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Planning services in Iloilo City: A diagnostic study of the implementation of the Department of Health Training Courses for family planning providers in Region II and Cordillera Administrative Region

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A DIAGNOSTIC STUDY OF THE IMPLEMENTATION OF DEPARTMENT OF HEALTH TRAINING COURSES FOR FAMILY PLANNING PROVIDERS IN REGION II AND CORDILLERA ADMINISTRATIVE REGION

PHILIPPINES

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None of the institutions or individuals named here are responsible for the conclusions offered in this report.

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EXECUTIVE SUMMARY

This study is one of several being undertaken under the auspices of Family Planning Operations Research and Training (FPORT) program the Population Council. It began with several meetings among researchers and health personnel, as were held in order to shape research questions that would be of use to the Department of Health as it implements its training programs. Actual fieldwork began 15 October 1993, while the team held Research Utilization Conferences in Baguio City and Tuguegarao in April 1994.

The team observed trainings for family planning providers (Preceptors, Interpersonal Communication Skills, and Basic/Comprehensive) in both Region II and the Cordillera Administrative Region (although C.A.R. had no Basic/Comprehensive course during this time period). Beyond observations, we administered questionnaires to the trainees both before and after the trainings, and did exit interviews of clients after having observed their interaction with trainees during the practicum phase of the Basic/Comprehensive course. In addition, we interviewed mayors and supervisors about their attitude towards the Family Planning Program. Finally, we conducted focus group discussions with the trainers, in order to get their views on the trainings.

When we focused on trainee absenteeism and drop-out, we found very little absenteeism and no drop-outs. There had been speculation that physicians, in particular, would find absence from their place of work too costly and the technical level of the course too low, thus causing absenteeism and dropping-out, respectively. However, what little absenteeism we found was due to late notification of potential trainees. It also appeared that trainors were able to engage the interest of physician trainees to the same extent as other trainees, insofar as all trainees were retained throughout the courses.

When we turn to specific aspects of the training, we conducted a post-training evaluation of our own, and looked at the DOH post- training evaluation. Typically, trainees rated the entire course very highly, but judged that it took slightly too long and that subject matter coverage was slightly too broad.

Any difference in the trainee's commitment to the FP program was measured by having the same questions asked both pre-training and post-training. Few systematic differences were found from this exercise.

The selection of trainees was done through a variety of channels, with the trainees typically having little say in their own selection. Often there were other possible candidates for training, but these would be accommodated in later trainings. We have no evidence for favoritism in trainee selection. There were a variety of costs and benefits--professional, economic, and personal--cited by the trainees. It is noteworthy that Region II trainees were more likely to cite direct economic benefits since they were

able to receive savings from accommodations costs (a practice which was not possible in C.A.R.).

As noted, we did interviews to ascertain the attitude of local government executives. We found them generally supportive of the FP program, but not very aware of its health emphasis: "Family Planning Saves Lives." In addition, persistent complaints on the part of health personnel cast some doubt on the strength of support from local government officials for health programs in general, and FP in particular.

With respect to practicum requirements in the Basic/Comprehensive course, we found that trainees felt confident and competent after only seven IUD insertions, indicating that perhaps the practicum requirements are too long. We found clinic conditions that were less than the ideals set out in the Preceptors course, and some lapses in procedures followed by trainees. In addition, the stationing of two trainees in each preceptor area during this first provincial practicum led to considerable pressures on clients to accept IUDs, thus infringing on the principle of free choice by clients.

When we turn to values being emphasized, we measured religious and moral values, along with more general non-traditional attitudes of the trainees. We did this both at the beginning and the end of the trainings, to measure changes.

We also focused in particular on the recently introduced "Quality of Care" framework from Judith Bruce. This framework attempts to create more client-oriented service provision. We found increased trainee adherence to "quality of care" values in all the trainings, despite the fact that it is only in the Preceptors course where these values are included explicitly. This suggests that "quality of care" has been broadly internalized by the trainors and transmitted in all trainings.

Finally, during the practicum clients felt they had been treated in a caring and friendly manner during their clinic visit, and were satisfied. However, a much smaller percentage reported having received full explanations from the trainees.

CHAPTER 1

OVERALL INTRODUCTION

I. Background to the Research

This particular research project is one of several being undertaken in the Philippines under the "Family Planning Operations Research and Training" (FPORT), program of the DOH and the Population Council. The general aim of FPORT is to train and utilize researchers to provide information to family planning practitioners which will be of value in the operations of family planning programs. During preliminary meetings, it was decided that researchers in northern Luzon would focus on family planning trainings undertaken by the Department of Health.

The research project, "A Diagnostic Study of the Implementation of Department of Health Training Courses for Family Planning Providers in Region II and the Cordillera Administrative Region," was the subject of several meetings among researchers and health personnel, in order to shape research questions that would be of use to the Department of Health (DOH) as it implements its training programs. This was in line with treating Health Providers as the "clients" of operations research. In short, we would like to view the design of the project as a joint effort of researchers and DOH Personnel.

We began with two meetings in Manila, hosted by Marilou Costello of FPORT-Philippines. Here researchers and DOH personnel (both from the Central Office and Region II) brainstormed on a number of different ideas, in the end focusing on a tentative topic, the Basic/Comprehensive Family Planning Course for Physicians, Nurses, and Midwives. In particular, we discussed Judith Bruce's (1990) client-centered "Quality of Care" framework as it affects family planning operations. It was also decided at this time to emphasize the process of training rather than its outcome. The former decision was to make sure that the operations research was in tune with the latest thinking in the Department of Health; the latter decision (to focus on process) was to increase the likelihood that program interventions based on the research findings would be clear and specific.

A preliminary research proposal was prepared and then discussed in two September 1993 meetings (one in Manila and one in Tuguegarao). In addition to the researchers and DOH personnel who had attended at earlier meetings, this session included one of the authors of the family planning training modules, to insure that the team fully understood the trainings. It was also at this second set of meetings that it was decided to expand the focus of research

to include other courses for family planning providers, specifically Interpersonal Communication Skills and the Preceptors Course (for those who would later be supervising the practicum phase of the Basic/Comprehensive course). At these meetings the schedule of the research, to begin on 15 October 1993, was finalized.

II. The Research Questions

Based on the discussions outlined above, it was decided that the general objective of the study would be to observe and describe the conduct of the training courses in Region II and the Cordillera Administrative Region (CAR). This would be particularly relevant in light of the devolution of health services to local government units which has taken place as a result of the 1991 Local Government Code. A set of specific research questions was thus drawn up. (See Figure 1.1.)

The first set of questions revolves around the conduct of the trainings and their outcomes. It should be noted in this regard that the operations research team took for granted the increased knowledge of the trainees. Not only does the Department of Health conduct pre- and post-training tests, but other research (Family Planning Service, 1993) has demonstrated, at least for the Basic/Comprehensive course, the persistence of increased knowledge. Hence, we did not include this question in the research.

Rather, we began our inquiry by looking into the possibility of absenteeism and dropout. As the full title indicates, the "Basic/Comprehensive Family Planning Course for Physicians, Nurses, and Midwives" exemplifies the "team approach" adopted by the Department of Health. It was felt during the research planning sessions that within this team approach lurked the danger that it would be difficult to train participants with widely varying levels of medical competence within a single session. Specifically, it was feared that physicians might be less likely to attend (since their time could be considered much more valuable), or less likely to persist in attending (since they felt already competent in some of the subject matter).

The next set of questions had to do with course content and effects. We were interested to obtain a detailed analysis by the trainees of various aspects of the training. In particular, what improvements could be suggested in the courses as they are actually implemented? We also wanted to know whether attendance at trainings increased commitment to the family planning program, perhaps reducing thereby personnel turnover.

The third set of questions, on trainee selection, reflects concerns that, under the devolved set-up, local governments would not necessarily send personnel who met DOH criteria. This could be due either to local favoritism, or to lack of support by the local government for the family planning program.

The fourth set of questions revolves around a specific program, the "Basic/Comprehensive Family Planning Course for Physicians, Nurses, and Midwives." This course includes a practicum phase, where trainees are under the supervision of preceptors in field areas while family planning services are provided. The focus is on a fixed number of pill prescriptions and insertions of inter- uterine devices (IUDs). The research team was concerned whether such requirements could be better expressed in terms of competencies, rather than a fixed number of accomplishments. In addition, given the newly devolved set-up, the provision of family planning services in preceptor areas needs to be examined.

The last set of questions deals with the inter-related topics of values and client-centered quality of care. The Department of Health has been interested in recent work done on the "quality of care" issue by Judith Bruce (1990), and has even incorporated her work in the Preceptors Training Course. Bruce's framework revolves around six factors:

1) Choice of Methods,
2) Information,
3) Technical Competence,
4) Interpersonal Relations,
5) Mechanisms for Continuity, and
6) Appropriate Constellation of Services.

The other family planning training courses also have modules on values, reflecting the Department of Health's central concern with this issue. For instance, in the Basic/Comprehensive course there is a discussion of specifically Filipino traits and values, and how these might relate to the family planning health worker. In the Interpersonal Communication Skills course, there are exercises in values clarification and how this relates to the family planning field worker. The research team thus examined value questions in all trainings. We were also interested, for the practicum phase of the Basic/Comprehensive course, in client reactions and clinic conditions, in order to judge the quality of care being provided.

Figure 1.1 SPECIFIC RESEARCH QUESTIONS

I. On Trainee Absenteeism and Drop-out

1. How prevalent is the phenomena of dropping-out and absenteeism among specific groups of trainees?

2. What are the reasons for dropping-out and absenteeism? Do these vary for different groups?

II. Course Contents and Effects

1. How do trainees perceive specific aspects of the training:

   a) content
   b) duration
   c) trainor's competency
   d) utility
   e) structure

2. What are some of the strengths and weaknesses of course contents? How can these be improved?

3. Has the training made a difference in the trainees' commitment to the program?

III. Selection of Trainees

1. How were the trainees selected to participate in the training course? Who was/were responsible for their selection?

2. Do trainees view the coourse in a positive light? What costs and benefits are entailed for them once they agree to attend?

3. Did the trainee have any say in the decision? What did he/she think was the basis for his/her selection?

4. Were there other candidates beside herself/himself?

5. What is the level of commitment of the trainee to the FP program?

6. What are the attitudes of LGU executives to family planning and its training component?

IV. Practicum Requirements for Basic/Comprehensive Course

V. Values and Client-Centered Quality of Care

III. Methods

The team observed trainings (Preceptors, Interpersonal Communication Skills, and Basic/Comprehensive) in both Region II and CAR (although the latter region had no Basic/Comprehensive course during this time period). Beyond observations, we administered questionnaires to the trainees both before and after the trainings, and did exit interviews of clients after having observed their interaction with trainees during the practicum phase of the Basic/Compre course. In addition, we interviewed mayors and supervisors about their attitude towards the Family Planning Program. Finally, we conducted focus group discussions with the trainers, in order to get their views on the trainings.

With all trainings, the regional researchers and their assistants carefully observed the didactic phase as it was administered in the field. The research team had copies of the training manuals, and was therefore able to compare the actual conduct of the training as opposed to the ideal training regimen.

In addition, a questionnaire was administered to all trainees at the beginning and after the end of each training. The sections of the questionnaires are given in Figure 1.2. As can be seen, some of the questions were repeated, [Post-training QRE, sections b,c,d]

Figure 1.2 SECTIONS OF THE QUESTIONNAIRES

Pre-Training	Post-Training
A. Personal Information	A. End of Training Questionnaire
B. Family Planning Practice	B. Family Planning Practice
C. Attitudes of Personnel	
D. Service Delivery (Q of Care)	C. Service Delivery (Q of Care)
E. Things I Like to Do	
F. Social Values	D. Social Values

in order to measure any change that might have occurred. These before-and-after measurements were conducted on trainee's attitudes towards family planning practice, client-centered quality of care, and more general social values. In addition, in the pre-training questionnaire we measured personal characteristics of the trainees, their attitudes towards their job (in order to measure morale and job satisfaction), and their "need for achievement" in terms of things they like to do.

A large section of the post-training questionnaire was their evaluation of many different aspects of the training.

Another questionnaire was administered during the training in order to obtain the trainees' perceptions as to how they were selected and the cost benefits to them of attending the trainings.

The research team observed the trainees during the "Basic/Comprehensive Course in Family Planning" as they worked in their preceptor areas. Several instruments were used:

1. Observation Guide for Client-Trainee Interaction,
2. Exit Interview of Client, and
3. Clinic Inventory.

These instruments were adapted from the manual, "Guidelines and Instruments for a Family Planning Situation Analysis Study" (Fisher et al., 1992). They were applied by observation teams of two persons each, which included the researchers from the Cordillera Administrative Region, despite the fact that the practicum was occurring in Region II. Observations centered on the Quality of Care that clients were receiving, while the exit interview focused on client perceptions.

In order to capture some of the data about the devolved family planning program, we first observed Family Planning Updates conducted by the Department of Health. These, however, were found to be sparsely attended, so we then made special trips to talk to local supervisors of all trainees. In these discusssions, we asked the supervisors (Mayors or local Health Officers) some of the same questions we put to the trainees in the questionnaires.

Finally, in order to tap expert opinion on training issues, we conducted focus group discussions with the regional family planning trainors.

CHAPTER 2

CORDILLERA REGIONAL REPORT

I. INTRODUCTION

The CAR research team observed family planning (FP) trainings such as the Interpersonal Communication Skills (ICS) and the Preceptors Course. Questionnaires were administered to two out of five batches of ICS trainees, particularly those trained on November 7-13 (second batch) and November 15-21, 1993 (third batch). The team also observed the Preceptors Course conducted on November 30-December 12, 1993 at Milton Hotel, Baguio City. Also, pre and post questionnaires were answered by the trainees.

The results of these observations and surveys are presented in this chapter.

II. INTERPERSONAL COMMUNICATION SKILLS

Baguio City had been identified as one of the ten pilot areas for the National Communication Campaign (NCC '93). As such, there were five batches of ICS trainings conducted in late October 1993 up to early December 1993. The venue of these trainings was at Mountain Lodge, Baguio City. As was mentioned earlier, two of these batches were studied by the research team.

The trainees of the ICS include medical and non-medical program workers. For the second and third batches, there were 15 nurses, eight midwives, two physicians and six non-medical workers who participated. 14 of them had 1-5 years of service, two had 6-10 years of service, three had 11-15 years of service and 12 belong to the 16 years of service and over.

The Tables 2.2.1 and 2.2.2 below show the year when the trainees first underwent a basic/comprehensive course:

Table 2.2.1 YEAR OF BASIC/COMPREHENSIVE COURSE
FOR THE SECOND BATCH OF ICS TRAINEES

Year	Frequency	Percent
70s	4	22
80s	5	28
90s	3	17
No Answer	6	33
	18	100%

Table 2.2.1 YEAR OF BASIC/COMPREHENSIVE COURSE
FOR THE THIRD BATCH OF ICS TRAINEES

Year	Frequency	Percent
1991	2	15
1992	2	15
1993	1	8
No Answer	8	62
	13	100%

Both tables show that many trainees did not give the year they underwent a basic/comprehensive course training. This means that they either have not undergone the training yet or they could not remember when they had one. The lead trainer of the ICS training admitted during the research utilization conference conducted in Baguio City on April 15, 1994 that there were 13 out of 100 trainees who had no basic/comprehensive course prior to the ICS training.

The trainees of the third batch evaluated the background materials or handouts, time allocation per activity, presentation per trainor, usefulness of the module in daily work and how much subject matter was discussed. The results of their evaluation on the content, duration, trainor's competency and utility of the modules are presented below.

A. Trainees Ratings of the ICS Course

A.1 Background Materials or Handouts

All the background materials or handouts for Modules I-IX of the ICS training were considered very relevant by a majority of the trainees. The percentage of trainees which consider each module as very relevant is shown below:

Table 2.2.a.1 PERCENTAGE OF TRAINEES WHO RATED EACH MODULE VERY RELEVANT

MODULES	% VERY RELEVANT
I. Introductory Module	73%
II. Understanding Self	73%
III. Contraceptive Technology	82%
IV. Interpersonal Communication	82%
V. Dev. and Using Comm. Materials for Interpersonal Comm.	73%
VI. Understanding FP Clients	73%
VII. One-on-One Interaction	73%
VIII. Group Communication	73%
IX. Counselling	91%

Comparing the nine modules, the module which had the highest percentage of trainees (91%) who said the background materials were very relevant was Module IX (Counselling). Interpersonal Communication and Contraceptive Technology ranked next highest in terms of perceived relevance (82% ranking these as "very relevant") while all other modules garnered a 73% "very relevant" statistic.

A.2 Time Allocation per Activity

It was observed during the training that the time allocated for each activity in the ICS manual was strictly followed. The evaluation of "a little more than just right" for most of the activities seems fitting (see Figure 2.2.a.2).

A.3 Presentation per Trainor

The competency of the ICS Bagiou trainers was generally evaluated highly. The percentage of trainees who evaluated the trainer as "excellent" is shown below:

Table 2.2.a.3 PERCENTAGE OF TRAINEES WHO EVALUATED THE ICS TRAINER AS EXCELLENT

MODULES	% EXCELLENT
I. Introductory Module	73%
II. Understanding Self	82%
III. Contraceptive Technology	82%
IV. Interpersonal Communication	82%
V. Dev. and Using Comm. Materials for Interpersonal Comm.	81%
VI. Understanding FP Clients	91%
VII. One-on-One Interaction	100%
VIII. Group Communication	100%
IX. Counselling	100%

It is significant to note that trainers who handled Modules VII (One-on-One Interaction), VIII (Group Communication), and IX (Counselling) were rated by all the trainees as excellent.

The results of the rating for trainer's competency are not surprising because the lead trainer of the ICS-Baguio attended a rigid trainer's training for ICS. Said training was conducted by UNDP a couple of years ago. She thus claims to be a licensed ICS trainer.

The two trainers who were tapped from DOH-CAR also underwent the trainer's training for ICS. They are also trainers for other FP trainings. Based on the focus group discussion conducted on March 10, 1994, they also believe that their attendance at various trainings helped them gain more knowledge and skills in the conduct of trainings. All these account for their competency as trainers.

A.4 Usefulness in Daily Work

In terms of usefulness of the modules in the trainees' daily work, an overwhelming majority of them believed that all the modules of the ICS are very useful. The results are as follows:

Table 2.2.a.4 PERCENTAGE OF TRAINEES

WHO RATED THE MODULES AS VERY USEFUL

MODULES	% VERY USEFUL
I. Introductory Module	82%
II. Understanding Self	82%
III. Contraceptive Technology	82%
IV. Interpersonal Communication	100%
V. Dev. and Using Comm. Materials for Interpersonal Comm.	100%
VI. Understanding FP Clients	82%
VII. One-on-One Interaction	100%
VIII. Group Communication	91%
IX. Counselling	91%

All the trainees in the ICS evaluated Modules IV (Interpersonal Communication), V (Developing and Using Communication Materials for Interpersonal Communication), and VII (One-on-One Interaction) as very useful in their daily work. Nearly all (91%) of the trainees said Modules VIII (Group Communication) and IX (Counselling) are also very useful while the rest of the modules are likewise important in their daily work according to 82% of the trainees.

It is significant to note that all the modules were appreciated by the trainees. Such appreciation could be attributed to several factors which were noted during the course of our observations:

a) emphasizing the importance or objective of the module;
b) bridging one module to the other by the trainers;
c) using actual situations as examples;
d) asking the trainees questions on the application of the skill in actual work;
e) sharing of "back home" experiences; and
f) asking learnings at the end of the module.

These were the mechanisms employed during the ICS training. It seemed to the team members that they have been proven effective.

A.5 Subject Matter Coverage

Subject matter coverage per module was generally evaluated to be just right. The result per module is presented in Table 2.2.a.5.

Table 2.2.a.5 PERCENTAGE OF TRAINEES WHO RATED THE SUBJECT MATTER COVERED PER MODULE JUST RIGHT

MODULES	% JUST RIGHT
I. Introductory Module	54%
II. Understanding Self	46%
III. Contraceptive Technology	46%
IV. Interpersonal Communication	46%
V. Dev. and Using Comm. Materials for Interpersonal Comm.	46%
VI. Understanding FP Clients	46%
VII. One-on-One Interaction	46%
VIII. Group Communication	46%
IX. Counselling	46%

In general, the subject matter covered in the ICS training ranged (on a five point scale) from a mean of 3.55 to 3.73, meaning it was more than just right, yet, not too broad (A score of 5 corresponds to "too broad" while a 1 indicates "too limited".) There was therefore some sentiment that the subject matter covered was a little too broad. Considering the time alloted and background materials used, such an evaluation from the trainees is justified.

B. Modifications

The manual was generally followed. Minor modifications include skipping the activity Zip Zap Zop, enriching topics like the Philippine Family Planning Program, and Counteracting Rumours and Misconceptions. Methodologies for the Probing, Listening, Observing and Telling (PLOT) and Counselling were also modified.

Most of the participants came from Baguio Health Department (BHD). The trainer probably decided to skip the activity, Zip Zap Zop because they knew each other already.

C. Observations and Suggestions

The researchers also observed that some of the activities in the ICS training may need some modifications to fit their purpose. Activity 1 in Module 2, called "Where do I belong?," makes the participants go to where most persons are out of a desire to conform. They may not necessarily agree but they join the group with the biggest number.

Plotting one's job satisfaction over the past seven years assumes (1) that the trainee has rendered seven years of service in the DOH and (2) that the trainee can remember her satisfaction and dissatisfaction in those years. These may not be realistic assumptions. It would thus be better if the different aspects of the job such as pay, fringe benefits, promotions, physical demand, etc. be used instead of years. The present time should be used as a reference point. In this way, something can still be done with what they are experiencing at the moment. (See the last section of this report which discusses the job satisfaction of ICS and Preceptors Course in the CAR.)

In general, role plays are not natural. Activity 5 in Module 4 (The Skill of Probing and Observation) was not natural. This was noted by the trainees themselves. In the role play, they even forgot to get the name of their client. Cards were also being read during the role play activity.

III. PRECEPTORS COURSE

There were 15 participants of the Preceptors Course. These included seven physicians and eight nurses. More than half of the trainees (53%) had 1-5 years of service. 20% had 6-10 years length of service while only 13% belong to the bracket, 16 years and over. Another 13% did not give an answer or simply did not have a year of service yet.

Most of the trainees (60%) took their basic comprehensive course in 1992 while 27% took it in 1991. Another 13% did not give an answer as to when they underwent the basic comprehensive course in FP.

As observed by the research team, no participant dropped out. Also, no absenteeism was observed during the duration of the course.

A. Trainees Ratings of the Preceptors Course

A.1 Background Materials and Handouts

The mean scores on a question about the relevance of background materials and handouts is presented in Table 2.3.a.1. In general, most trainees did see these materials as being relevant for the course.

Table 2.3.a.1 MEAN SCORES, RELEVANCE OF BACKGROUND MATERIALS AND HANDOUTS

MODULE	MEAN
I. The Department of Health	4.O
II. Self Awareness and Value Clarification	4.27
III. Adult Learning	4.27
IV. Management of FP Clinic as a Field Training Area	4.40
V. The Preceptor as an Effective Communicator	4.33
VI. Precepting Techniques and Teaching Aids	4.40
VII. The Preceptor	4.29
VIII. Supervision of Trainees by Preceptors	4.20
IX. Evaluating Trainees Performance	4.33
X. Plan of Activities for Practicum	4.27

Comparing the different modules of the Preceptors Course, Module I on the DOH has the lowest mean for the relevance of the background materials and handouts provided to the trainees. Perhaps the trainees felt these materials are no longer needed since they are now devolved. It is also possible that they know much about the DOH already having been in the service for several years now. Also, the organizational structure of the DOH should have been presented for the trainees to situate themselves now that they are under the local government. (The manual does not discuss this question, either.)

Based on the evaluation of the training team with regard to the written materials and aids used in the course, 60% said they were satisfied and 40% said they were very satisfied.

A.2 Time Allocated

With regard to time allocation, the different activities in the ten modules of the Preceptors Course were generally evaluated just right by the trainees. (See Figure 2.3.a.1.) Again, however, there was also some slight sentiment that "too much" (rather than "too little") time had been allotted to the activities. This latter problem was particularly true for the lecture of Module II.

Overall, 20% of the trainees said that they are very satisfied with the amount of time spent for this course while 33% said they were satisfied. Some 33% stayed neutral while only a few said they were dissatisfied (7%) or very dissatisfied (7%).

Trainees were asked if there was a section of the course which they felt should be expanded or given more time. A majority of the trainees (47%) said there was none while another 20 percent did not answer the question. This probably means that there is no section they want to be expanded or given more time. Among those who did ask for an expansion, 80% cited community work/field work/field visit. They suggested that more time for exposure be allowed to observe more FP clinics. The other 20% said that "communication topics" should be alloted more time. These trainees were those with no previous training in the ICS course.

The lead trainor believes that the duration of the training (12 days) is actually too long. Six to seven days will do but assignments and heavy readings at night should be discouraged. In addition, she suggested that sessions could start at 8:00 a.m. and end at 6:30 or 7:00 p.m. She felt that flexibility could be excercised depending on the participants' learning pace. Trainers/resource speakers should be good time managers according to her.

The Preceptors Course lasted for only nine days instead of the twelve originally scheduled. In addition, an update on immunization was conducted on the ninth day. According to the lead trainer, it has been a tradition in the DOH-CAR that if there are trainings, the other program managers will take the opportunity (provided there is available time) to give updates and instructions on some important concerns in relation to the tasks of the field workers who are participants to the training course.

A.3 Presentations by Trainor

The lead trainer of the Preceptors Course was the medical training officer of the Training Division of DOH-CAR. The trainers include two physicians, the head of the training division, the Regional FP Coordinator, and two nurses from DOH-CAR.

The trainors for the Preceptors Course were uniformly rated as either good or excellent. The table below shows the percentages of trainees who said they were

excellent. As can be seen therein, most presentations were quite good, the only possible exception being "Self Awareness and Value Clarification."

Table 2.3.a.3 PERCENTAGE OF TRAINEES WHO EVALUATED THE PRESENTATION OF TRAINERS EXCELLENT

MODULES	% EXCELLENT
I. The Department of Health	67%
II. Self Awareness and Value Clarification	20%
III. Adult Learning	47%
IV. Management of FP Clinic as a Field Training Area	53%
V. The Preceptor as an Effective Communicator	53%
VI. Precepting Techniques and Teaching Aids	46%
VII. The Preceptor	53%
VIII. Supervision of Trainees by Preceptors	47%
IX. Evaluating Trainees Performance	53%
X. Plan of Activities for Practicum	47%

In some cases the trainers were not those originally selected for the course. Also, during the field visit and in Module VI, there should have been two resource speakers or facilitators. In this case, though, the other one did not make it. Work-related reasons (i.e., in a meeting, in a different program, or prioritized another activity) cause replacements of trainers and shortage of trainers.

The lead trainer reported that in the choice of resource speakers, Modules IV, VI and VII were planned to be handled by physicians or nurses who are actually managing clinics. It was felt that their experience in supervising their clinics would be useful for a successful training experience. They had thus targetted some people who had been a Preceptor and Trainer for quite some time. One person gave her approval to handle one of the modules but she priotized another activity instead during the training. As per assessment, according to the lead trainer, some of these targetted are effective managers and supervisors but "cannot be effective trainers nor resource speakers."

Despite these circumstances, all of the trainees said they were "satisfied" or "very satisfied" with the facilitators' ability to explain topics, workshop mechanics and to respond to the needs and doubts of the participants.

A.4 Usefulness in Daily Work

The ten modules of the Preceptors Course were generally perceived as useful for the daily work of the trainees. Mean scores on a question about this are presented in Table 2.3.a.4.

Table 2.3.a.4 MEAN SCORES ON PERCEIVED USEFULNESS OF THE MODULES

MODULES		MEAN
I. The Department of Health		3.87
II. Self Awareness and Value Clarification		4.47
III. Adult Learning	4.47	
IV. Management of FP Clinic as a Field Training Area	4.47	
V. The Preceptor as an Effective Communicator	4.47	
VI. Precepting Techniques and Teaching Aids		4.47
VII. The Preceptor		4.47
VIII. Supervision of Trainees by Preceptors		4.47
IX. Evaluating Trainees Performance		4.40
X. Plan of Activities for Practicum		4.47

It is significant to note that Module I, The DOH, has the smallest mean in terms of its usefulness to the trainees' daily work. This result may be due to the perception of the trainees that they are no longer part of the DOH since the devolution. On the other hand, this result should be taken as an indication of how the devolved DOH personnel view their status which may have an effect in the implementation of the DOH programs.

A.5 Subject Matter Coverage

In describing the scope of the subject matter covered in the Preceptors Course, a five-point scale was used. A score of "5" meant "too broad" while a "1" was equivalent to "too little". A "3" was therefore intepreted as "just right". Mean scores on this scale are given below:

Table 2.3.a.5 MEAN SCORES REGARDING SCOPE OF SUBJECT MATTER

MODULES		MEAN
I. The Department of Health		3.75
II. Self Awareness and Value Clarification		3.53
III. Adult Learning	3.67	
IV. Management of FP Clinic as a Field Training Area	3.73	
V. The Preceptor as an Effective Communicator	3.67	
VI. Precepting Techniques and Teaching Aids		3.67
VII. The Preceptor		3.67
VIII. Supervision of Trainees by Preceptors		3.73
IX. Evaluating Trainees Performance		3.67
X. Plan of Activities for Practicum		3.60

Modules I, IV and VIII were the ones which had much (perhaps too much) coverage in terms of subject matter. Most of the modules were also rated as being a little bit beyond the "just right" stage. This was somewhat less true, however, for Modules II and X. This may be due to the time constraint which happened during the training. The module on Value Clarification was presented in the afternoon of the second day, until 7:30 p.m.

B. Modifications

During the observation of the Preceptors Course, the research team made use of the blue manual, "Preceptors Course in FP" (1993) as the basis for observation. The discussion below attempts to present the modifications, deviations, or enrichment of the manual. Reasons of the trainers for the modifications of some modules also form part of this section. Thus, this section was prepared in consultation with the lead trainer of the Preceptors Course.

It should be noted that the trainers were provided leeway in the conduct of the training. They can enrich the module provided the objective is met. A different activity may also be substituted, as long as the key learning point is made.

With regard to the sequence of modules, Module I Unit II (The RP/FP Program of the DOH) was presented first. It was followed by Module II (Value Clarification and Self Awareness). These modules were discussed prior to Module I Unit I (DOH: Its Mandate, Mission, Guiding Principles, Values, Organizational Structure) because the resource speaker for the latter was out on official business. Succeeding modules were presented according on the sequence in the manual.

Modules with some modifications include Modules I (The Department of Health), III (Adult Learning), IV (Management of FP Clinic as a Field Training Area), VII (The

Preceptor) and VIII (Supervision of Trainees by Preceptors). Modules which were enriched are Modules I (The Department of Health), III (Adult Learning), V (The Preceptor as an Effective Comunicator), and VI (Precepting Techniques and Teaching Aids). Parts of Modules II (pages 40, 41 and 42 of the manual), III (page 85) and IV (video) were skipped.

Module I: The Department of Health
(Modified/Enriched/Deleted)

According to the trainer, the content of Module I has not been updated. Unit 1 has the same contents with that of the Basic/Compre FP Course Manual, a restatement of the Vision/Mission of the DOH, its Policy Statements and Strategies.

The trainer presented the policy statements, major strategies, post devolution health systems, and structural and operational set-up of the the DOH system.

The organizational structure of the DOH is not found in the manual. Nor was it provided in the lecture.According to the trainer this had not yet been finalized. However, she presented the post devolution health system and pointed out where the DOH lies in relation to the devolved health personnel/facility (LGU). As far as structure is concerned, she discussed the presence of Headzones and the role of Field Health Service and Hospitals being centers for prevention and cure, respectively.

In Unit 2, additional information was provided to the participants specifically on the RP/FP program. Contents of this unit were the same with the Basic FP Course Manual. Topics such as the FP, its legal mandate, policies, goals of FP, and strategies, which are not found in the manual were shared with the group.

The activity (group work) for operationalization of Integrated Health service was skipped.

For Unit 3, there was a modification for the assignment on the "Health Benefits of FP." Instead of dividing the participants into three groups and picking flash cards which contain the concept related to one's respective group (i.e., health benefits of the child, health benefits of the mother and characteristics of high risk women), one representative per group would get a flash card and paste it below "high risk mother," "benefits to the child," or "benefits to the mother." This modification helped all the participants become aware of the three concepts and not only his/her respective group/concept.

It was observed by the research team that "risk of abortion due to unwanted pregnancies" should have been categorized as a benefit of the mother, rather than treated as a characteristic of a high risk mother.

Another observation was that this activity seemed to be too simple since it is easy to differentiate a child from a mother. Of course, a benefit is different from a characteristic. Thus, when the participants were asked to explain further their answers, they all gave an extensive explanation.

The trainer emphasized that the health benefits of FP should be underscored during advocacy.

Module 2: Self Awareness and Value Clarification
(Modified/Skipped)

In Unit 1 (Self Awareness), the participants shared the personal information of their partners: age, number of children, designation, address, etc. or answers to Who am I? However, only their unique attributes as a person were discussed. The unique attributes of a preceptor were missed. The three boxes, "my definition of precepting," "a meaningful experience I had with a trainee," and "something I like about my role as a preceptor" were not tackled. Moreover, the relation of the activity with regard to precepting was not made clear, as if the activity was a separate task on getting to know the participants.

The structured learning experience (SLE) on "Johari Window" was mofified. Some of the modifications and observations are as follows:

1. Assets and liabilities (from others perception) were not covered.

2. No individual feedback sheets were used. Instead, Manila papers were used by all the participants.

3. Each participant went in front to write her assets and liabilities. As such, the feedback sheet was according to one's self. This means that it did not serve its purpose.

4. There was no assessment of disclosure and feedback because the trainees did not determine which of the aspects they revealed.

In Unit 2 on Value Clarification the steps in adopting a value were not discussed. Also, the manual uses "achievement motivation" or "team work." This needs to be clarified.

Module III: Adult Learning
(Modified/Enriched)

Instead of letting the participants write their answers to the question, "What is the most significant learning experience in your life?," the trainer asked them to answer verbally.

The question, according to the trainer, was given them to internalize and answer. A chosen few were called to answer verbally. It was then pointed out that these significant learning experiences were of serious value to the the participants. In general, these experiences took place when they were already adults or mature idividuals.

The last teaching/learning process on page 70 of the manual was not conducted. Although it was deleted, it was pointed out that conventional or traditional learning was usually followed for children. This approach is not very effective if you are dealing with adults.

The trainer also differentiated traditional learning from experiential learning with her own summary such as follows:

Traditional Learning (conventional)	Experiential Learning
1. teacher-centered	1. learner centered
2. one-way communication	2. open communication
3. passive	3. active
- sense of hearing	- all the senses
- lectures	
4. formal	4. encourages information flows
5. following schedules	5. flexible

On page 71, an activity aimed at applying the principles of learning was modified by dividing the group into four instead of three. Role play was also used as a methodology rather than group discussion.

The trainer felt that role play is more effective because more learning is experienced since we are dealing with application. Prior to the role play, the group gets to discuss first about their understanding of a particular principle of learning. The principles, according to the trainer, are actually not difficult to understand, so they can be better understood by means of a role play.

Not all of the principles of learning found on page 72 were explained. According to the trainer, most of these are self-explanatory. She added that some principles are interrelated and can be covered simultaneously. It is significant to note, though, that the trainer's examples were consistently related to FP and precepting.

For Maslow's Hierarchy of Needs, instead of letting the participants read the article in the evening and relating the theory to the practical aspects of training, they were divided into three groups and were asked to rank the needs. This turned out to be better than a lecture. Examples of the different needs were again related to FP and percepting.

The trainer perceived that a lot of participants were not aware of "needs". She therefore dropped the lecture and had the group work on their own needs. It came out that they did not even know how to rank these. This activity motivated each participant to think, to discuss ranking and reasons for such rank of the needs. Almost all deliberated, first with their groupings then to the big group. The activity seemed to give a better learning process than the standard lecture format.

The experiential learning model found on page 85 of the manual was not presented.

To emphasize learning points, the trainer researched on some quotations related to the topic. This highlighted the learning, and caught the attention of the trainees to appreciate and internalize their lessons.

Module IV: Precepting Techniques and Teaching Aids
(Skipped/Modified)

The participants were supposed to be given the FP Clinical Standards Manual. Instead they were only provided with a copy of a particular chapter/topic which had been assigned. There were no available manuals. The trainers thought it was not practical to have the lone manual in the region to be reproduced. According to a message from Manila, it was still a draft and not yet final.

The field clinic visit was modified. Some observations on the conduct of the quality of care assessment using the quality assurance checklist are as follows:

1. Instead of staying one whole day in the clinic the trainees (five members in a group) visited two out of four clinics in one day.

2. The trainees were asked to submit a narrative of the strengths and weaknesses of the clinics. They were reminded to give emphasis on clinic management. (At first, they narrated their itinerary instead of the results of their activity.) They also kept their own checklist for future use.

3. Based on their reports, the trainees knew "quality assurance." However, they have some limitations like small office space, irregular water supply, inavailability of facilities and equipment, etc.

4. It was noted by the trainees that in their respective areas, there is no proper identification. The interns are the ones in white uniform.

5. It was also suggested that clients should be greeted at once.

In reaction to the above observations, the trainer said that the trainees did not stay in the clinics for one whole day to give them a chance to see two FP clinics being managed. Seeing two FP clinics in one day gives the participants a better grasp of how to manage FP clinics. Assessing these two clinics will let them compare what is good in one clinic and not being followed in the other clinic. They can also compare those clinics with their own clinic (in their area of assignment).

Another reason for observing two clinics is the schedule of FP clinic day. If the trainees are assigned in one clinic and it happens that it is not a FP clinic day in that facility, then they would be missing a lot compared to a clinic with a lot of patients because it is FP clinic day. Seeing two clinics will ward off comments like, "We were assigned in one facility, it's not FP clinic day so how do you expect to see Quality Patient Care as part of managing an FP clinic where there are no patients?"

As mentioned earlier, the majority of trainees (80%) suggested that there should be more time alloted for the field visit. This suggestion stems from the fact that two clinics were visited instead of one.

Taking the video during the group presentations during the first part of the module was not followed. Video rental is expensive and was felt to contribute to the artificiality of the learning process.

Module V: The Preceptor as an Effective Communicator
(Enriched/Modified)

Unit I of this module focuses on communication skills. Content of the PLOT portion included only the definition (what to probe, listen to, observe and tell). The "hows" or manner of probing, listening, etc. were included because it is important. It is knowing and doing the "hows" which will help the trainee practice her skills in communicating. The trainer added that, whenever one listens, she should do it assistingly, attentively, actively and respectfully. Whenever one tells, observe ABCS, i.e. be accurate, brief, clear, and simple.

The activity, "Roleplay: Veginots" was not well appreciated by the participants. They did not know the meaning of veginots, and they could not identify with either their role or the setting.

In Unit II (Communication Barriers), illustrations on the barriers of communication were presented in the transparencies for the participants to identify. For barriers which they cannot identify like semantics, inflections, pre-conceived notions, etc., the trainer provided the answer. Examples related to FP were emphasized. Instead of doing a role play, the group was divided into two with each being assigned a case study to work on. Guide questions were similar to those used for processing the role play (see manual). Emphasis was on overcoming the barriers.

Module VI: Precepting Techniques and Teaching Aids
(Enriched)

In Unit 1 (Precepting Techniques), additional inputs deemed important in the list of guidelines for the group discussion and role plays were included to enrich the manual.

The following were added to the guidelines in the group discussion (page 192 of the manual):

1. Give short simple instructions.
2. Take time to instruct.
3. Repeat instructions.

In addition to the manual, guidelines for roleplays, (see pages 217-218 of the manual), are as follows:

1. The roleplays should be simple and short.
2. Observers should be silent.
3. Allow both players to speak.
4. Use a one-line response.
5. Ask for volunteers.
6. Not a drama, only a practice.
7. Do not end by apologizing.
8. Process the role play, starting with actors and actresses.

In Unit 2 (Teaching Aids), a very timely theme ("Seeing the FP Benefits during Christmas Time.") was used for the activity on visual aid preparation. A contest was held to determine the trainee who was best able to capture this theme for visual aid.

Module VII: The Preceptor
(Modified)

The teaching/learning process advocated in the manual was modified during the course of the training.

The participants' positive and negative idea/experiences of a preceptor was done as an individual activity before it was shared to the group. Their responses were not written on the board. As the trainer defines a role, one member pastes the answer on the board.

Instead of two groups, the participants were divided into three groups to brainstorm the roles of a preceptor, which had not been extracted from the participants: These included various images of the preceptor, including "coordinator," "counselor," "evaluator," "facilitator," "teacher," planner," "supervisor," and "leader."

The activity on the qualities of a preceptor was also modified using a "buy and sell" activity whereby the participants purchased the qualities of a preceptor.

Module VIII: Supervision of Trainees by Preceptors
(Modified)

This module was generally conducted as based on the manual. However, "Methods/Techniques and Corresponding Tools Used in Supervising Trainees" was skipped.

Methodologies in the manual were not strictly followed according to the lead trainer. These were either modified, enriched or skipped. However in the conduct of the learning process, the trainers were guided by the fact that, despite the change in methodology, objectives have to be met and some topics (facts, general principles or SOPs) cannot be done away with. The resource speakers also gave updates and additional information not provided by the manual.

According to the evaluation conducted by the training team, 93% were either "satisfied" or "very satisfied" with the methodologies used in the Preceptors Course. Also, 87% said that they were satisfied or very satisfied that the course had achieved its stated objectives. In terms of facilities used for the course, 40% were satisfied and 20% very satisfied. Overall, 73% were satisfied or very satisfied with the course.

C. Suggestions

The lead trainer suggested that various methodologies not found in the manual should be used to make learning more meaningful, encouraging and participative.

In the provision of topics, the trainees felt that emphasis should be Modules III (Adult Learning) IV (Management of FP Clinic as a Field Training Area), VI (Precepting Techniques, except the Unit on Teaching Aids), VII (The Preceptor), VIII (Supervision of Trainees by Preceptors), IX (Evaluating Trainees Performance) and X (Plan of Activities for Practicum). These are the basic topics in preceptorship. The other modules are already included in the Basic/Compre FP Course. As such, they can either be skipped or given less time.

For future trainings, the ICS Course could be included as a prerequisite for the Preceptors Course. Focus would then be given to the core topics of preceptorship namely:

1. Adult Learning
2. Management of FP Training Area/Clinic
3. Precepting Techniques
4. The Preceptor
5. Supervision of Trainees
6. Evaluating Trainees
7. Planning for Practicum

It is suggested also that Module V, Unit III (Quality Assurance) be simplified. Actual situations can be used so that simple and specific examples would substantiate the six elements of quality assurance. Likewise, explanations about the impact of quality should be simple and concise.

Planning for the training is a crucial factor during the pre-training activities. Under this stage comes scheduling, choice of resource speakers and approval of management. Schedules were not followed to give way to more important and priority activities. When the actual schedule came, resource speakers considered earlier cannot always deliver their topics for they had been assigned to activities going on simultaneously with the FP Preceptors Training. While it is true that flexibility and preparedness have to be exercised, this leaves the full time trainer a job to manage and administer the training and at the same time to handle modules not originally assigned her. Whereas knowledge, attitude and skill are factors for a trainer to be effective, it will not always be true that trainers can do the job. Not all the trainers are the same. Also, she may not be an expert in the topic. Planning, scheduling and choice of resource speakers and alternates should therefore be given a very high priority.

Communications should be given as early as one month before the course. All communications should be coursed through the mayor.

Based on the evaluation conducted by the training team, 73% of the trainees were dissatisfied or very dissatisfied with food and accommodations. They said that the venue was not conducive for trainings because of the disturbances caused by noise from

traffic/vehicles. The food was also perceived by the trainees as not commensurate with the budget. The waiter was uncourteous. He seemed irritated when the trainees requested anything. Plates were removed immediately, just after the last spoon of food, noted one trainee. Despite the unsatisfactory service, the management was not open for discounts and was also asking trainees to pay for board and lodging costs not actually incurred. Some wanted to live-out or be given the option to choose where to stay as long as they came to the training area on time. If possible, for those living-out, the same training allowance would be given them.

Thus, with regard to the venue, there is a need to look for an alternative. Trainees should also be consulted with regard to their food and accommodation preferences. Training allowances should be equal.

IV. SELECTION OF TRAINEES

The information on the selection of trainees was gathered from different individuals: a) the trainees, b) the mayors who are the trainees' supervisors, and c) the provincial FP coordinator.

During the training, the trainees were requested to answer a questionnaire with regard to their selection as participants in the training. In this section of the report we arrange the findings according to the seven major items found on this instrument.

Question 1. HOW WERE YOU SELECTED TO PARTICIPATE?

The participation of trainees in the ICS and Preceptors Course had been decided by other people, not by the trainees themselves. In general, they were either selected/identified (25%), assigned/appointed (19%), informed (9%) or recipients of a special order (6%). Twelve percent of the trainees said that they were chosen to participate because everybody in their agency was supposed to attend the training. Another 16% believed that participation in trainings is one of their functions. Nine percent did not know how they were selected and 3% did not give an answer.

On the other hand, when the mayors of the trainees were asked about this question, they claimed that whenever there is a communication calling for participants in a training, they refer the communication to the Municipal Health Officer (MHO) to recommend who will participate. The mayor approves the recommendee and signs the required travel order.

In Kalinga-Apayao, the researchers learned that, whenever the PHO receives a communication from DOH-CAR asking for FP trainees from the province, he asks the supervising nurse of the technical division of IPHO (who is also the Provincial FP

Coordinator) to give him a list of possible participants. The Provincial FP Coordinator makes a list based on a training book containing the list of participants of previous FP trainings so she knows who is qualified based on the criteria provided by DOH-CAR and who had undergone the training already. She makes it a point that all municipalities are represented.

It is interesting to note that different people give different accounts on the selection of trainees. There seems to be no standard procedure in the selection of participants for FP trainings.

Question 1.a WHO WAS RESPONSIBLE FOR YOUR SELECTION?

Many of the trainees (39%) did not answer who was responsible for their selection. Nineteen percent said the training staff were responsible for their selection while 13% believed that it was the chief nurse/PHN/nurse. Some others said it was the chief of the hospital (6%), the FP Coordinator (6%), DOH-CAR (6%), Baguio Health Department (6%) or their supervisor (3%).

Question 2.a WHAT BENEFITS DO YOUR EXPECT TO OBTAIN FROM THE TRAINING?

A majority of the trainees (55%) did not answer this question. Twenty-three percent said they do not expect any monetary benefit, while 10% expect transportation allowance and another 10% expect per diems.

During the Preceptors training, however, some of the participants expressed their expectation of monetary benefits such as daily allowances. The representative of the funding agency explained at this time that such amount will be paid to the hotel for their food and accommodation. Thus, only their per diems and travel expenses from their place of assignment to the training venue (and vice-versa) were provided.

One of the trainees from Ifugao was requesting for the replacement of his expenses when he came over for a Preceptors Course training but it was re-scheduled. However, this request was not granted.

In terms of one's career or promotion, 25% said that the training can improve their knowledge, attitude and skills while 19% said it could enhance their profession or career. Six percent expect additional tasks and functions after the training. The rest (31%) did not give an answer.

According to 31% of the trainees, their skills (communication and precepting) will be improved after the training. Another 22% believed they could render an improved/quality service after the training. Sixteen percent said they can become more effective and 19% did not give an answer. It may be that these respondents do not expect much change in their working condition, despite the training, because there will still be the problem of the availability of supplies and equipment.

Question 2.b WHAT COSTS WERE CAUSED BY ATTENDING THE TRAINING?

The professional costs for attending trainings according to the trainees include missing routine, work load and clients (44%) and trainings being conducted in their respective areas (12%). Many (44%) did not give an answer.

The supervisors of the trainees believe, however, that there are no costs or disadvantages of letting them attend trainings. This is because they have substitutes while they are on training. Their position is not left vacant.

One of the mayors felt that trainings are disadvantageous both to the government and to the trainee. To the government, they spend money. To the trainee, the per diem is not enough for her accommodation in Baguio City. Remember, he said, that we are limited to a kind of per meal allowance, so sometimes, our employees do not like to go because they have to shoulder additional expenses aside from the amount that the government gives.

Forty-seven percent of the trainees did not answer the question on the personal costs of attending the training. One out of four said they miss their family while 15.6% do not miss anything at all.

One of the local executives suggested that the trainers conduct the training in the province. Those who come from adjacent municipalities could be trained together. The absence of trainees, according to him, hampers their services.

Question 3. DID YOU HAVE ANY SAY IN YOUR SELECTION?

A majority of the respondents (94%) said that they do not have any say in their selection to participate in FP trainings. Another 3 percent did not answer this question. Thus, only a mere 3 percent were involved personally in their selection.

Question 4. WHAT WAS THE BASIS OF YOUR SELECTION?

One out of four trainees said that the basis of their selection was because FP is part of their job. Another 22% said that they were identified by their superiors while 16% said they have not attended any training in the previous years. About 16% believed that they do meet the criteria set by the Integrated Provincial Health Office (IPHO).

Question 5. WERE THERE OTHER POSSIBLE CANDIDATES BESIDES YOU?

A majority (78%) of the trainees said that there were other possible candidates to attend the trainings besides themselves. Only 16% said no other candidates were available to attend FP trainings while 6% did not answer.

Question 5.a (IF YES) WHY DID THESE OTHERS NOT ATTEND THE TRAINING?

In about half of these cases (48%) the trainee said that the other possible candidates who did not attend the training are scheduled for the next batch. Some 16% did not make it to the training because they are far from the training venue. Some 12% had their own personal reasons (e.g. pregnancy).

V. PRE AND POST TRAINING

This section discusses the pre and post training results of the questions on the trainees' knowledge of the client-centered perspective, social values of trainees, and on FP practice.

The respondents include the trainees in the ICS (third batch) and the Preceptors Course.

A. CLIENT-CENTERED PERSPECTIVE

Before and after the training, 100% of the trainees said that FP programs should concentrate on the continuity of use by existing acceptors. Thus, there was no change in this regard before and after the training.

There were more trainees (96%) who believed that the FP service provides the widest possible choice of FP before the training than after the training (83%). Also, from 4%,

there was an increase to 17% of trainees who said that FP service should concentrate on a few FP methods to have smooth delivery after the training.

The same percentage (95%) of the trainees before and after the training said that it is more important that clients should be informed by service providers regarding sustained advice, support, supply, and referral to other methods and related services, if needed.

There were less trainees (81%) after the training rather than before the training (95%) who believed that the clients should be informed of the range of FP methods available and their contraindications. Only 19% (post training) and 5% (pre training) believed that clients should be informed only about the FP method they specify when entering FP.

There was a slight increase of trainees from 91% before the training to 95% after the training who said that clients evaluate providers more on the amount of time they spend with them and on their provider's caring attitude than on the observance of asepsis and medical standards.

There was a decrease of the percentage of trainees, from 90% (pre-test) to 75% (post-training) who said that the interpersonal aspect of care is more important for the client's ability to participate in long-term family planning.

There were more trainees (78%) during the pre-test who said that it is more important that training of FP service providers should ensure assessment of FP provider competence in field delivery than in the post-test (57%).

There was also a decrease (from 71% to 48%) in the percentage of trainees who said that a client's ability to practice contraception for a long time is more enhanced by the availability of a variety of FP methods.

With regard to the achievement of better demographic results, 65% of the trainees believed during the pretest that programs can achieve better demographic results when they concentrate on satisfying a smaller number of continuing acceptors. In the post test, more trainees (75%) agreed with this statement.

During the pre-test, 62% of the trainees said that the health services most connected to FP should be determined by views of clients as to their health needs. In the post-test, there was an increase with 71% of the trainees choosing this statement over the alternative, "Health services most connected to FP services should be determined by medical evidence about how overall health is related to FP."

Half of the trainees during the pre-test said that integration of FP services with other health service is a cultural problem of the community residents rather than a technical problem of the DOH management. In the post-test, there was a slight increase for this, from 50% to 55%.

B. Social Values

Various statements about important social values were presented to the trainees. In general, no significant differences were found between pre-test and post-test scores for these items. In interpreting these results, the reader should bear in mind that a high mean score indicates a fairly high level of disagreement with the statement in question.

The highest mean (3.56) for a social value is that of "Despite how hard people try, things generally do not change." This is followed by 3.32, which is "It is ok to pay a man with a family a higher salary than a single woman for the same job." The third ranking social value is "Parents should make sure they have at least one son and a daughter before practicing family planning" which has a mean of 2.88.

"Promotions should be based on length of service" has a mean of 2.76. "The father should be the head of the family and his decisions followed" has a mean of 2.72. "Health workers must have consideration for the individual needs of clients, even if it means making exceptions to the rules" has a mean of 2.44. The statement, "In today's world, each person should be treated the same, regardless of who they are," has a mean of 2.16.

Greater agreement is found for statements with an average which is close to, or below 2.0. This is true for the statements that "There are qualities a child can have that are more important than discipline" and "In daily life, relations among people should be based on specific ways they can help each other, rather than on a more general feelings they have for each other". Each of these has a mean of 2.12.

The statement "DOH workers should not let their feelings about any particular client affect how that client is treated," has a mean of 1.88. Surprisingly, the statement, "An important value of FP is a woman's right to control her own body," has a mean of 1.77 only.

C. FP Practice

The trainees of the ICS and Preceptors Course were also asked questions on FP practice. The results of both pre-test and post-test are presented in Figure 2.5.c.

IS IT IMPORTANT TO HAVE THE ABILITY TO CONTROL FERTILITY OR PLAN A FAMILY?

During the pre-test, there were 96% who said that it is important to control fertility or plan a family. In the post- test, the same percentage was noted. The training thus had no effect with regard to the trainees' knowledge that it is important to have the ability to control or plan a family.

SHOULD GOVERNORS/MAYORS SUPPORT OR BE AGAINST THE FREE CHOICE BY COUPLES OF A METHOD OF FP?

Originally, 62% believed that governors or mayors should support the free choice by couples of a method of FP. After the training, there were a few more (67%) of the trainees who said local executives should be supportive of couple's free choice of FP method.

DO YOU APPROVE OF UNMARRIED INDIVIDUALS HAVING ACCESS TO CONTRACEPTIVES?

Before the training, 25% of the trainees approved that unmarried individuals may have access to contraceptives. After the training, the same percentage showed approval. There was thus no change in this regard. In general, a majority of the trainees do not approve of unmarried individuals obtaining access to contraceptives.

FOR CERTAIN CULTURAL, RELIGIOUS, ETHNIC, MORAL OR RELIGIOUS REASONS, SOME PERSONS ARE NOT COMFORTABLE WITH FP. ON THE OTHER HAND, OTHER PERSONS FEEL IT IS OKAY. DO YOU FIND THE IDEA OF FP COMFORTABLE OR NOT?

During the pre-test, there were 80% who were comfortable with the idea of FP. However, during the post-test, there were only 68% who felt this way.

AS YOU KNOW, IN THE PAST THERE HAVE BEEN DISAGREEMENTS BETWEEN THE ROMAN CATHOLIC CHURCH AND THE GOVERNMENT REGARDING FP. WHERE ON THIS SCALE WOULD YOU PLACE YOURSELF?

For both pre and post test, 28% said that they are for the side of the government. Also towards the government side (or 4 in a scale of 5) are 20% and 16% during the pre and post test respectively. There were 52% in the pre and the post training who stayed neutral. In the post training, 4% of them placed themselves towards the church side.

WHICH OF THESE STATEMENTS MOST FULLY EXPRESSES HOW YOU FEEL:

1 I can promote FP with no reservation
2 I have a few reservations about promoting FP
3 I have many reservations about promoting FP
4 I am unwilling to promote FP

With regard to this question, there were less (64%) who could promote FP with no reservations before the training rather than after the training (72%).

VI. ATTITUDES OF SUPERVISORS AND TRAINEES ATTITUDES

This section discusses the attitudes of trainees and supervisors which include mayors, municipal secretaries and provincial health officers.

The first part will deal with attitudes toward several FP methods and abortion while the second part will be on attitudes toward FP issues.

A. SUPERVISORS' AND TRAINEES' ATTITUDES TOWARD SEVERAL FP METHODS AND ABORTION

The means of the supervisors and trainees attitudes toward several FP methods and abortion are presented in Table 2.6.a.

Table 2.6.a. MEANS OF THE SUPERVISORS AND TRAINEES ATTITUDES TOWARD SEVERAL FP METHODS AND ABORTION

FP METHODS AND ABORTION	M E A N S	
	Supervisors	Trainees

Natural Family Planning Method	4.00	4.18
Rhythm Method	3.86	3.91
Use of Condoms	3.47	3.86
Inter-Uterine Devices (IUD)	3.40	4.12
Birth Control Pills	3.14	4.28
Injectable Birth Control	3.21	3.45
Tubal Ligation	3.36	4.39
Vasectomy	3.00	4.07
Abortion	1.57	1.21

These data indicate that the trainees show greater approval than do the supervisors when it comes to the use of the different contraceptives especially the IUD, birth control pills, tubal ligation and vasectomy. There is only a small difference for natural FP, condoms, and injectable birth control. Both supervisors and trainees had means approaching 4 with regard to approving the practice of the rhythm method. (That is, this method was approved more than any other.)

The tendency of supervisors to rather stay neutral is probably attributed to their limited knowledge on the contraceptives. During the interview, they asked the researchers about the different techniques, especially methods other than condoms (e.g. injectables).

With regard to the approval or disapproval of abortion, the means of the supervisors and trainees are 1.57 and 1.21 respectively. This indicates fairly widespread disapproval of this practice.

B. SUPERVISORS AND TRAINEES' ATTITUDES TOWARD FP ISSUES

A question was asked on whether it is important or not to have the ability to control fertility and to plan a family. A majority of both supervisors (93%) and trainees (94%) said that this is important to them.

Sixty-seven percent of the supervisors and 69% of the trainees believe that governors and mayors should strongly support the free choice of couples of a method of family planning. Thirty-three percent of the supervisors want them (governors and mayors) to do this. For the trainees, 26% said they want the local officials to support free choice.

When asked to choose which is more important in a moral life (i.e., following one's own conscience or following the teachings of one's religion), a majority of both supervisors (93%) and trainees (84%) find following one's own conscience more important in this regard.

A majority of the supervisors (73%) and trainees (76%) do not approve of unmarried individuals having access to contraceptives.

For the supervisors, 40% said married couples should begin the use of contraceptives any time, 20% said after the first child while another 20% said when no more children are desired. Twenty percent said none of the above choices. On the other hand, a majority of the trainees (56%), said that a married couple should begin the use of contraceptives after the first child as compared to 31% of the trainees who said a married a couple should begin the use of contraceptives at any time. The rest said after several children (4%) or when no more children are desired (4%).

In a scale of 1 (comfortable) to 5 (not comfortable), the supervisors and trainees plotted their comfortability with the idea of FP. The supervisors said that they are comfortable with the idea of FP by answering 1 (40%) or 2 (33%). Thirteen percent stayed neutral while another 13% said they are not comfortable. For the trainees, a large majority of them (85%) said they are comfortable with the idea of FP, answering either (1) or (2). Another 4% were neutral while 11% were not comfortable with the idea of FP.

A majority of the supervisors (73%) and trainees (71%) feel that they can promote FP with no reservations. Only 13% among the supervisors and 7% among the trainees are unwilling to promote FP.

On the issue of FP, more than half of the supervisors (53%) and 36% of the trainees placed themselves fully on the side of the government. Another 20% of the superisors and 13% of the trainees are towards the government side (4). Other preferred to remain neutral (49 percent of the trainees and 27% of the supervisors).

A majority of both supervisors (47%) and trainees (52%) believe that integration of FP services to other health services is a technical problem of the local government units and DOH management. Most of the other respondents gave greater emphasis to the cultural side of this issue.

Forty-seven percent of the supervisors and 32% of the trainees strongly agree that an important value of FP is a woman's right to control her own body. Another 27% and 41% of supervisors and trainees, respectively, agree with this statement. Among supervisors, 7% disagree and 13% strongly disagree. On the other hand, the trainees who disagree come to 11% while those who strongly disagree comprise only 2%. Fourteen percent of the trainees do not know whether to agree or disagree with this idea.

In terms of the statement, "Parents should make sure they have at least one son and one daughter before practicing FP," only 33% of the supervisors and 39% of the trainees agree or strongly agree to this statement. Those who disagree to the statement comprise 33% and 39% among supervisors and trainees, respectively. Another 13%

among the supervisors and 18% among the trainees strongly disagree with it. Twenty percent of the supervisors do not know whether to agree or disagree while 4% of the trainees gave no answer.

VII. INTERVIEW WITH MAYORS

In line with the objective of knowing the attitudes of LGU excutives to the FP program, the mayors of those who attended the different trainings were also interviewed by the research team.

The team asked about the devolution of the DOH in general before focusing on the FP program. Topics on the FP program include the mayor's support for the program, the FP trainings, the Generic MOA, FP Update and their suggestions for the program.

A. DEVOLUTION OF THE DOH

The mayors generally approve of devolution. They say devolution is good. However, they consider the lack of financial support (funding) as a major problem.

The mayors typically feel that the devolution of the DOH is quite disadvantageous to the municipal government considering the wide scope of health programs. Also, MOE, supplies and other needs for their operations are not included in the funds.

Salaries and benefits of the health workers represent another problem the mayors have to solve. Applying the local hiring rate makes the pay of devolved health personnel at least 20% lower than the national hiring rate. Before the devolution, a mayor said that the barangay health workers (BHWs) received an honorarium of P500.00 per month. Now, they no longer have an honorarium.

The benefits of the health workers which are stipulated in the Magna Carta (i.e., laundry expenses and subsistence) are sources of demoralization on the part of the municipal employees especially because the health workers are already categorized as municipal workers. Even the mayor will be receiving lower than that of the doctor if the Magna Carta will be implemented. Some mayors said that they cannot implement the Magna Carta because they are not provided with the funding necessary for this.

Thus, the mayors' problems with regard to the devolution of the DOH is on motivating the health workers and how to implement the various health programs given the lack of funding. Some of them are therefore recommending the return of the DOH to the national government.

B. THE FAMILY PLANNING PROGRAM

B.1. SUPPORT FOR THE FP PROGRAM

Most of the mayors claim to support the FP program. They point to the pre-marriage counseling of couples at the RHU prior to the issuance of marriage licenses. Information dissemination is another activity the mayors conduct to support the program. This is usually done during medical outreach, barangay meetings or in coordination with other agencies.

When asked why they support the program, the mayors said that they know the disadvantages of having a big family or not spacing children. They said this means not being able to send children to school and not being able to take good care of them. Personal experiences such as belonging to a big family and having been a FP user are also reasons for supporting the program.

Cultural support for large families in the Cordillera (where having more children is seen as an asset) was mentioned as one of the problems encountered in the implementation of the FP program.

Religion of the people is also considered as the problem encountered in the implementation of the FP program. Provincial health officers (PHOs) agree that religion is a problem. To quote the PHO:

> "Sometimes, I can say that the problem is from above. But the biggest problem is the Catholics. If only they will cooperate, then we can succeed. They are more effective in their campaign against us. Their organization has extended to the very roots, their credibility is very great. Their mass approach is very effective. The only ones who listen to us are those who really understand us. But, when they go to the church and listen every now and then, there will be a tendency that they will follow the sermon of the priest. So, what we do is change their attitudes. I was in this program eversince and I did not see any improvement or progress. I believe ten years from now, pareho pa rin (It will still be the same). People's religion does not change."

Comments on the slogan, "FP saves lives"

Mayors were asked to comment on the slogan, "FP saves lives." Some simply said that this idea is fine with them. Others, however, find it inappropriate because they are

confused about the meaning of "FP saves lives." Their confusion arises from what FP can do to the user and to the potential baby.

Another source of confusion is on what it means to "save" a life. A mayor said that, for families who have many children, FP saves them from poverty. However, he does not think FP saves lives literally. According to this mayor, it only controls life but does not save it. If it saves lives, he said, it has another conotation especially if we go to the moralistic side of it, or Christian side or our relationship with God or our religion.

A number of mayors were simply not aware of the slogan.

B.2 Generic MOA

The Philippine FP program participation agreement is supposed to be executed and entered into by and between the DOH and the municipality. Most of the mayors have neither heard about nor signed the Generic MOA as of the conduct of this interview (February and March 1994).

B.3. FP Updates

During the FP Updates conducted per province in the CAR, the research team observed that there were no mayors who attended. When the team asked why, they were told that the mayors were not aware of such an activity. Those who were informed sent representatives who are medical personnel because they believe it does not personally concern them.

B.4. Suggestions for the FP Program

A massive information campaign is a unaninous suggestion of the mayors for the success of the FP program. They say that this should not only deal with the use of the different contraceptives but also on the overall idea of FP. This would help prevent people from equating FP with the different methods.

For the FP trainings, some mayors suggested that these will be conducted in one of the adjacent municipalities. They could be put together for training to cut down on expenses.

A provincial officer suggested that FP should be a "consistent and continuing policy" that even if the (Protestant) president is no longer there, it should be continued.

VIII. JOB SATISFACTION OF C.A.R. FP TRAINEES

The mean values for the job satisfaction of the FP trainees in CAR according to the different job aspects are shown in Figure 2.8.

The health personnel are generally happy about their job (3.93). They are satisfied with the challenge (4.05) posed by their work, with their co-workers (4.02) and also with availability of staff training programs (4.02).

Pay (2.55) and fringe benefits (2.60), however, seem to give a relatively low satisfaction to the trainees. To some extent, they are also quite dissatified with regard to promotions (3.23) and with their supervisor (3.29).

According to the mayors, benefits and allowances stipulated in the Magna Carta are given to the health personnel. This, however, causes demoralization on the part of the other local government employees. One mayor also said that the municipal health officer (MHO) would receive more than he does. He believes that being the officer occupying the highest position in the municipality, he should receive the highest salary.

Chapter 3

IMPLEMENTATION OF THE DOH TRAINING COURSE FOR FAMILY PLANNING PROVIDERS IN THE CAGAYAN VALLEY

I. Introduction

Training is one of the components of the DOH Family Planning Program which is premised on the context of preventive health care and life-preserving measures. The DOH trainings aim to develop adequate staff for the delivery of services, to assure quality of and access to these services, and to provide technical and administrative assistance. With the team approach as a strategy, the training program trains physicians, nurses, and midwives together.

The Interpersonal Communication Skills (ICS) training is for all family planning personnel. It seeks to improve their ability to communicate to clients and other interested persons about the FP program. The modules covered in the training are the following: I - Introductory Module; II - Understanding Self; III - Contraceptive Technology; IV - Interpersonal Communication; V - Developing and Using Communication Materials for Interpersonal Communication; VI - Understanding FP Clients; VII - One-on-one Interaction; VIII - Group Communication; and IX - Counseling.

The Basic/Compre Course in FP for Physicians, Nurses and Midwives is aimed at enabling them to acquire knowledge, attitudes, and skills for the delivery of comprehensive FP service. The training consists of two phases: didactic and practicum. The didactic phase covers nine modules, namely: I - The DOH; II - The RP/FP Health Worker; III - Human Sexuality in FP; IV - Human Reproductive System; V - Health Assessment; VI - Family Planning System; VII - Related Productivity Health Services; VIII - Interpersonal and Educational Communication Materials; and IX - Management of FP Clinic Services.

On the other hand, the practicum phase is a two-week hands-on experience in the FP service for all the participants under the direction of the preceptor in the preceptor clinic. An additional two weeks of practicum is required for midwives and nurses who qualify to complete the training.

Another training is the Preceptors Course, a two-week didactic training for those persons who will supervise the practicum phase of the Basic/Compre course. Participants should have had training in ICS and Basic/Compre to qualify for this training. The training is designed to equip health workers with the knowledge, attitudes

and skills needed for the effective delivery of services in the field of training areas. The modules include the following: I - The DOH; II - Self- Awareness and Value Clarification; III - Adult Learning; Module IV - Management of FP Clinic as a Field Training; V - The Preceptor as an Effective Communicator; VI - Precepting Techniques and Teaching Aids; VII - The Preceptor; VIII - Supervision of Trainees by Preceptors; IX - Evaluating Trainees' Performance; and X - Plan of Activities for Practicum.

In Region II (Cagayan Valley), three training courses were observed in 1993. One ICS training was held at Cindy's and Mindy's in Cauayan and one Basic/Compre training was held at Isabela State University (Cabagan Campus). These were conducted by the Isabela Provincial Health Office. There was one ICS training conducted in Bayombong, Nueva Vizcaya. Held in Villa Margarita Resort, this training was managed by the Nueva Vizcaya Provincial Health Office. It is noted that these trainings were the first ones conducted under the auspices of the provincial health office under the devolved set-up.

In each of the trainings observed, the research team (i. e., regional researcher, research assistant, interviewer) made day- to-day observations of the activities, taking note whether the training module was followed. During the practicum phase of the BASIC/COMPRE course, the research team was assisted by the research team from the Cordillera Administrative Region (CAR) in order to observe the trainees twice in the preceptor areas.

A pre-training questionnaire was given to all the trainees before the formal opening of the training. It consisted of personal information about the trainee, their commitment to the family planning program, job satisfaction, attitudes toward the client-centered perspective on family planning service, and social values. A structured interview guide was likewise used to determine the way in which the trainees were selected to participate in the training and its perceived effects.

At the close of the training, another questionnaire was given to the trainees. This instrument elicited the trainees' assessment of the content, duration, trainor's competency, utility and structure of the specific aspects of the training. It also had items on commitment to the family planning program, client-centered perspective towards family planning service, and social values. The repeated items were used as a basis for determining the effects of training on the participants.

During the practicum phase of the BASIC/COMPRE course, several aspects were looked into. An observation guide was used to document the interaction between the trainees and clients. To validate the observations, an exit interview with the client was conducted after the interaction. In addition, an inventory guide was used to assess the adequacy and/or status of the facilities at the preceptor area.

To assess the support of the local government for the family planning program, the trainees' supervisors were interviewed using a prepared guide. By supervisors, is meant the town mayor, municipal administrator, municipal planning and development officer, and municipal population officer.

II. RESULTS

A. Training Observations

In all of the observed trainings, the first session did not start as scheduled. Instead, it opened late in the morning or even in the afternoon. To make up for the delay, the training session ususally extended up to early evening on these days.

Oftentimes, the main reason for the delay was the late arrival of participants. They typically leave their stations only on the morning of the first day. Other causes were the delayed communication to the mayor for such attendance and the failure of the mayor to act on the travel order of the participants.

The sequence of the modules was followed in the ICS training. However, as the participants were aware of DOH functions, only the most crucial information was discussed by the trainor in Module I (The DOH). The activities as suggested in the modules were undertaken, except for film showing. There were no video tapes on the following: "The Field Worker and the Community" for Activity 2.2.2 and "Heartsell..." and "Sa Totoo Lang" for Activity 4.3.2. In lieu of these activities, brainstorming or role playing was done.

Modules reproduced by copier in Isabela ICS were not legible. Writing boards were too small, and there was no screen for the overhead projector.

As regards the Basic/Compre training, there was a change in the sequence of training. Module V (Health Assessment) was taught before Module III (Human Sexuality in Family Planning) and Module IV (Human Reproductive System). The unavailability of the lecturer required this change.

The lecturer for Human Reproductive System failed to adequately discuss the male reproductive system. She had not been informed that her talk would include this topic. Instead, her lecture dealt almost entirely with the female reproductive system.

At the start of the practicum, some preceptors were reluctant to accept some participants because the request for the use of their facilities in the preceptor area and their technical guidance had been made late. For this reason, trainees had difficulty getting enough clients. Some trainees were therefore re-assigned to other preceptor areas.

Only two preceptors had attended the latest Preceptors Course which integrates the Quality of Care approach. All others had their training two to three years earlier.

B. Characteristics of the Respondents

The trainees for the ICS training were predominantly midwives (92 %); only 8 % were nurses (Table 1). Sixty percent had served 16 years or more as a health worker; 35% had been in the service for 11-15 years, while 5 % had stayed in the service for 6-10 years. Not all the ICS trainees had Basic/Compre training as required for participation. Only 55 % reported attendance at this training.

On the other hand, one half of the Basic/Compre trainees were nurses. The remainder were either midwives (45%) or physician (5%). These trainees were less experienced. Thirty percent were in the service for 1-5 years; 15 % for 6-10 years; 25 % for 11-15 years; and 30 % for 16 years and over. No one had attended a training related to family planning.

C. Trainees' Job Satisfaction

Mean job satisfaction scores were computed for the trainees. The facets that made the trainees happy about in their job are the following: supervisor (4.12), goal attainment (4.09), staff training (4.09), challenges of the job (4.05), and promotions (4.05).

What made them least happy about the job are the pay (2.40), fringe benefits (2.72), and physical demand (3.07). Apparently, the low salary and the non-giving by some LGUs of the fringe benefits which were given to them before the devolution were causing the health workers to be less satisfied with their job. Reported mean salary was P3,144.00 for the ICS trainees and P3,846.68 for the BASIC/COMPRE trainees. Moreover, as they are handling several health programs, besides the family planning service, they felt that their job made a lot of physical demands on them.

D. Trainees' Absenteeism and Drop-out

No cases of dropping-out or absenteeism were reported in any of the trainings. Among the 20 trainees in the Preceptors Course, there were three doctors who remained throughout the duration of the training.

A minimal incidence of tardiness was observed. Tardiness happened when trainees residing near the training venue were allowed to commute instead of staying in

the hotel or dorm. For this reason, the "stayers" suggested that the training site should be outside the province so that everybody would be forced to stay in.

E. Trainees' Assessment of Specific Aspects of The Training

1. ICS training. Generally, ICS trainees assessed the background materials or handouts given for each of the nine modules as very relevant, with means ranging from 4.77 to 4.92 (Figure 3.2.e.1.1). As regards time allocation for the activities in each module, mean assessments bordered from "just right" to "much" (Figure 3.2.e.1.2). Based on the mean values for the activities in each module, time allocated for Modules I (3.53), II (3.39), III (3.56), IV (3.46), V (3.47) and VIII (3.54) were perceived as just right, while the other modules (Module VI, 3.73; VII, 3.66; and IX, 3.61) were considered "much". The activities that had much time were discussion (3.84) for Module I; discussion (3.75), brainstorming (3.75), and role play (3.75) for Module VI; role play (3.72) in Module IX; sharing (3.75) and role play (3.70) in Module VII.

As pointed out earlier, no films were shown because there no video tapes were given to accompany the training manual. As perceived by other trainors, there was also difficulty of getting a machine operator from the regional or provincial health offices.

On the trainors' presentation of subjects, the ICS trainees generally assessed it as excellent. The mean ratings for the different modules ranged from 4.60 to 4.76.

The trainees generally considered the competencies gained from the subjects to be very useful to their daily work (Figure 3.2.e.1.4) . In terms of the extent of subject matter covered in each module, ICS trainees generally assessed it as somewhere between "just right" and "too broad "(Figure 3.2.e.1.5).

Comparing these results from the evaluation results conducted by the training management, similar findings are noted. All trainees from this course considered the ICS training worthwhile. Eighty percent considered the length of the course just right. Trainees agreed that the subject matter taken was in consonance with the objective of the course. All of them likewise expressed that their expectation of the course had been attained. (See Table 3.2.e.1.)

The training module was assessed as satisfactory. As regards quality of the training materials, 65 % considered it satisfactory. Training handouts given in ICS Isabela were not readable because they were poorly reproduced by a low-quality copier.

All the ICS trainees claimed that the course content greatly applied to their work, especially on motivating clients.

Trainees evaluated their trainors as accommodating, understanding, and approachable. They were knowledgeable, explained well and clearly, and had a sense of humor.

2. BASIC/COMPRE training. The trainees considered that the handouts given were relevant. Mean ratings ranged from 4.22 to 4.58. In terms of time allocation for the activities in all modules, the trend of their assessment is it was just enough (Figure 3.2.e.2.2). The trainors' presentation of the subject matter was generally assessed as excellent as shown by the mean ratings ranging from 4.40 to 4.65. On the whole, trainees perceived the training to be very useful to their job as a Family Planning worker. Mean ratings ranged from 4.65 to 4.80.

Generally, the subject matter covered in each of the modules was assessed as "broad" by the trainees. The mean ratings ranged from 3.70 to 3.80. Again this range is somewhere between "just right" and "too broad". One topic which the trainees claimed to have not been fully explained was the rhythm method. They expressed lack of confidence in recommending it to clients because they could not explain how it works and how it is done.

Evaluation results (Table 3.2.e.2) provided by training management indicated that the trainees generally considered the training course and its contents valuable to their job. The trainees considered the training methods good and speakers' ability to transfer knowledge very good. The usefulness of the audio/visual aids was considered good. The value of the handouts/modules was assessed very good. In terms of duration of training, the trainees considered it just right.

Trainees perceived the training to have succeeded in attaining its objectives. In general, the trainees considered the training to have provided them with additional knowledge and skills in the delivery of FP services. One is the skill of inserting IUDs.

The ability of the facilitator to manage the training was rated very good. Trainees' participation in the discussion was likewise assessed as very good.

F. Trainees' Commitment to the Family Planning Program

1. ICS trainees. The commitment of the trainees to the Family Planning Program was compared before and after the training. For the ICS trainees, there was consistent belief on the importance of being able to control fertility or to plan one's family, as well as for the need for mayors/governors to support the free choice of couples of an FP method (Figure 3.2.f.1). However, the trainees did not approve of unmarried individuals having access to contraceptives.

A significant finding is the stable response of the majority of the trainees who would side with the Government on the issue of family planning. Only a small proportion of the trainees held a neutral position on this.

What is disturbing is the finding that only a slight majority of the trainees found the idea of family planning comfortable after the training. A slightly smaller proportion of the group had neutral feelings about it.

The majority of the trainees stated their ability to promote FP without reservations before and after the training. It is noted, however, that after the training, about one fourth of them still had reservations in promoting family planning.

2. BASIC/COMPRE trainees. The trainees had a more stable level of commitment to family planning. All of them agreed on the need to have the ability to control fertility and the need for governors and mayors to support the choice by couple of a family planning method (Figure 3.2.f.2).

After the training, the majority of the trainees were on the side of the Government regarding family planning issues. The idea of family planning being comfortable was felt by the majority of them. Others had a neutral stance. However, only a little more than two-fifths of the trainees expressed confidence about promoting FP without reservations. One-fourth of them were unwilling to promote it while the others had reservations.

G. Selection of Trainees

Trainees reported that the Provincial Health Officer and the Chief Nurse in the province were the key people who were instrumental in their selection as participants to FP trainings. The training staff likewise had responsibility for the selection of trainees.

The majority of the trainees recognized that there are monetary benefits to their participation to training. About 22 % identified free traveling expenses as a benefit, while 30 % mentioned daily allowance/take-home pay. As observed in the Isabela and Nueva Vizcaya trainings, whatever remainder in the budget per trainee (P400/day) after considering the board and lodging costs, is given to them or given in kind. Usually, training management used the amount to buy things the trainees need in the performance of their job, e.g., umbrella, bags and the like. The trainees were observed to be appreciative of the monetary benefits given them.

Moreover, a majority of the trainees (51 %) considered the additional knowledge and skills gained from the training as the advantage of their participation to their career. About one fifth of them anticipated professional advancement, while 7 % mentioned additional tasks after coming back from the training.

In terms of training benefits for their clients, 76 % of the trainees mentioned improved delivery of FP services. There were 12 % who recognized they would have additional clients to serve. FP service would then be added as additional function of the trainees in their health center.

Professional costs caused by trainees' attendance at the training were missing their clients (as pointed out by 39 % of the trainees) and missing their work in the clinic (36 %). The personal costs caused by their training attendance were generally missing their home, family/children and friends.

About 71 % of the trainees agreed to their participation after they were informed of the training. The majority (53 %) of them mentioned they were chosen because they had not attended any FP training yet. The basis of other trainees' selection varied: training criteria met, 15 %; seniority, 10 %; motivated by PHN, 9 %, good performance, 3 %. (See Figure 3.2.g.4.)

Nearly 75 % of the trainees were aware that there were other candidates besides them. Reasons for these other staff not being selected included the following: scheduled for next training (34%), limited slots (20%), new or retirable (8%).

H. Trainees' Attitude Toward the Use of FP Methods

Both ICS and BASIC/COMPRE trainees approved the following FP methods: natural family planning, condom, IUD, pills, tubal ligation, and vasectomy. However, they disapproved the use of abortion. This attitude was true before and after the training (Figures 3.2.h.1 and 3.2.h.2).

The BASIC/COMPRE trainees had a significant change of attitude towards using the rhythm method. While they approved (4.13) of it before the training, they were generally undecided (3.0) after. On this issue, ICS trainees approved it to be used. One factor of the shift on BASIC/COMPRE trainees was the inadequate knowledge they had about rhythm as this was not adequately covered during the didactic phase. The reason for the less emphasis given on the method is it belongs to the methods which FP workers are encouraged to know, as opposed to the methods they must know.

Moreover, BASIC/COMPRE trainees approved the use of injectable contraceptives. In contrast, ICS trainees significantly changed from disapproval (2.19) before the training to indecision (3.02) after the training.

On the time when married couples should use contraceptives, both ICS and BASIC/COMPRE trainees suggested their use after the first child. Between 65 and 80

percent of the respondents gave this answer, both before and after they had attended the training.

I. Trainees' Attitude Toward Client-Centered Provisions of Family Planning Service

On the whole, both ICS and BASIC/COMPRE trainees recognized that it is important for the Family Planning program to cater to the client's needs (Figures 3.2.i.1 and 3.2.i.2). They believed that clients should be informed by service providers regarding sustained advice, support supply, and referral to other methods and related services if needed. Moreover, they acknowledged the need to concentrate on the continuity of use by existing acceptors and to provide clients the widest possible choice of FP. Related to this is their concern to inform clients about the range of FP methods available and their contraindications. Likewise, both groups of trainees were aware that clients evaluate providers more on the amount of time they spend with them and on their caring attitude. Thus, they believed the interpersonal aspect of care is more important for the client's ability to participate in long-term family planning.

On the other hand, they realized that programs can achieve better results when they concentrate on satisfying a smaller number of continuing clients. Besides, trainees recognized that health services most connected to Family Planning should be determined by the views of clients as to their health needs.

What the majority of both groups of trainees failed to appreciate are the following: integration of Family Planning service with other health service is a cultural problem of community residents; and client's ability to practice contraception for a long time is more enhanced by the availability of a variety of FP methods.

Generally, the effect of training in changing the attitude of trainees on matters related to client-centered provisions of family planning service was more evident among BASIC/COMPRE trainees. After the training, more BASIC/COMPRE trainees recognized the need for a client-centered perspective in Family Planning. This may be because quality of care issues are part of these training modules. In contrast, the ICS training does not have it as part of the modules, although it is integrated in the lectures.

J. Trainees Social Values

The social values of both the BASIC/COMPRE and ICS trainees were generally favorable toward Family Planning (Figures 3.2.j.1 and 3.2.j.2). Both groups of trainees strongly agreed that an important value of family planning is a woman's right to control her own body. They also recognized that there are qualities a child can have that are more important than discipline. In daily life, they agreed that relations among people should be based on specific ways they can help each other, rather than on more general

feeling they have for each other. In this connection, they agreed that DOH workers

should not let their feelings about any particular client affect how that client is treated, as each person should be treated the same, regardless of who are they. However, the trainees seemed to contradict themselves when they agreed that health workers must have consideration for the individual needs of clients, even if it means making exemption to the rules.

The trainees generally diasagreed on the following: parents having at least one son and one daughter before practicing FP; the father being the head of the family and his decisions to be followed; paying a man with a family a higher salary than a single woman for the same job; and things generally do not change, despite how hard people try.

The two groups of trainees differed in their belief about seniority as the basis of one's promotion. While the BASIC/COMPRE trainees seemed to disagree with this idea, the ICS trainees agreed. This pattern may be a function of the fact (noted earlier) that the latter group has more seniority in the DOH than the latter.

K. Local Government Supervisors' Attitude Toward Family Planning and Its Training Component

The supervisors (town mayors, municipal administrators, and municipal population officers) of the trainees were interviewed to assess the support of local governments for the family planning program. It is noteworthy that all of these persons did indeed express support for the program, indicating that they consider it to be a worthy effort on the part of the government. They claim to show their support by integrating family planning during community meetings, participating in Family Planning Week, and supporting pre-marital counselling. Besides these, municipal health personnel are sent to FP trainings. Trainees are given traveling expenses and per diems.

Both the local government supervisors and their trainees believed the importance of controlling fertility or family planning. Large majorities also preferred that mayors/governors would support the free choice of couples of a method of family planning, that persons should follow one's conscience on moral issues and that couples should use contraceptives after the birth of their first child. Of significance is the expressed support of the two groups for the government (rather than the church) when it comes to FP matters. Two-thirds or more took this stand while another 18 percent said they were neutral.

The two groups, however, differed on some issues. While a big majority of the supervisors (91 percent) found the idea of family planning to be a comfortable one, fewer trainees felt this way. A majority of the supervisors could promote family planning without reservations, but more than half of the trainees had either "a few" or "many" reservations about this.

More trainees than supervisors believe that an important value of family planning is a woman's right to control her own body. Indeed, every single one of the trainees agreed with this statement, as compared to only 73 percent of the supervisors. The same trend is noted on the issue of parents having at least one daughter and one son before practicing family planning. More trainees disagreed with this idea (36 percent vs. 27 percent). However, more trainees (54 percent) agreed that promotions should be based on length of service. The comparative figure for supervisors was only 27 percent.

As regards the use of family planning methods, both supervisors and their trainees approved the use of natural family planning, condoms, the intra-uterine device, birth control pills, rhythm and tubal ligation. They disapproved (1.34) the use of abortion, while they were undecided (3.1) if injectable contraceptives should be used. However, the two groups differed on the use of rhythm. While the supervisors strongly approved (4.54) of it, the trainees were less favorable (3.73).

L. Practicum Requirements and Trainees' Accomplishments

Two BASIC/COMPRE trainees were sent to each of the 10 preceptor areas in Isabela. Among the requirements were the following: 15 IUD insertions, 10 pill prescriptions, 30 physical examinations.

The trainees considered the requirements to be reasonable. However, they found difficulty meeting the required IUD insertions as there were limited to walk-in clients who wanted the IUD as a method. Thus, they went to the barangays to motivate clients. The regional trainors commented that this situation could have been remedied had the request to the municipal health officer and the preceptor in the preceptor areas been sent earlier. The previous practice was for the preceptor areas to be informed a month before the posting of trainees. Thus, the preceptors were able to mobilize the midwives to motivate would-be clients ahead of time. When the trainees arrived, they had enough clients to serve.

The situation was perhaps understandable as this training was the first to be conducted under the devolved set-up in which the provincial health office manages the FP trainings. The regional trainors only provided support to the provincial trainors during the training.

Based on the report of the Isabela provincial FP coordinator, all the trainees completed the requirements on physical examinations and IUD insertions/check-up (Table 3.2.l.1). Only 17 or 85 percent of the trainees dispensed pills. Of this number, 71 percent completed the 10 requirements. Eight trainees dispensed a mean of 3 condoms. Only five trainees conducted a laboratory analysis.

After two insertions, most (85 percent) trainees claimed they were not yet confident. Eighty percent of them mentioned they were confident with few exceptions after inserting five IUDs. Generally, all of them were confident in all situations after the seventh insertion. These perceptions of the trainees were similar to the observations of the preceptors who rated their performance as satisfactory.

The trainees suggested that they should be provided with adequate supplies before they leave for the practicum. As experienced by almost all the trainees, they did not conduct a laboratory analysis due to inadequate reagents in the preceptor areas. They had limited gloves to use during examination and IUD insertion. In one clinic, the physical examination table used during the first two weeks was a long wooden bench. Gooseneck lamps were not available in the majority of the preceptor clinics.

M. Values and Client-Centered Issues From Practicum Observation

The trainees were observed twice in the preceptor areas to assess whether the client-centered provisions which were taught in the didactic phase of the BASIC/COMPRE training were followed in the client-provider interactions. A total of 60 cases were observed. The results of the observations for new acceptors and revisits are only presented, as the other reasons for the visit such as consulting about problem with the current method used, discontinuing/switching the method used had limited cases.

1. New acceptors. Of the 17 new acceptors, 76 % were IUD acceptors. Eighteen percent subjected themselves for tubal ligation while only 1 accepted pills. We compared these data with those from the preceptors' clinics during the preceding month. The records in this case showed that only 26 percent of new acceptors had an IUD insertion. The IUD acceptance rate during the practicum was thus unusually high.

The majority of the observations involving new acceptors showed that the trainees asked about the client's reproductive health (88%), about the last day of menstrual cycle (71 %), about unusual vaginal bleeding (58 %), and about pelvic pain (65 %) (Table 3.2.m.1). Likewise, the trainees usually took the client's medical history (59% of the observations) and blood pressure

(65 %).

Most performed physical examinination (88 %) and pelvic examination (76 %). About 71 % of the observations showed trainees using sterile speculum in inserting the IUD. Only 76 % of the observations had trainees using gloves to perform the examination.

All observations had trainees informing clients when to return for a follow-up. There were 82 % of the observations with trainees telling clients what to do if they experienced problems with the method used.

The following practices were performed by the trainees in only some observations: informing the client of what is involved in pelvic examination (47 %), taking the client's weight (41 %), asking about unusual discharge (41 %), washing hands before the examination (35 %), doing laboratory screening for STDs (18 %), asking the client if she had any question (18 %), and telling the client where to go for a resupply (18 %). The percentage on the last item is small as the method chosen was usually available at the clinic.

Only 35 % of the observations showed the trainees discussing other health issues during the interaction. These issues centered on maternal nutrition (24 %), growth monitoring (24 %) and immunization (24 %).

2. Revisits. For the revisits, 23 clients were attended to by the trainees. Of this number, 7 or 30 % were IUD users. As most of the clients came for resupply, some of the provisions for quality of care were not carried out by the trainees.

Based on the trainee-client interactions involving revisit cases, 61 % of the observations had trainees inquiring if clients had problems with the current method being used. Nearly 48 % of the cases showed trainees asking about the clients' reproductive health, while 43 % had them asking if the client was breastfeeding.

About 57 % showed trainees informing the client when to return for a follow-up and 35 % telling clients what to do if she experienced a problem. Health issues were likewise discussed but only in 39 % of the observations. Discussed were child nutrition (35 %), child illnesses (22 %) and maternal nutrition (13 %).

Only limited observations showed providers performing the following required practices: asking the date of last menstrual cycle (17 %), taking client's medical history (9 %), asking about pelvic pain (9 %), taking client's blood pressure (9 %), telling client where to go for resupply (9 %).

There were only 4 % of the observations with trainees performing the following: asking about unusual vaginal bleeding, asking about unusual discharge, taking client's weight, doing laboratory screening for STDs, performing physical examination, performing pelvic examination, telling client what is involved in a pelvic examination, using a sterile speculum, and using gloves to perform examination.

N. Clients' Perceptions of the Services Received

1. New acceptors. The responses of the 17 new acceptors in the exit interview indicated that the majority of them perceived the trainees to have explained clearly how the method works (59 %). They also felt that they had shown how the method works (53 %), had described the possible effects (53 %), had told what to do if there were side effects (53 %), and had asked if they had any question (53 %) (Table 3.2.n.1). Likewise, 82 % of the clients reported that the trainees told them to return for a follow-up.

About 88 % of the clients felt they received the FP services that they wanted during the visit. There were 94 % of the clients who believed the clinic staff were friendly during the consultation, and that their explanation was easy to understand. More than three-fourths (76 %) reported they were satisfied with their visit to the clinic.

Very few new acceptors reported trainees who told them where to get the method. Only 18 % mentioned that other methods were discussed.

2. Revisits. The same trend was noted in the responses of the 23 clients who came for revisits, except for trainees' telling the client where to get the method. More revisit clients (61 %) reported it to have been mentioned by the trainees.

What is common in the observations was the trainees' emphasis on the use of IUD among new acceptors because they would like to meet the required number of IUD to be inserted. They had difficulty convincing walk-in patients. They thus resorted to going out to the barangays to convince would-be users. In one preceptor area, one trainee was re-assigned to another preceptor area because of limited clients to serve. For this reason, the provision for choice of methods seemed to have been neglected by the trainees.

Apparently, the BASIC/COMPRE trainees applied the knowledge and skills learned during the practicum. Most notable is showing a caring and friendly attitude to the clients. Generally, they had the technical competence to insert an IUD and to discuss other FP methods, except for rhythm. They claimed to be not be confident to discuss this

method with clients. To a limited extent, the constellation of services was likewise evident in their interaction with clients.

What was neglected or overlooked by them was medical asepsis in handling patients. A possible reason for this situation was the inadequate reagents and other supplies (like gloves) in the preceptor clinics. Some clinics do not have running water. When there were many clients to serve, some trainees had no time to wash their hands or to sterilize properly the apparatuses used after each client.

O. Clinic Conditions in the Preceptor Areas

The clinics in the ten preceptor areas were assessed to find out if the conditions of facilities would ensure the provision for quality of care. Observations showed that 90 % of the clinics had a waiting area, and 80 % had seating for all clients. Although 80% had functional toilets, most of them were untidy. While 60 % of the clinics had visual privacy in the counseling room, there were only 20 % with auditory privacy. Eighty percent of the clinics had a separate room for physical examination which provided auditory and visual privacy. However, only 10 % of the clinics were found to have a physical examination area that was clean, that is, the room was not dusty and the table had new linen each day. One clinic had a crocheted material to cover the physical examination table. The linen in one clinic had blood stains, while another clinic had a course cloth at the area of the table where the client's buttocks would rest during the examination.

Only 70 % of the clinics had an adequate source of light in the examination area, while only 60 % had an adequate amount of water. This condition was one of the reasons why some trainees did not wash their hands.

All the clinics had an inventory of FP commodities. These had been inventoried according to the expiry date. However, only 80 % had adequate storage facilities for contraceptives. Cartons of contraceptives were just stacked in one corner of the storeroom which was not properly protected from sunlight.

Ninety percent of the clinics had separate client records, containing their addresses recorded in sufficient detail. Only 50%, however, had a well-ordered client record system. Sixty percent had a daily family planning register.

CHAPTER 4

SUMMARY, CONCLUSIONS, RECOMMENDATIONS

In this final chapter of the research report, we step back from the detailed presentations of findings to summarize what we found, and offer conclusions and recommendations. But even before we do this, a prefatory note is in order.

If family planning operations research involves the search for "problems"--discrepancies between ideal and reality--we may have been looking in the wrong place by spending so much effort on the didactic phase of trainings. As should be apparent from the two previous chapters, on the whole trainings go very well in both regions, with committed, well-prepared trainors presenting well- thought out materials to receptive trainees. This overall conclusion needs to kept in mind as the context within which to interpret the material that follows.

In this chapter, we first present the summary answers to the "specific research questions" (see Figure 1 of Chapter 1). We then summarize other findings which are not captured by the specific questions. The third section of the chapter offers some overall conclusions, and we end by listing recommendations.

I. Answers to Specific Research Questions

HOW PREVALENT ARE THE PHENOMENA OF DROPPING-OUT AND ABSENTEEISM AMONG SPECIFIC GROUPS OF TRAINEES?

WHAT ARE THE REASONS FOR DROPPING-OUT AND ABSENTEEISM? DO THESE VARY FOR DIFFERENT GROUPS?

As noted in the first chapter, these are important questions because they bear on the Department of Health's "team approach." By having physicians, nurses, and midwives train together, it is more likely that team-work will be apparent in the field delivery of services. However, status discrepancies, differential knowledge, and the fact that the time of physicians is more valuable all lead to the suspicion that physicians would be less likely to attend trainings once nominated, or to sit through all modules once they have arrived at the trainings.

Since these are important questions, it is correspondingly important that <u>we found no evidence of either absenteeism or dropping-out</u>. To re-emphasize, we looked at six training sessions covering all types of trainings, and found no willful cases of either phenomenon, whether physician or no. The only cases of absenteeism were caused by late notification of trainees.

It is a tribute to the skill of the trainors that they were able continually to engage the interest of physicians attending the trainings. It was frequently mentioned to the researchers that trainors need to handle physicians in particular ways--by using them as sources of expertise, or to treat them in some ways as co-trainors. These tactics seem to work, and to obviate problems that were foreseen.

Having found a zero degree of prevalence, we naturally cannot answer the second question as to the reasons for these. There were none.

HOW DO TRAINEES PERCEIVE SPECIFIC ASPECTS OF THE TRAINING?

Both regional chapters demonstrate overwhelmingly positive feelings about the materials and trainors. The background materials were relevant, the training was very useful for daily work, and the presentations by trainors were excellent. It will, however, be noticeable from the data that these tend to be global judgments, with very little variation among modules. Neither the researchers nor the DOH trainors were able to do session-by-session evaluations as the training proceeded. It was felt that time was so tight that the only possible time for evaluation was at the end. Naturally, this inhibits the ability of trainees to make fine distinctions among the myriad of activities undertaken in the entire training. Yet, once again the main point bears re-emphasizing: the trainees have very positive overall ratings of the trainings.

When we come to the duration and scope of the trainings, we have a more differentiated picture. For the Inter-Personal Communication Skills and Preceptors courses, the trainees rated the courses as somewhat "too long." This is true whether we look at the ratings obtained by the research team, or at those obtained by the Department of Health. Correspondingly, the subject matter was rated as somewhat "too broad." We will return to these findings when discussing the next research question.

With respect, however, to the Basic/Comprehensive course, the trainees did not find it too long. In fact, the duration was almost exactly "just right" on the average. But the scope was still considered "too broad." When juxtaposing these findings with those discussed above, we can say there is less scope for cutting the length of the Basic/Comprehensive course than for the Preceptors and Inter-Personal Communication Skills courses.

WHAT ARE SOME OF THE STRENGTHS AND WEAKNESSES OF COURSE CONTENTS? HOW CAN THESE BE IMPROVED?

To begin with an easy, mechanical observation: to the extent that video is supposed to be part of the training modules, this objective is not being achieved. Video tapes are not being distributed, and the use of video as part of the trainings themselves

does not always happen. This observation may have applicability to other far-flung regions of the Philippines.

Substantive observations are somewhat more difficult to make. Let us begin with the question of length. In the focus group discussions and research utilization conferences, trainors tended to agree that the Preceptors course could be shortened, but were doubtful as to whether this could be done for the Inter-Personal Communication Skills course. If we are looking to shorten these courses, we must remember we are making hard choices. Anything we eliminate will have value because the training modules were carefully constructed. Still, some observations can be made.

First, the introductory modules could well be eliminated. Material about the Department of Health should now be presented differently due to the devolution of health care. Such orientations should now be specific to the local government unit, and office-based in the locality. In future trainings, the participants may all come from one local government unit, in which case the introduction will no longer be necessary. Even if they should still come from several different LGUs, the introduction currently in use will not be appropriate.

Suggestions put forward in the analysis of the Preceptors course (cf. Chapter 2) should be adopted. If participants had gone through the sequence of Basic/Comprehensive and Inter-Personal Communication Skills courses before the Preceptors course, the latter could be shorter and more focused.

More information on natural family planning should be provided. Such methods should be upgraded from the "nice to know" to the "need to know" category in training. Not only do some clients desire this method but, given the current socio-political context of the Philippine FP program, signs that the DOH is serious about including natural family planning in its cafeteria of methods could reduce the level of acrimony in public debates.

HAS THE TRAINING MADE A DIFFERENCE IN THE TRAINEES' COMMITMENT TO THE FAMILY PLANNING PROGRAM?

When we reflect that trainees already have a high level of commitment to the family planning program to begin with we should not expect to find much scope for change. For instance, virtually one hundred per cent of trainees felt--even before the training-- that it it important to have the ability to plan a family. However, agreement is not so unanimous on other aspects of the family planning program. This was the case for questions on support by officials, access by unmarried individuals, level of comfort with family planning, the government's clash with the Catholic Church, and promotion of family planning. Further still, there is no systematic indication among all these

attitudes that the training had the expected impact. One reason verbalized for this was that trainees became more cautious due to emphasis on side-effects of family planning methods, which caution counter-balanced any enthusiasm generated by the training.

A striking finding with respect to specific family planning methods was the fact that attendees at the Basic/Comprehensive course became less approving of the rhythm method. This can be connected to the earlier remarks on the need for more material on natural family planning methods in the Basic/Comprehensive course. Trainees learned that the method was complicated and unreliable, without learning more positive material about natural family planning methods.

HOW WERE TRAINEES SELECTED TO PARTICIPATE IN THE TRAINING COURSE? WHO WAS/WERE RESPONSIBLE FOR THEIR SELECTION?

DID THE TRAINEE HAVE ANY SAY IN THE DECISION? WHAT DID HE/SHE THINK WAS THE BASIS FOR HIS/HER SELECTION?

This constellation of questions was measured both by questionnaires given to the respondents, and by interviews of mayors and other supervisors. One striking thing about the trainees' responses was that none of them cited the local government official who supervises them. Rather, they said it was health personnel who were doing the selection. Our interviews with supervisors confirmed this impression, with mayors and governors merely endorsing selections by health personnel. We must remember that these selections happened during the first year that local officials had supervision over health personnel, so these officials may as yet be only beginning to exercise authority. On the other hand, they may be respecting the expertise of health personnel in identifying trainees. It is still too early to decide between these two competing interpretations for the lack of political favoritism in trainee selection.

Trainees regarded themselves as "accepting" the selection. Depending on whether or not they regarded this "accepting" as "having a say," they either answered yes or no, respectively. The bases of their selection were such technocratic criteria as lack of trainings, fulfillment of the criteria set, and the like. Again, there was no hint of political favoritism, contrary to fears expressed when the role of local government officials in selecting trainees was discussed in meetings preliminary to this research.

Two important points need to be made as part of the answer to these questions. First, despite it being a prerequisite for the Inter-Personal Communication Skills training course, there is repeated evidence that some trainees for this course had not yet undergone the Basic/Comprehensive training. If the sequence of trainings were to be streamlined as suggested above, strict enforcement of prerequisites would be required.

Second, it is instructive to note that no trainee in the Preceptors course mentioned the condition of their clinic as a basis for their selection. The condition of the clinic is supposedly used by the DOH to chose Preceptor course trainees,
inasmuch as it is expected that trainees in the Basic/Comprehensive course will be sent to those clinics as part of the Basic/Comprehensive practicum. However, this criterion does not seem very salient to the Preceptor trainees. This fact will become significant when we discuss the clinic conditions actually found during the practicum observations.

DO TRAINEES VIEW THE COURSE IN A POSITIVE LIGHT? WHAT COSTS AND BENEFITS ARE ENTAILED FOR THEM ONCE THEY AGREE TO ATTEND?

We have seen repeatedly that trainees are enthusiastic in their response to the trainings. When asked directly about costs and benefits, trainees mentioned their personal and professional costs. All types (and not just physicians) cited missed clients and work.

This is one case in which a systematic difference between the two regions can be noted. By the end of the training, participants in Region II were still citing monetary benefits, while those in the Cordillera Administrative Region were not. In point of fact, CAR trainees did express expectations at the beginning of their trainings that they would receive a financial benefit in the form of savings from accommodations and meals during the training. However, it was explained to them that this would not be possible, and by the time we gave them the questionnaire they were no longer citing these expectations.

WERE THERE OTHER CANDIDATES BESIDE HERSELF/HIMSELF?

Three-fourths of all trainees said that there were other candidates. Roughly half of these said that these other candidates would be able to attend a later training. Again, we found no evidence of favoritism.

WHAT IS THE LEVEL OF COMMITMENT OF THE TRAINEE TO THE FAMILY PLANNING PROGRAM?

As cited in the earlier discussion, the level of commitment of trainees is quite high as they enter the training program. It is therefore not surprising that the training did not increase their commitment.)

WHAT ARE THE ATTITUDES OF LOCAL GOVERNMENT EXECUTIVE TOWARD FAMILY PLANNING AND ITS TRAINING COMPONENT?

Based on the responses which they gave our interviewers, LGU executives would seem to be quite supportive of family planning. Two things must be said, however, to put this finding into context. First, we are not sure about the extent to which this verbal support is translated into action. We do have the example of a mayor who directly provided for the needs of a clinic being used as a preceptor area. On the other hand, we have widespread anecdotal evidence of tensions which accompanied the devolution of personnel from the DOH to local government units.

And this is the second point--that the attitude of local chief executives towards family planning is linked to their general attitude towards the devolved health services. Ironically, if family planning is regarded as a health intervention, this linkage is exactly what we should expect to happen. However, it does mean that all the problems which devolution entails for health services (status discrepancies between executives and doctors, delayed or reduced benefits, confusion as to the status of maintenance and operating expenditures, etc.) are visited on family planning.

WHAT ARE THE REQUIREMENTS BEFORE A TRAINEE BECOMES A CERTIFIED PROVIDER?

This research confined itself to the requirements of the practicum phase of the Basic/Comprehensive course: thirty physical examinations, ten prescriptions for pills, and fifteen insertions of inter-uterine devices.

It is important to note that the most salient requirement is the insertion of inter-uterine devices. All trainees completed this requirement, but when it came to dispensing pills, only sixty percent were able to do so.

HOW DO TRAINEES FEEL ABOUT THESE REQUIREMENTS IN TERMS OF DETERMINING COMPETENCE?

AT WHAT POINT (THAT IS, AFTER HOW MANY INSERTIONS, PRESCRIPTIONS, COUNSELINGS) DO TRAINEES FEEL CONFIDENT ABOUT THIER SKILLS?

The analysis in Chapter 3 shows quite clearly that trainees feel confident after only seven insertions of inter-uterine devices. This is considerably less than the fifteen which are currently required. This would seem to offer the possibility of shortening the

practicum phase of the Basic/Comprehensive, in line with a shift to competency-based training rather than training focused on numerical targets.

However, there is a caveat which must be included here. During this practicum, the trainors for the Basic/Comprehensive course were busy with further trainings, and were not able to supervise the performance of the trainees. The supervision was left to the preceptors in the preceptor areas. This problem is related to the bunching and rushing of many trainings--which will be discussed later. The important point here is that, if competency-based training is to be adopted, the trainors must be given enough time to supervise trainees in order to determine their competence. In the trainings we observed, this would have been impossible due to conflicting time pressures.

WHAT SUGGESTIONS CAN THEY MAKE FOR IMPROVING THE PRESENT SET-UP OF THE PRACTICUM?

First, we can say that there was an overload in each site. This is attributable to the practice of sending two trainees to each preceptor area. Secondly, the preceptors received very little notice that trainees were arriving--sometimes the notice and the trainee arrived simultaneously. Both of these factors were noted as constraining the quality of the practicum, as were the clinic conditions and lack of supplies.

Another thing noted by the trainees was their lack of preparation in natural family planning methods.

WHAT ARE VALUES BEING EMPHASIZED IN THE MODULE? ARE THESE RELEVANT IN CREATING A MORE CLIENT-ORIENTED SERVICE PROVISION?

Discussions and clarifications of values have been incorporated into all the family planning training courses, with different courses dealing with different values. For instance, in the Basic/Comprehensive course there is a discussion of "The FP Health Worker (Traits and Values)" using material from "The Filipino Character" based on Senator Shahani's "A Moral Recovery Program." The discussion covers the following:

1. Strengths

   Pananampalataya
   Pakikipagkapwa-tao
   Family Orientation
   Joy and Humor
   Flexibility, Adaptability and Creativity
   Hard Work and Industry

Ability to Survive

2. Weaknesses

Extreme Personalism
Extreme Family Centeredness
Lack of Discipline
Passivity and Lack of Initiative
Colonial Mentality
Kanya-Kanya syndrome
Lack of Self-Analysis

Following the substantive presentation there is a "values clarification," in which the trainees may "reflect if their values are influenced by the Filipino traits and the factors previously discussed."

It seems that these exercises are in the same category as introductory discussions of the Department of Health. That is, they represent extremely important material but they do not belong in a specialized family planning training which brings together people from different offices. This sort of basic values training should be office-based, so as to provide trainees a supportive context within which to reflect on "Filipino values." Besides, there is little relevance of this value set to client-oriented service provision.

In the Interpersonal Communication Skills course there are sections on "Values Clarification" (which emphasize that "each person has a unique set of values") and "Me as a Field Worker," which discusses the roles and communication patterns of family planning providers. These do impact on client-oriented service provision, by giving the family planning provider means to consider how each client is unique, and how that uniqueness interacts with the provider's role in a communication situation.

It is in the Preceptors course that client-oriented service provision is most directly addressed. There is, once again, a values clarification exercise, which considers "the relevance of values to the role of preceptor." It is in Module IV, "Management of an FP Clinic" under the rubric of "Quality Assurance" that the "Quality of Care" framework is explicitly considered. The reader will remember that this client-oriented quality of care focuses on six elements:

1) Choice of Methods
2) Information
3) Technical Competence
4) Interpersonal Relations
5) Mechanisms for Continuity
6) Appropriate Constellation of Services

A thorough discussion of this framework ensues in the Preceptors course manual, with liberal citation of material from this "Quality of Care" school of thought.

But, we must point out a certain amount of confusion between "Quality Assurance" as espoused by the DOH and the client-oriented "Quality of Care" espoused by Judith Bruce and her colleagues. In fact, it is this confusion which has led the research team to adopt the phrase "client-oriented quality of care" instead of merely "quality of care." Repeatedly, both in written and in oral communication, DOH personnel collapse client-oriented quality of care into merely quality assurance. In fact, in the Preceptors course, the discussion of the Judith Bruce material is immediately followed by a "Quality Assurance Checklist" for clinics.

The point is that "quality assurance" focuses almost exclusively on one aspect of the client-oriented quality of care: technical competence. Quality assurance deals with aseptic procedures, refrigeration chains, and the like. While these would be regarded as necessary considerations under the client-oriented quality of care framework, they are not sufficient conditions. There are the other five factors to consider.

WHAT ARE THE EXISTING ATTITUDES OF TRAINORS REGARDING FAMILY PLANNING? ARE THESE COMPATIBLE WITH VALUES BEING PROMOTED IN THE TRAINING?

In the welter of detail being presented in this report, it is well to pause to remind ourselves of the trainors. From all indicators, in all ways, these are a group of highly motivated, dedicated, and usually overworked individuals. They are committed to family planning in general, and, more particularly, to training in order to improve service. The Department of Health has also carefully trained these people.

In terms of quality of care, the trainors are more comfortable with "quality assurance" which is technical (asepsis, etc.). However, it should be said that they, like many other DOH personnel, are also interested in client-oriented quality of care issues. Continued emphasis on this latter dimension should sharpen the distinctions made in trainings between the narrower quality assurance and the more encompassing client-oriented quality of care.

WAS THERE ANY CHANGE IN ATTITUDES OF TRAINEES AFTER GOING THROUGH THE COURSE?

For purposes of this summary, we will look at the series of questions asked about client-oriented quality of care.

Two facts are striking about these results. First, despite the fact that explicit consideration of these topics is only a couple of years old, there was already a high degree of agreement with many of the assertions coming from the work of Judith Bruce and her colleagues. Client-oriented quality of care is certainly compatible with the pre-existing corporate culture among health personnel.

Secondly, despite the fact that it is only in the Preceptors course that the client-oriented quality of care perspective is directly presented, there tends to be an increase in adherence to these values after all trainings. This supports the earlier contention that trainors have already imbibed these values. Thus, they are carried over into all trainings, inasmuch as the same trainors tend to be involved in all the different courses.

The exceptions to the above generalization are also interesting. Concern about integration of family planning services with other health services as a technical problem, and with family planning methods with few side effects, increased by the end of the training. This is perhaps not surprising, given that the trainings focus on technical problems, and on the side effects of family planning methods. If it is desired that trainees move away from this narrow focus on technical matters to a wider client-oriented framework, special efforts must be exerted.

ARE THESE VALUES TRANSLATED IN THE PROVIDERS' BEHAVIOR IN PROVIDING FAMILY PLANNING CARE DURING THE PRACTICUM PHASE?

ARE CLIENT-PROVIDER INTERACTIONS CONDUCTED IN A COURTEOUS AND CARING WAY?

As discussed in Chapter 3, observations made during the practicum do in fact show that clients were treated in a courteous and caring way.

However, it must be noted that one of the basic tenets of both the Department of Health program and the client-oriented quality of care framework--freedom of choice among methods--was regularly infringed. This is clearly because of the pressure trainees were under to fulfill their quota of fifteen insertions of Inter- Uterine Devices. (There certainly seems to be less pressure about prescribing pills.) This pressure was exacerbated because two trainees were assigned to each preceptor area, so that each area had to produce thirty inter-uterine device acceptors in a short amount of time.

This infringement of freedom of choice can be seen in the fact that during the practicum, the proportion of new acceptors who opted for inter-uterine devices is much

higher than it normally is in those preceptor areas. Infringement can also be directly observed in the sometimes heavy-handed persuasion utilized by trainees.

Interestingly enough, when it comes to the more technocratic asepsis procedures, the lapses are more serious. It would have been understandable if recently trained personnel were concerned about medical correctness while ignoring interpersonal aspects of family planning provision. In fact, the reverse is true. While a courteous and caring attitude is the norm, strict adherence to asepsis is not.

The clinic situation is often a hurried one, so that in order promptly to attend to many clients providers are apparently willing to take shortcuts. This problem is exacerbated by the lack of facilities in the clinics, to which we will return.

DO CLIENTS FEEL THEY HAVE BEEN TREATED IN A COURTEOUS AND CARING WAY?

Again, as documented in Chapter 3, clients did feel they were treated in a friendly manner, and went away satisfied with the services they had received.

However, when we probed for specific aspects of client-oriented quality of care, we received much lower levels of affirmation from the clients. Even explaining clearly about the particular method only received affirmation from fifty to sixty percent of clients. Discussion of other methods--crucial for the cafeteria approach to family planning provision--was even less frequent. This is not very surprising insofar as the trainees were focused on getting enough inter-uterine device acceptors.

To repeat, clients expressed satisfaction with the services they received. This may be a drawback to a "client-oriented" approach: clients with low levels of expectations are easily satisfied.

WHAT ARE THE CLINIC CONDITIONS IN THE PRECEPTOR AREAS? DO THEY HAVE THE BASIC FACILITIES TO ENSURE QUALITY OF CARE IN PROVIDING SERVICES TO CLIENTS?

On the face of it, the findings of Chapter 3 on this topic are appalling. These are supposed to be model areas, yet barely half had adequate water, few were clean (in the sense of no dust), and only half had well-ordered client records.

We must remember that these clinics had little or no warning that a practicum was to occur, so they did not have time to prepare. On the other hand, this reflection

would imply that the conditions found are more likely to be the normal conditions. What must we think when we find that clinic conditions fall short of standard operation procedures

(which we suspect they always do)? Further still, there are some reasons to believe that conditions in the non-practicum areas are even worse. How does this impact on the general quality of care? It does not necessarily mean that quality care cannot be made available, but more time needs to be spent on how providers can spot and correct deficiencies.

II. Other Relevant Findings

Two more topics which were investigated can round out our summary of findings. The first has to do with the social values of the trainees, while the second deals with their job satisfaction.

It is well-known that there is a conflict between the government and the Roman Catholic church about family planning. As we have seen, when asked directly about their stance on this controversy, trainees tend to split between those on the side of the government and those who prefer to stay neutral. Few take the side of the church.

It may be, though, that one's position on family planning issues is not so much tied up with religious beliefs, as with whether the general social values of the person are "traditional" or "modern." Without getting into a controversy about the meaning of these terms, we can refer to the data on responses to questions that were phrased to reflect a dichotomy. As we have seen in both Chapters 2 and 3, our family planning providers are on the "modern" side of this dichotomy.

The only exception to this generalization was for responses to the item, "Health workers must have consideration of the individual needs of clients, even if it means making exceptions to the rules." The theoretically "modern" response to this is to emphasize rules. However, it is encouraging to see that health workers are in fact emphasizing the individual needs of the clients. This, after all, is the bedrock of a client-oriented approach.

The last topic has to do with job satisfaction. We have seen in Chapters 2 and 3 that trainees are satisfied with most aspects of their jobs--with the exception of pay and benefits. It would be interesting to see if there has been any change in the latter, since by 1994 devolved health personnel were guaranteed the benefits previously granted to them

under the Magna Carta for Health Workers. During 1993, there had been considerable uncertainty over whether they would continue getting these from the local government units.

Regarding the subject of pay, it seems that there is not much which can be done to alleviate dissatisfaction. One's satisfaction depends on one's reference group, and a salient reference group for health workers in the Philippines is the vast number of health workers abroad. No matter what the Philippine government does, there is no prospect of being able to offer pay competitive with what can be earned in the Middle East, North America, or Australia. Rather, attention must be paid to insure that satisfaction with other aspects of the job remains high.

III. Conclusions

By this point, conclusions can be briefly stated.

As emphasized at the beginning of this chapter, the process of the training seems to be going quite well. Modules are well constructed, trainors are skilled and dedicated, and trainees are motivated. The anticipated problem of physician absenteeism did not materialize, due at least in part to the skill of the trainors.

There are a number of contextual factors which do disrupt this happy picture. First, trainings tend to be bunched together, so that trainors are overworked. Weeks can go by with no break in a series of trainings. A shortage of trainors develops, so that those who do trainings are not able to think deeply about what they are doing. Trainors are frustrated about this, as they know about supplementary materials which they feel would enrich the modules. Yet, they do not have time to work with these materials.

Similarly, they do not have time to supervise trainees, something which would be crucial if there were to be an emphasis on competency-based training (rather than on fulfillment of certain norms).

A related problem is the short notice given for trainings. Since they are bunched, particularly at the latter part of the year, they come suddenly for trainors, preceptors, and potential trainees. The start of trainings is delayed as arrivals are delayed, due to short notices.

Finally, the short notice means that preceptor areas do not have time to improve their facilities. What should be operating as a model, inspiring trainees to imitation when

they return to their places of assignment, turns out to be "normal" clinics with all the problems and deficiencies to which trainees are accustomed.

To return to the plus side of the ledger, the family planning providers we studied (trainors and trainees alike) are motivated and committed to the family planning program. They are interested in providing client-oriented quality of care and respond to this concern when it is presented to them.

Yet, the quantitative orientation to practicum requirements vitiates this interest, because trainees must pressure clients to accept inter-uterine devices. We have already concluded that the quota of fifteen is excessive, and can be reduced. But even a reduced number would still be a quota, rather than the approach taken when competency-based training is used.

There are many obstacles to competency-based training, but the main one suggested by this study is the difficulty of finding supervisors who will judge competency. Objectively, given the bunched schedule of trainings, trainors are busy elsewhere and cannot follow-up trainees. Subjectively, this frustrates the trainors, who know perfectly well that the real test of their impact is on the practice of the trainees. Yet, they have no way of knowing how their trainees perform in the field.

In terms of curriculum, there seems to be scope for streamlining the training system. A radical approach would be to have the Basic/Comprehensive course followed by the Inter-Personal Communication Skills course, to be topped off by the Preceptors course. It should be possible to channel the requisite number of Preceptors through this system within a short time (say, two years) so that highly similar topics do not have to be repeated. Refresher courses in family planning technology might be necessary to target those who had Basic/Comprehensive training a long time ago, rather than including the refresher in the other courses.

Clearly, a key link in the current system is the preceptor area. Much more attention needs to be given to constructing model sites. A Department of Health commitment that each time a preceptor is trained his or her station will be upgraded would certainly increase the incentive for both potential preceptors and their supervisors. In short, rather than "accepting" that the SOPs of Manila cannot be followed, produce a few well-chosen quality sites which create a demonstration effect. Initially these could comprise 10 to 20 centers per province.

Now that health services are under devolution, mayors need to be pressured by their constituents into providing quality services. We noticed earlier that a possible weakness of a client-oriented approach might be that clients are too easily satisfied.

Pressure on their political leaders is more likely when constituents have a visible quality standard rather than "accepting" whatever they have been receiving.

Thus, quality precepting areas would influence both trainees and clients by proving a high standard. At the visible linchpin of the family planning training system, spread effects could be quite large.

We might speculate that, just as a higher contraceptive prevalence rate is gained by continuity of care rather than lots of new acceptors, client-oriented quality of care can be gained by fewer family planning personnel who are better trained, rather than lots of trainees. Throughout the training system, we suggest less quantitative pressure and more focus on quality.

IV. Recommendations

1. Maintain the current "team approach to training."

2. Basic orientation-type subjects, such as the health care delivery system or how general Filipino values affect family planning delivery, should be undertaken in office-based trainings. This would leave more time for specifically family planning topics in family planning trainings.

3. Be cautious in switching over to "competency-based" training, because supervision might be inadequate.

4. More attention needs to be paid to scheduling, both as a means of avoiding a bunching up of courses and as a way of providing a smooth progression through Basic/Comprehensive to the Inter-Personal Communication Skills and Preceptors courses.

5. As a means of reducing pressure to obtain IUD acceptors, there should be a strict enforcement of a one-trainee-per-preceptor-area norm. The quota of IUD insertions should also be reduced.

6. A "model" family planning clinic should be created each time a preceptor is trained.

7. More attention needs to be paid to natural family planning methods, both in light of clients' desires and the socio-political context in which the family planning program operates.

8. The emphasis on client-oriented quality of care should be maintained in order to encourage the ongoing trend for health personnel to think in these terms rather than merely quality assurance.

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