x		x		x		x		x		x		x		x	
Measles	x		x		x		x		x		x		x		x		x	
Hepatitis B	x	x	x		x				x		x	x	x	x	x	x		
Tetanus for other women			x		x		x				x		x				x	
Tetanus for pregnant women	x		x		x		x		x		x		x		x	x	x	
	6	2	7		7		6		6		7	1	7	1	6	2	6	

1* - Does this health facility usually provide the following immunization services?

2* - Has the drug for the immunization been out of stock in the last 6 months?

Laboratory facilities for STD, HIV and pregnancy testing

The only clinic with any laboratory testing (Gonorrhea, gram stain and pregnancy tests) is Malaybalay. All other tests are only available in the four existing hospitals in Bukidnon Province.

Commodity management and client records:

All clinics were found to have acceptable contraceptive commodity record keeping and storage. Malaybalay is the only one of the nine which has any STD drugs available and they are appropriately stored.

All the clinics were found to keep orderly client records and updated lists of clients.

Clinic staffing

One of the problems noted, especially in Barangay Health Units, is the availability of personnel. Two RHUs have doctors, nurses, midwives and sanitary inspectors on their staff. Seven barangay clinics are each staffed by one midwife and may have a part-time volunteer Barangay Health Workers (BHW). Some, but not all, barangays have allocated minimal monetary allowances for the BHWs.

Health talks:

Providers were asked if they conduct health talks to groups . All nine clinics claim they do. Topics for such talks include family planning, prenatal, maternity and postnatal care, child immunizations, CDD, nutrition, breast feeding, etc. Pre-marriage counseling and talks on STDs and HIV/AIDs are apparently seldomly discussed. During the interviewers' visits, talks were being given on family planning in two clinics and prenatal and postpartum care, immunization and breastfeeding in another clinic.

3. Interviews with KAANIB staff

KFI has 28 staff members, most of them outreach workers with backgrounds in agriculture, business, economics or engineering. The following findings are derived from interviews with 16 staff members. Most of the informants are young and married. The youngest member (a field technician) is 22 years old. All staff have completed college while two are pursuing post graduate studies and one has a Masters degree in psychology. About half of the staff joined KFI in the 90's.

Staff roles:

Ten staff members work directly with member-beneficiaries. One informant stated he gets in contact with farmer-beneficiaries every other day and two of them stated they meet beneficiaries twice a month; two others said they interact whenever necessary. Some stated they have occasion to meet with non-members in the families.

Staff work includes giving orientations, conducting meetings and training, teaching individuals and/or groups, organizing, validating reports, monitoring and facilitating program implementation, attending beneficiary meetings, assisting with financial record keeping and problem solving, presenting updated information, etc.

How new technologies are introduced and strategies for involving members

All ten respondents who have direct contact with members state that there is great receptivity for new ideas. New ideas are usually introduced by individual consultations, trainings seminars and workshops, group meetings, meeting with leaders and Boards of Directors, modeling, demonstrations of new practices, etc.

Not all members are immediately cooperative, however. In order to encourage them, KFI staff uses varying strategies. These include SWOT (Strengths/ Weaknesses/ Opportunities/ Threats) analysis, one-on-one consultations, re-orientations, group processing, problem solving, providing examples, issue clarification, etc.

Sustaining enthusiasm of farmer beneficiaries:

Informants were asked how they maintained members' interest and enthusiasm. They said that most beneficiaries are naturally enthusiastic and cooperative. The following strategies assist staff members in this: building and maintaining good working and personal relationships, constant contact through fora, meetings, conducting regular activities, giving incentives, making members feel they are important, publicly recognizing achievements and good work, being always available for individual consultations.

KFI staff objectives

Informants were asked what their objectives were. Among these, they mentioned:

a. To be able to emphasize people empowerment to their members
b. To be able to help their members to develop their potential
c. To be able to develop responsible members
d. To train members in varied marketing skills for future independence
e. To help People's Organizations (POs)
f. To develop sustainable communities with economic growth and social equity

g. To help members improve their life conditions and allow them to have better access to basic social services
h. To see holistic human development taking place among members, including political, socio-cultural, economic, environmental.
I. To see a strong PO federation and a coalition of POs and NGOs and that may be strong advocates of democracy and social justice
J. To help people develop and maintain productive community enterprises

KFI staff opinion about implementing a male involvement project

Informants were asked if it is possible for the present KFI staff to add a completely new activity into their program. All, but one who said he did not know, had affirmative responses. However, six respondents stated that manpower shortage would be a problem. They felt that more people might be needed to work on the new program. Two mentioned the need for additional financial resources for transportation, training, and honoraria for staff. Four mentioned concerns about the capability of present staff to undertake such a different type of program and felt the need for training. One expressed concern about the difficulty in integrating program components so different from their established ones. Two persons did not see any manpower problem: they thought the existing staff could implement the new program. Apart from manpower, all the staff foresees some problems in terms of knowhow since none of them is knowledgeable about reproductive health.

KAANIB strengths for implementing a reproductive health intervention:

The informants stated that KAANIB has advantages over other organizations when considering a new reproductive health activity:

a. KFI has an established base network of POs
b. KFI is used to handling new projects and knows how to work with members
c. KFI has linkages with other NGOs, the church, media
d. KFI has a dynamic staff, facilities, communication system, etc.
e. KFI's operation is area based; it is very familiar to POs and their members
f. KFI has a Gender and Development program and has conducted training among its members, including women, on this topic
g. KFI has assisted many people and will not have difficulty in getting cooperation
h. KFI has a skilled and capable staff
I. KFI has a good 15 year track record
j. KFI's partners are stable organizations

All those interviewed expressed interest in learning about reproductive health and family planning. A woman stated she does not wish to be involved in the implementation but can help with office work. Some of the roles that KFI staff said they would like to have include:

a. Training Officer/Lecturer
b. Researcher/gather data from the field
c. Manager
d. Facilitator
e. Organizer
f. Implementor

Most of the informants thought that their new roles would not affect the performance of their present duties. The seven informants who thought it would are concerned about the time investment but are optimistic that this can be addressed satisfactorily.

4. Focus group discussions with KAANIB beneficiaries

The purpose for having focus group discussions was to obtain information on the operation of KFI and the members' experience working with the Federation. Three focus group discussions (FGDs) were conducted in each of the 3 municipalities in the study, Impansung-ong, Malaybalay and Valencia. The FGDs were all held in November 1997. Standard discussion guides were used. The participants were members of cooperatives assisted by KAANIB. Participants (mostly men between the ages of 24 and 75, all married) were selected from KFI member lists. Twenty seven percent of participants have been members for six or more years**.** FGDs were conducted in the local language and transcripts were subsequently translated into English.

Purposes of KAANIB according to its member beneficiaries:

KAANIB members identify KAANIB as an NGO which provides technical assistance regarding diversified farming, training and loan assistance. They also see KAANIB as an organization to train and help farmers organize themselves and form cooperatives.

"*KAANIB provides assistance to cooperatives and gives technical assistance regarding diversified farming through the training that they conduct. They also grant loans to cooperatives.*" *(60-year-old farmer from Valencia)*

"*KAANIB initiated the formation and helped strengthen our organization. They introduced the TRIPARD (Tripartite Partnership on Agrarian Reform for Government*

Development) program to us. This program includes three components: the Land Time Improvement, Seeds Social Infrastructure in Strengthening Building, and the Productivity System Sustaining Development." *(40-year-old farmer and member of KAANIB for six years)*

"*I see KAANIB as the instrument that will help change the outlook of farmers. They do not only aspire to improve their production but also take care of preserving nature and the environment. This is what we call* "*total human development.*" *(40-year-old member-beneficiary of KAANIB)*

We also asked the farmers their opinion about the extent of KAANIB's attainment of its objectives. With eptions, most of the participants believe that KAANIB was able to implement its programs successfully.

"*The farmers have changed their outlook and methods of farming. They are more careful now especially in the use of pesticides and other chemicals which they regard as harmful to their health and the environment. So, I can say that KAANIB is beginning to see the fruits of their labor.*" *(30-year-old female member-beneficiary from Malaybalay)*

"*I think they have not fully achieved their goals yet. I think that they are still beginning. Their target is community building and not all in the community is a member. They also have three important things to do in our community: to improve production, to conduct training, and to teach us new farming technologies.*" *(49-year-old farmer from Valencia)*

"*In my assessment and observation, not one of the cooperatives organized by KAANIB ever collapsed. Even we can say that we have not really improved our conditions in life considerably, still I can say that we have improved in some sense through the assistance of KAANIB. I can say KAANIB is about 75% successful.*" *(6-year member-beneficiary from Impasug-ong)*

FGD participants were also asked to describe why KAANIB is successful. Most of the respondents think that ining conducted by KAANIB has been very helpful to them. One respondent stated that KAANIB has provided the miss between the farmers and the government.

"*The new technology that they shared with us, the marketing assistance that they extend to farmers. Those are some of the aspects that helped the farmers who are members of the cooperative. And these are also the things that we expect KAANIB to provide for us.*" *(1-year member of KAANIB from Valencia)*

"*The MASIPAG program that KAANIB initiated is very good. It advocates for the non-use of chemicals that can be harmful to one's health.*" *(29-year-old female member from Valencia)*

"*They provide us with our needs like seeds. They also extend small loans to us.*" *(4-year and 6-year member-beneficiaries from Impasug-ong)*

"*Aside from the technical trainings, they also help train us to be leaders.*" *(40-year-old member from Impasug-ong)*

"*KAANIB has just introduced loan and marketing assistance. These were not available before. I like this marketing assistance because now we have a product that we can be proud of and that is chemical-free.*" *(40-year-old farmer from Malaybalay)*

The farmers were asked what are other ways in which they think KAANIB can help members/community residents. The respondents enumerated several more functions or services that KAANIB can perform. They want KAANIB to conduct more training, to see to it that the farmers are followed-up regularly, to provide linkage to other agencies of the government which have expertise on cooperatives, and to assign a technician (preferably a college graduate) who will assist them regularly.

> "*They should follow-up the farmers to make sure they are doing it correctly. Somebody should remind them of what they learned during the training.*" *(40-year-old farmer from Malaybalay)*
>
> "*Maybe they can help if they can link us to other agencies who can provide assistance to improve our cooperative.*" *(43-year-old farmer from Valencia)*
>
> "*More training and lectures.*" *(29-year-old female member from Valencia)*
>
> "*If they can hire a technician, who is a graduate in*

agriculture and who can teach us." *(58-year-old farmer from Impasug-ong)*

The RHA intervention study was introduced to the FGD participants. We informed them that RIMCU of Xavier University is working with KAANIB to try to look for ways to increase men's awareness and responsibility in taking care of their family's health. We asked them if they think this is an issue that should be pursued. We asked them whether involving men is a valid and relevant concern. The respondents think that it is about time that the men should be involved in health matters. They also commented that if women are involved in farm activities it is also important that men be concerned with the health of the family.

"*I think we should start now. I like that idea of involving our men because they are the head of the family.*" *(30-year-old member farmer from Impasug-ong)*

"*It is very important for men to be involved in health issues for the family because they are the head of the family. I am happy that KAANIB is now pursuing this.*" *(49-year-old farmer from Valencia)*

"*Because we, the women, are involved in farming, so it is but important that the men be involved in the health concerns of the family too.*" *(44-year-old female member from Valencia)*

The respondents think there will be a positive reaction to this initiative. They think that they will be happy to be as involved as the women in matters concerning the health of the family.

"*Because we are for it, it is possible that they will also support it. If ever there will be some who will oppose it, I think they will be very few. Only those who will refuse to understand.*" *(40-year-old farmer from Malaybalay)*

"*Those who will disagree do not appreciate good health. Those are men who have relegated all the responsibilities to their wives.*" *(6-year member from Impasug-ong)*

When asked if they thought that the men would come if KAANIB invites them to a meeting or training session, the participants were sure that the men would participate, except for one respondent who said that those who are busy may not come.

> "*I think they will attend because this is for the good of the family.*"

> "*I think they will attend. It was very easy to assemble them for training that were initiated by KAANIB. In other words, if we do the same to the members, they will possibly attend.*" *(48-year-old member from Malaybalay)*

> "*It depends if they have time. There are others who cannot attend because they are busy.*" *(43-year-old farmer from Valencia)*
>
> "*I know them already. I can say that they will be active in this endeavor. I think even the non-KAANIB members will like this if we also invite them.*" *(49-year-old farmer from Valencia)*

The issue of whether KAANIB is in a position to do such tasks now was raised with the FGD participants. Most participants are positive that this is possible for KAANIB. They thought that in most programs introduced by KAANIB, a health component has always been included. They foresee, however, that KAANIB may have some problems with regard to funding. One participant also voiced that KAANIB may need the assistance of resource persons.

> "*I think they can do it. In their training for MASIPAG, they always emphasize the importance of good health. Thus, if there is this special project specific on health, I think they can do it. Their only problem maybe is funding.*" *(48-year-old farmer from Malaybalay)*

> "*I think KAANIB has the capability. What is important is that the purpose of the program be made clear and who in the barangay will provide the information.*" *(40-year-old farmer from Malaybalay)*

"*The KAANIB can do it. All the training they have conducted had a health component. They have even conducted a survey on health. I can tell because of my experience with them.*"
(49-year-old farmer from Valencia)

"*It depends because this is something new. If they had been trained in this regard and will be assisted by the proper agency, then they can do it. They can always ask for resource speakers.*"
(40-year-old farmer from Impasug-ong)

The respondents think that the best opportunity to discuss this issue with the members is now. It can be built into the existing training that is conducted by KAANIB or they can schedule separate training for this. To them, what is important is that such programs be implemented in their community.

The FGD participants expressed concern that KAANIB should be assisted by other agencies. All the respondents believe that the Department of Health (DOH) should have an important role. Others mentioned that the Department of Agriculture should also provide assistance. Some also suggested that PHILDRRA and other NGOs will be of great help to KAANIB in this endeavor; others brought up the idea that the Church can also be involved.

The results of the interviews with the KAANIB staff, and the FGDs with the KAANIB member-beneficiaries, revealed that while this new endeavor is something new and different from the usual work programs that KAANIB has implemented, a new program on reproductive health is a welcome activity and one that KAANIB is capable of doing. Their long experience in working with organizations composed predominantly of male members is an important factor.

The farmers feel that it is about time that KAANIB also includes health in their programs. With the eagerness and enthusiasm that the KAANIB staff has articulated regarding this and the positive feedback from member-beneficiaries, there is optimism that the objectives of this health activity can be accomplished to benefit the community.

5. Key informant interviews: Profile of KAANIB communities

The following information was obtained by interviewing several key informants: barangay officials and older and knowledgeable residents in the community.

Languages:

Most residents speak and understand two local languages: Binisaya and Ilongo. The distribution of all languages spoken in the area is found in the next table.

Table 40.--Language Spoken by Residents of the Study Communities

Language	Impa-lutao	Kawa-yan	Malay-balay	Apo Macote	San Martin	Sima ya	Sinang -lanan	Valencia	Kaha-ponan	Tongan-tongan	Vintar
Binisaya	X	X	X	X	X	X	X	X	X	X	X
Ilongo	X	X	X	X	X	X	X	X	X	X	X
Ilocano				X	X	X	X	X	X		X
Binukid	X	X	X	X	X			X	X		
Tala-andig	X				X						
Higa-onon	X										
Tagalog					X			X			

Population:

Populations vary between the largest community, Malaybalay with 112,000 inhabitants and the smallest, Kawayan with 750 residents.

Table 41. Population and household size of the study areas

Municipalities	Total Population*	Total No. of Households*	Average HH Size
Impalutao	2,545	444	5.7
Kawayan	750	148	5.1
Malaybalay	112,277	20,529	5.5
Apo Macote	7,266	1,297	5.6
San Martin	2,232	393	5.7
Simaya	2,927	565	5.2
Sinanglanan	2,861	54	5.3
Valencia	128,623	24,359	5.3
Kahaponan	4,463	901	5.0
Tongan-tongan	6,249	1,186	5.3
Vintar	1,825	401	4.6

Occupations:

With one exception, farming is the main occupation in all the communities studied. In Valencia, commerce and trade are the most important occupations.

Table 42. Occupations engaged in by residents (Ranked According to Number of Persons Engaged)

Occupations	Impa-lutao	Kawa-yan	Malay-balay	Apo Macote	San Martin	Sima ya	Sinang -lanan	Valencia	Kaha-ponan	Tongan-tongan	Vintar
Farming	1	1	1	1	1	1	1	2	1	1	1
Fishing						7		11	7		9
Mining & quarrying								10		11	
Manufacturing			6								
Government service	4			3		8	5	5	3	3	5
Construction	8		8	7		2			7	5	4
Commerce	2	3	2	2	2	3	2	1	2	2	6
Transportation	6	5	4			5	3	3		6	3
Services	7	7	7			6	8	8	6	10	
Recreation			10					6			
Housekeeping	3	2	5	5		4	4	11	5	4	2
Sewing		6		6				7		8	
Handicraft							7	9	7	9	7
Professional & Executives	5	4	3	4			6	4	4	7	8

Activities after working hours:

There are few recreational facilities, especially in the barangays. For men, the preferred recreation is sports; other activities include billiards, cockfights, drinking, dancing and playing cards. In the larger towns of Valencia and Malaybalay, men can watch television and movies.

For the women, their time after work is spent getting together with neighbors. In Valencia women like to shop because there is a large department store in this community.

Religion:

Most residents are Catholic; others belong to various Protestant denominations. Muslims are found, in smaller numbers, in Malaybalay and Valencia.

Health services:

Not all barangays have regular health services. In some, a rural midwife visits once a month. Otherwise, residents can obtain services from Barangay Health Stations in adjoining communities or they may go to Rural health Units in municipal populations. In the latter there also are private doctors. Midwives and hilots are found in most barangays except in Kawayan where there is no midwife.

Table 43. Type and Number of Health Facilities Present in the Community

Municipalities	Government Hospital	Private Hospital/Clinic	RHU	FP Clinic/BHS
Impasug-ong			1	
Impalutao				1
Kawayan				None
Malaybalay	1	7	1	
Apo Macote				
San Martin				1
Simaya				1
Sinanglanan				None
Valencia	2	19	1	
Kahaponan				1
Tongan-tongan				1
Vintar				1

Table 44. Number of Practitioners Residing in the Community

Municipalitiy	Doctor	Nurse	Midwife	Dentist	Pharma-cist	Hilot	Optometrist	Optician	Med Tech.	Sanitary Inspector
Impalutao			1			10				
Kawayan						6				
Malaybalay	176	7	560	10	10	1312	5	5		
Apo Macote		1	1		1	10				
San Martin			1			7				
Simaya			2	1		10				
Sinang-lanan		1	1			5				
Valencia	42	111	85	5	13	14	5	1	18	4
Kahaponan			1			4				
Tongan-tongan			5			14				
Vintar		1	1			2				

Public utilities and facilities:

Only Malaybalay and Valencia have a full range of utilities; other barangays have electricity but lack other utilities.

Table 45. Number of public utilities and facilities found in the community

Facilities	Malaybalay	Apo Macote	San Martin	Simaya	Sinanglanan	Valencia	Kahaponan	Tongan-tongan	Vintar
Telephone: Public									
Private	2					2			
Telegraph: Public	1					1			
Private	2					2			
Post Office	1					1			
Messengerial Services	2					5			
Radio Station	4					2			
TV Station									
Printing Press	3								
Newspaper Publisher	2					3			
Police Force	1					1			
Fire Dept.	1					1			
Electricity: Public	1	1	1	1	1	2	1	1	1
Private									
Streetlights	100			28	10	100	4		1

Organizations found in the communities:

It is very common for residents to join one or more community organizations. The existing organizations are listed in the following table

Table 46. Number of distinct organizations found in the community

Type of organizations	Impalu-tao	Kawa-yan	Malay-balay	Apo Macote	San Martin	Simaya	Sinang-lanan	Valencia	Kaha-ponan	Tongan-tongan
School-oriented	2	1	2	1		1	1	1	1	1
Church-related	2	1	21	2	2	3	1	5	1	2
Civics	1	1	2	2	1	1	1	5		
Sports	1		2					2		
Professionals			1					3		
Marketing Cooperatives			1					1	1	
Consumers Cooperatives	1	1	1	1		1	1	3	1	
Irrigation Cooperatives	1		1	2	1	1	2	2	1	2
Compact Farm	1									
Samahang Nayon	1									
Credit Union								2		
Women's Club	1	1	2	1			2	5	1	2
Youth Club		1	2	1		2	2	4	1	1

Transportation:

Transportation is available in all communities studied, although it varies in mode, frequency, etc, depending on the size of the community.

Table 47. Transportation Facilities Available for Community Use

Transport	Impalutao	Kawayan	Malaybalay	Apo Macote	San Martin	Simaya	Sinanglanan	Valencia	Kahaponan	Tongan-tongan	Vintar
Trisikad*1				x	x		x				
Tricycle/ Motorela*2	x		x	x		x	x	x	x	x	x
Bus			x					x			
Jeepney	x	x	x	x	x	x	x	x	x		x
Taxi cab/van			x					x			
Multicab		x	x					x			
Habal-habal*3	x			x	x	x					
Bus/jeep terminal			x	x				x			

*1 bicycle-driven cab

*2 motor-driven cab

*3 single motor bike which load cargoes and passengers

6. Issues and program implications: Summary of findings

Table 48. Summary of issues and program implications gleaned from the findings

ISSUES	A. *Availability of Resources*	B. *Strengths and Weaknesses (Culture)* *Strengths*	*Weaknesses*	C. *Strengths and Weaknesses (KAANIB)* *Strengths*	*Weaknesses*	D. *Program Implications*
1. Gender Inequality	- Lack male services - TOUCH, GROUP, PHILDHRRA -PAKISAM PALAMBU, BWOI - Gender modules - Development capability training can be accessed by NGOs	- Income inequality between husband and wife - Low priority given to women's health needs - Power inequality within the family	- Conventional tribal structure of male & female relationships/ roles	- KAANIB has a GAD program: staff is trained on gender issues - Core group (male)	- Continuing education on gender	- Income generation of women [be sure this will not reinforce double burden of women (multiple roles)]
2. Lack of knowledge on Family Planning	- Available literature (appropriate) - Curriculum available for FP/NFP - Bukidnon Family Development - Development capability training can be accessed by NGOs	- It is a felt need	- People are not open to discuss the topic - Considerable misinformation	- KAANIB has a GAD program: staff is trained on gender issues - Core group (male)	- Inexperienced in health and RH	■ Training of KAANIB staff on RH
3. Poor communica-	- Interpersonal commun-ications skills		- Poor communication	- KAANIB has a GAD program:		- Couple-focused and youth programs

tion	- ICS module - Conflict-resolution management modules - Development capability training can be accessed by NGOs		skills	staff is trained on gender issues - Core group (male)		- Couple awareness campaign - Role playing: skills and training processes (Communication & power sharing, listening, empathy between husband & wife) - Possible networking
4. Lack of RH use	- For males: infertility services, etc. not available -COBRA community-based radio group - Development capability training can be accessed by NGOs	- Church support for NFP	- Church resistance on the issue of FP - Low use	- KAANIB has a GAD program: staff is trained on gender issues - Core group (male)		
5. Low male FP use	- LGU health clinics are not male friendly for FP - AVSC program training already provided - hospital based - Development capability training can be accessed by NGOs		- FP is thought to be a woman's responsibility - Low use - Lack of manpower	- KAANIB has a GAD program: staff is trained on gender issues - Core group (male)		
6. Unintended/ unmet pregnancies			- High levels	KAANIB has a GAD program: staff is trained on gender issues - Core group (male)		- Education awareness facilities for men (FP)

7. High prevalence of RTI's			- High prevalence	- KAANIB has a GAD program: staff is trained on gender issues - Core group (male)		
8. Prenatal and postpartum problem	- Males an "untapped source" for safe motherhood UNICEF safe motherhood program		- Many such problems	- KAANIB has a GAD program: staff is trained on gender issues - Core group (male)		- Involving males in parenting/health related tasks - Community involvement
9. Domestic violence	- Bukidnon Women's Org. (BWOI) - Cagayan de Oro Bantay Banay/ DSWD program against domestic violence - No crises center - Conflict resolution management modules - PHC module on counteracting domestic violence - DRA foundation	- Recent laws passed prohibiting domestic violence R.A. 7192	- Much domestic violence - A private family affair as perceived by the community - Substance abuse as a contributing factor (e.*g.*, *alcohol*) - Housing structure is a contributing factor	- KAANIB has a GAD program: staff is trained on gender issues - Core group (male)		- Bantay Banay: Monitor Domestic Violence - Educational program should take alcohol-related problems into account - Conflict resolution: focus on domestic violence

DATA UTILIZATION AND DISSEMINATION ACTIVITIES

The Reproductive Health Awareness intervention in Phase II of this Operations Research Project will be based on the findings of the Phase I diagnostic study. To develop the project proposal and initiate preparatory work on the intervention, a workshop was held from December 8 to 11, 1997. Participants included representatives from the Institute of Reproductive Health of Georgetown University (IRH), the Population Council, the KAANIB Foundation, the Department of Health (national and regional), the LGU health units, the Research Institute of Mindanao culture (RIMCU) and other NGOs such as PHILDRRA and the Women's Forum X.

The overall workshop objectives were to:

- Present and analyze data from the community survey, facility inventory and structure of the communities studied: and,
- Develop a plan for the KAANIB Reproductive Health Awareness Program .

The first three days of the workshop were devoted to the presentation of preliminary data including the methodology for data collection and analysis. Results were amply discussed by the participants and issues and concerns to be included in the intervention were identified. The following were the priority issues identified:

a. Gender inequality
b. Lack of reproductive health and family planning knowledge
c. Poor communication between spouses
d. Low use of existing reproductive health services
e. Low use of male family planning methods
f. Unintended pregnancies
g. Possible high prevalence of reproductive health infections
h. Prenatal and postpartum complications
I. Domestic violence

On the fourth day, findings from the study and the proposed project and intervention plan were presented to the KAANIB Board of Directors. A work plan was developed with the KFI staff and board members.

During the workshop, KFI concerns for implementing the project were identified. These included:

a. KFI needs one additional person on the staff because of the present staff's workload and other program priorities
b. KFI's need for reference and IEC materials dealing with reproductive health
c. Additional funds needed for transportation of staff and couple-leaders
d. Adequate time needs to be assigned for the new resource person for KFI
e. Establishment of clear linkages with LGUs; there is a need for partners to legitimize and discuss political and ideological conflicts existing between KAANIB and the LGUs
f. Appropriate timing of training to suit farmers' schedule based on their farming activities

Finally, on the fourth day of the workshop the following list of proposed activities for the RHA project was developed and presented to the KFI Board of Directors:

Table 49. RHA Program Proposed Activities and Time Frame

ACTIVITIES	TIME FRAME[1]
I. Training for Trainers (TOT)	
A. TOT 1 - Basic RHA Training of KAANIB Staff	
1. Participants:	
All KFI Staff and some PO couples who are literate in English	
2. TOT 1 Preparation	
a. Communicate/inform participants	
b. Prepare modules, invite participants	
c. Book the venue	
3. TOT 1 Actual Content	
a. Basic RHA/M & E System and Procedure	
b. Preparation for echo to 30 PO members	
c. Practicum on handling echo training	
B. TOT 2 - PO Couples	
1. Participants:	
2 Couples per PO (12 POs)	
Total of 48 couples	
2. Training Schedules	
a. 1st batch - PO 1-6/ 24 participants	
1) Lecture - Monday and Tuesday	
2) Echo - Wednesday	

[1] The timeframe for the activities will be determined pending consultation with RIMCU, IRH, KAANIB and Population Council in late July or August, 1997. The original timeframe set for these activities is no longer applicable.

b. 2nd batch - PO 7-12/ 24 participants	
1) Lecture - Monday and Tuesday	
2) Echo - Wednesday	
II. PO Basic Reproductive Health Awareness Echo Seminar	
1. Participants- 12 POs with 60 members per PO	
2. Training Schedules	
First Batch	
Second Batch	
III. KFI Reproductive Health Awareness Mainstreaming	
A. Foundation Re-engineering	
1. Review of 1998 Plan- RHA	
a. Board level	
b. Staff level	
2. Review of Staff Job Description and Targets	
3. KFI Linkaging	
4. Establishment of Technical Committee	
5. Hiring of Health Specialist	
IV. RIMCU Study Dissemination	
V. Symposia	
1. Content for four months	
* STD	
* Safe motherhood	
* RTI	
* etc.	

In addition to the workshop, dissemination seminars were held with KFI member organizations on March 30 and 31 in the following three communities: Kawayan, Impasung-ong with QUARBA and Farmers' Associations (CARABAO), in Kahaponang with Kapahonang Multipurpose Cooperative and in Sinanglanan with SMPC farmers. A fourth seminar, in Kapitan Bayong, was postponed indefinitely due to previous commitments on the part of member organization leaders. Two of the above barangays, Kawayan and Sinanglanan do not have established health services but a provider visits there once a month.

During the seminars (attended mostly by men of the member organizations and a few other residents and barangay officials) study findings and the proposed intervention were presented.

Participants expressed interest in being part of the study but also articulated grave concerns about the lack of health services and medicines in their communities. Women participants felt it was important for their husbands to learn about male methods; men, too, were interested in this topic.

Finally, the Population Council sponsored a National Research Dissemination Conference in Manila on May 28. Four projects were presented and discussed, among them were results of Phase I of the Male Involvement Study. The conference was attended by policymakers, program managers, donors and academe. Participants included representatives of the national and regional Department of Health, devolved Local Government Units (LGUs), provincial Health and Population Officers, municipal Health Officers, women's health advocates, USAID, UNFPA, representatives of university based researchers, and other CAs working in the Philippines. The Conference fulfilled the objectives of sharing results of the Phase I study, and stimulating links and networking with other initiatives on male involvement in the country.

The estimated initiation of Phase II is August 1998. The proposal for the intervention plan developed by IRH is submitted as Annex III of this report.

RECOMMENDATIONS FOR THE IMPLEMENTATION OF PHASE II

The following recommendations for the implementation of Phase II are the result of discussions held between the Population Council and RIMCU and are based on past experiences and lessons learned by the two agencies. We consider that the suggested considerations should be discussed with KAANIB and IRH before the intervention is implemented:

* The selection of couple-educators should be primarily the member agency's responsibility, with input and clearly spelled out selection criteria provided by KAANIB. This will contribute to the member organizations' sense of ownership of the intervention and will allow them to monitor couple educators' contributions and insist on the fulfilment of their commitments.

* KAANIB should carefully consider what incentives it can offer couple educators in return for the considerable time investment which is being asked of them. No direct financial incentives need to be considered as this would jeopardize the institutionalization of the intervention if it is evaluated as successful, useful and cost-effective. KAANIB has had experience with providing rewards for outstanding work, including indirect financial incentives such as a small reduction in loan interest rates, acquisition of produce at a better price, etc.

* KAANIB, the project's health technician and the member organization directors need to consider what strategies they will use to obtain 100% participation from their member couples, and how to sustain this participation through time. These strategies may include the incorporation of the RHA activities into existing agricultural and organizational ones. Consideration can also be given to incorporate some small sport or other entertainment activity in every couple meeting to increase the enjoyment of the meeting participants. However, they one must be watchful to avoid that these extras do not become the principal activities.

- Another concern is that as time goes by, men, due to agricultural demands, may attend meetings less frequently, delegating their wives as their representatives. As this is a couple involvement intervention, project managers should foresee this possibility and forestall its occurrence, giving men, as well as their wives', choices of times for their meetings and then encouraging them both to attend.
- KAANIB should consider what it will do to replace possible drop-out couple educators.
-

* During the meetings, consideration should be given to assist couple participants to develop communication skills on sexuality, not just between spouses, but also with their adolescent sons and daughters.

* It is strongly recommended that health service providers from the member organization's barangay be encouraged to attend the couple meetings as well as the couple educator training. This will insure that health messages will not differ depending on the messenger and that the same non-technical language will be used by the providers when they are with clients. Also, this may help sensitize providers about men's particular needs and to make services more male friendly.

* The referral system for accessing health services and other resources should be studied and pre-established. Referrals, though primarily to LGU services, should also include all existing services in the area, including the church for couple education in NFP, NGO health services, etc. Couple educators need to be provided this information and they also can complement it with their knowledge of available services.

* In order to offer vasectomy services which are now non existent in the province, providers in strategic SDPs need to be trained. The LGU may be interested in requesting training and equipment assistance from AVSC.

* The health technician's job description should include responsibility for assuring the cultural appropriateness of all intervention contents, activities, methodology and language used.

* A detailed cost analysis of the intervention should be performed so its cost-effectiveness can be determined; this may be a principal factor for decisions on institutionalization and replication.

* Careful process monitoring and lessons learned documentation is important for project replication.

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