1994

National Research Utilization Conference, September 1994

Family Planning Operations Reserach and Training (FPORT) Program

Final report

National Research Utilization Conference

Shangri-La's EDSA Plaza Hotel
Manila, Philippines
September 20, 1994

Family Planning Operations Reserach
and Training (FPORT) Program

The Population Council

Table of Contents

Overview and Summary

The National Research Utilization Conference, was held on September 20, 1994 at the Shangri-la's EDSA Plaza Hotel, Metro Manila. This was the third conference convened by the Population Council's Family Planning Operations Research and Training (FPORT) Program in collaboration with the Department of Health.

The FPORT program is being conducted under the Population Council's Asia and Near East Operations Research and Technical Assistance (ANE OR/TA) Project. The ANE OR/TA Project is funded by the U.S. Agency for International Development, under Contract No. DPE-3030-Q-00-0023-00, Strategies for Improving Family Planning Service Delivery.

This Conference is the culmination of activities which started in October 1992 with a workshop on Introduction to Operations Research in Family Planning. The first workshop brought together 35 family planning program managers and researchers to discuss program contraints and priority issues, oriented the participants to the concepts, techniques and advantages of the application of OR, and produced six group outputs on problem identification and justification.

The second workshop on Proposal Development held in January 1993 brought together once more the same participants to review the six research problems identified in the first workshop, enhance skills in OR proposal development, and produce completed OR proposals to be submitted for FPORT funding. Seven proposals on projects of high priority were submitted for funding consideration. Five of these were endorsed by the DOH and approved for funding by the FPORT.

The five OR subprojects were implemented by researchers in close collaboration with FP program managers in their respective localities. After each were completed, a local dissemination/utilization workshop was held. These workshops were attended by local government executives, DOH FP program managers and volunteers, NGO representatives, service providers and members of the academe.

The National Research Utilization Conference served as a venue to disseminate the results of the five OR studies conducted, discuss and evaluate policy and program implications of these studies, contribute to the legitimation of OR as a management tool, and help identify OR needs at the national and local levels.

Before the start of the Conference, a poster session was held illustrating the five OR studies. This gave participants the opportunity to interact with the principal investigators to discuss the studies on a one-on-one basis. This lasted for an hour. The Conference was attended by over 50 participants. These were health and population program managers and policy makers, led by the Secretary of Health, Dr. Juan Flavier. Also present were researchers on family planning and population issues from NGOs, the academic community and USAID collaborating agencies. The event was covered on national television and national daily news.

The Conference followed the following format: papers were presented by the principal investigators and followed by the collaborating FP program managers who discussed how the study results have been or will be utilized. Two kinds of reactions were then solicited, one from a member of the academic community and the other from a national level program manager/policymaker. An open forum followed each session.

A wide range of issues were raised and discussed in the open forums which followed each session including the following:

Session I: 1) Concern was raised on how many trainees ever used their training (e.g. insert IUDs after undergoing an IUD insertion training). It was noted that many trainees do not use their training for different reasons including religious, moral, lack of confidence, etc. Hence, it was suggested that selection criteria of providers for FP trainings should be reviewed, as well as the conduct of an OR study to determine the necessity of additional trainings to be conducted regionally; 2) The need to reduce the ratio of trainee per preceptor area was raised; 3) A need to look at the bias for IUd as a method often used in preceptor areas (due to provider bias in order to comply with IUD insertion requirements during training); 4) The use of pelvic models (dummies) for training purposes; 5) The need to map out where trained providers are deployed; 6) To make monitoring team visits unannounced because it defeats the purpose of monitoring if communities know about a forthcoming visit; and, 7) Local government officials support of FP program is critical especially with the devolution. This was raised in the light of a comment by one government official in Mindanao that his constituency does not need FP because more people means more government allocation. Recommendations were duly noted by the Family Planning Service Unit of the Department of Health headed by Dr. Rebecca Infantado.

Sessions II: 1) There was a suggestion to include as part of the criteria for companies to participate in the project, a stipulation to provide commercially purchased contraceptives after their three-year project or during re-enrollment. This was suggested because the companies continue to be dependent on the DOH for their free contraceptives; and, 2) Related to number one, the list of the DOH should be reviewed because many of the companies it supplies contraceptives to are in fact some of the biggest and most financially successful in the country. Many have in fact a reputation of providing generous employment benefits. Hence, it may be best if the DOH concentrate on providing free contraceptives to the companies least likely to do so.

Sessions III: 1) Concern was raised on the motivating and counselling role of volunteers. A question was raised asking if volunteers have enough knowledge and skills to counsel. (The study in fact showed that was least reported among the 5 functions identified by volunteers); 2) To re-think and clarify the roles and functions of the volunteers; and, 3) Concern was raised that although volunteers are now allowed to re-supply condoms and pills, this is not widely practiced.

The Role of Operations Research in the Philippines Family Planning Program

Dr. Rebecca Infantado
OIC, Family Planning Service, DOH

I wish to welcome everyone inasmuch as Dr. Flavier will not be able to do that until he comes to join us at 11:00 o'clock this morning. I am very pleased to be here today to share in this national research utilization conference of the Family Planning Operations Research and Training (FPORT) Program of the Population Council. I have been following the progress of the studies to be presented today and I can assure you that we will be discussing some very interesting results today. Based on this foreknowledge, I would certainly like to be the first to congratulate the different researchers and program managers who were involved in this whole effort.

Way back in 1992, the Assistant Secretary for Special Concerns, Dr. Carmencita Reodica expressed her hope that "in two or three years, we shall be able to look back and see that operations research has now been fully institutionalized within the Department of Health..."

Almost two years have now passed. I suppose it would be stretching the truth to say OR has now been fully institutionalized in our Department. But I am really quite happy that there has been some real progress along these lines. There are a number of operations research done and the results are being used to improve service delivery. I know for example that operations research study on monitoring the progress of our DMPA reintroduction program has already given some significant inputs to our office. And it seems as well that the regional-level program managers have also been trying their best to use the results that have been coming in from the five OR studies which we will discuss today.

I am sure we will all agree that these are very good signs. For research without utilization is most certainly an empty and fruitless exercise.

As you will note during the course of today's proceedings, the FPORT has put a lot of effort into working with regional-level researchers and program managers. I think this is quite relevant given our present context of devolution. Each locality will have its own problems and must therefore come up with its own answers. Indeed, a fully institutionalized OR program will have to include a strong regional emphasis.

But we shouldn't stop there. Even though most of these studies were carried out in the regions, they also have larger implications. I hope that today's conference can become a venue in which each one of us will critically analyze our own programs, in our own

particular area. For there is every reason to expect that the findings summarized today should be able to give all of us many valid and useful insights.

Another function of today's meeting will be to get us all thinking about the many questions and issues that will be needing inputs from a full-pledged OR program. In effect, we all should be working on a research agenda for our own programs today. And don't forget that this is a very important step in the OR process. For if the program managers don't engage in a steady consultation with researchers, a consultation that begins with the very process of identifying a critical and relevant study problem, then the whole research effort will be wasted. For what good is a highly sophisticated set of research findings if they refer only to issues that are of little or no concern to the program managers?

I note with satisfaction that the FPORTP did follow this model of constant consultation and interaction between researchers and program managers. I think that is a major reason why we are now beginning to see some results in terms of actually utilizing the knowledge generated by these researches.

But so much for the past. Maybe we can look beyond today's activity to ask the question, "Where do we go from here?"

For our part, there are certainly many program-related questions which we hope the FPORT Program can look into. I have already mentioned the DMPA Reintroduction project. We will want to follow up on that very closely, along with other new methods that we plan to introduce into the program, like the implants, the diaphragm and the female condom. We have also been looking at the recently released results from the Philippine Demographic and Health Survey (DHS), and it is clear that there are some areas here which will need follow-up. For example, while the DHS data show that knowledge of contraception is quite high in a general sense, a big proportion of married women are still in the dark about injectables. In addition, many of those who have heard about injectables don't know where to find a reliable supply source. There are also women who say they are using NFP and yet they don't really understand very much about the onset of their fertile period. What will be the best way to help these women? And how, too, can we reduce the unmet need for family planning which is still far too high, according to DHS statistics. Failure rates are also high for several methods, notably withdrawal, NFP and condoms. How can we overcome this problem? And how can we also deal with continued reports about side effects? Not only is this a major reason for discontinuation: the DHS data also show that it is an important reason why many women say that they do not intend to <u>ever</u> use family planning.

It is therefore my hope that the lessons learned from the five OR studies will truly be put into practice and used for the improvement of FP service delivery in our program, as

well as to enhance the quality of care now being offered. For that, it seems to me, is what Operations Research is all about.

I'm sure you all have your own ideas about how OR can be put to better use within the Philippine Family Planning Program. Nevertheless, I would like to suggest the need to develop a research agenda to continue this dialogue between researchers and program managers for the program; and to emphasize the dissemination and utilization of research results. I wish you all a lively and thought-provoking exchange of ideas. Thank you.

The Family Planning Operations Research and Training (FPORT) Program

Dr. Marilou Palabrica-Costello
Host Country Advisor, The Population Council

I am very happy to be here today for this national operations research utilization conference. And while I have the opportunity, I would like to extend a warm welcome to all of today's participants, particularly those who have had to travel a long way to join us. I know that you are all very busy but you have come here to share your expertise and, hopefully, to learn from the results of the studies which will be reported today. We appreciate your presence and the many inputs that I am sure you will all be providing throughout the day.

I also wish to acknowledge the support of the USAID Mission for FPORT activities in the Philippines. Beyond the financial support, I am sure that the OR participants here will agree with me when I say that the program has benefitted greatly from the inputs provided by Dr. Voulgaropolous and his staff, particularly Ms. Eilene Oldwine and Mr. Eph Despabiladeras in the conceptualization of this project. Even as I say this, though, I wish to emphasize that the presentations and reports today do not necessarily reflect the views of USAID.

I hope you will join me in congratulating our researchers. They have all been working very hard to complete their studies on time and to prepare for this research dissemination activity.

My main task this morning is to give a backgrounder on the Family Planning Operations Research and Training (FPORT) Program. This will entail looking into its past accomplishments, its current status and some of our plans for the future.

The FPORT is part of a larger initiative called the **Asia and the Near East Operations Research and Technical Assistance (ANE OR/TA) Project** of the Population Council which has been funded by USAID in partnership with family planning agencies in the region. The Program is a five year effort which started in 1990. It covers several countries in Asia and Near East; namely Bangladesh, Egypt, India, Indonesia, Nepal and the Philippines. It seeks to build on lessons learned from earlier operations research programs and to expand the availability of technical assistance and training for family planning programs.

To make sure that we are speaking the same language here, let me define OR from the program's perspectives. Basically, Operations Research (OR) seeks ways to improve Family Planning services. It uses systematic research and management techniques to diagnose and correct FP service delivery problems. OR involves learning by doing and focuses on day to day "operations" of the program. Another feature of this methodology is

that it concentrates on factors that are under the control of the program managers. The kind of OR projects undertaken should depend on program needs as well as on the local context of each country involved.

Technical Assistance (TA) is the second, and complementary component of the FPORT program. This concept refers to the extension of staff assistance for service delivery problems which do not require a formal OR project. Program managers can request TA for help in identifying strengths and weaknesses in existing systems and in developing workable solutions. TA can also be used for planning future OR projects or for help in proposal preparation.

Working in close collaboration with the Department of Health and with sponsorship by the Philippine Population Association, the FPORT began in the Philippines in 1992. The major goals of the program were to strengthen local capacity to undertake OR and to broaden the range of institutions in the country which could undertake high quality programmatic research. The program also sought to develop OR studies on priority issues at both the national and local levels.

The goals of the FPORT were formulated as a response to the particular context of operations research which has evolved over time here in the Philippines. As we all know we have a strong tradition of basic demographic research in this country. In comparison, the track record of OR has not been as strong. Linkages between program managers and researchers have been weak, particularly at the regional level. Indeed, most of the OR studies conducted during the 1970s and 1980s were carried out in or around Manila.

On a more favorable note, the support accorded to Family Planning under the administration of President Ramos seemed to indicate that the time was right for a renewed effort to strengthen operations research in the program. The movement towards a devolved health care system has also brought dramatic changes and demonstrated anew the need to work with researchers and program managers throughout the country.

In general, then, the FPORT has emphasized consultations between researchers and program managers, LGU representation, and program manipulable factors. These themes were already present during the two initial consultative and training workshops held in late 1992 and early 1993. A major output from these activities was a group of study proposals which were to eventually result in the five OR studies reported today. These deal with a variety of issues including the Family planning drop-out problem, training courses of FP providers, an industry-based FP program, and the performance of comminity-based health and family planning workers.

Various other activities have also been undertaken by the program. These revolve around the major themes of training, technical assistance, proposal preparation and funding for new initiatives. In all of these efforts a conscious attempt was made to work with the different

local institutions in order to enhance OR capabilities and to institutionalize the OR perspective within programs.

Dissemination activities have been conducted through a series of regional research utilization workshops which were held after each OR study was completed. We have also started a regular publication called Research News, the purpose of which is to update program managers on lessons learned from operations research which have been undertaken locally as well as internationally.

We are currently collaborating with the DMPA Task Force of the DOH to monitor the acceptance of this method in the 10 LGUs where it has been reintroduced. The purpose for this activity is to assist in determining levels of DMPA procurement as well as to get some feedback on how the program has performed. This activity should prove useful for pinpointing local-level supply and demand for DMPA, thereby facilitating speedy and accurate distribution. We will thus be working in close collaboration with the Logistics division of the program for this activity .

As a follow-up activity, we are conducting a longitudinal in-depth study of DMPA acceptors focussing on the client's perspectives concerning the management of side effects, as well as reasons for acceptance, continuation or dropping out. As with most of our FPORT studies, a major focus will be on quality of care. We feel that this could be an important factor affecting prospects for success in the Philippine program. Another noteworthy aspect of this study will be its attempt to look into the husbands' perspective as well as the internal dynamics which take place between couples when decisions are made about FP.

Today's conference has several objectives. As outlined in the program given out to you, these include:

1. To serve as a venue for disseminating results of our first five studies;
2. To discuss and evaluate the policy and program implications of these studies;
3. To contribute to the legitimation of OR as a management tool; and,
4. To help identify OR needs at the national and local levels.

It is clear that the realization of these objectives will require full participation on the part of everyone here. We invite your comments and suggestions. The spirit of OR is the spirit of dialogue. We have seen this already for the five studies which will be presented today. They all represent the product of a close working relationship between researchers and program managers. We want to keep these relationships alive and to sustain them. Our overall game plan is most certainly to continue collaborating with the different research institutions represented here today, as well as with the regional program managers. Today's activity therefore represents a culmination of this process but not, I am sure, the end of it.

Thank you and good morning.

Speech of Secretary Juan Flavier
Department of Health

I did not come here to deliver a speech. I came to learn and listen. The trouble with the Philippines is that, we don't know how to listen; and the few who listen do not understand; and the few who understand do not believe; and the few who believe do not take action. The reason I came is really just to show my solidarity with you, to show you I believe in what you are doing and therefore I'm here, I apologize that I could not come earlier because I did not expect to speak in this forum. As I said earlier I did not come to deliver a speech but to listen and I'm learning a lot but there are two things I want to leave with you.

One, I think operations research initiatives are so important for decision-makers like me who don't have the time to go into research but who need research to make our decisions rational and proper. It's as simple as this as far as I'm concerned. However, the studies must be relevant, I'm getting sick and tired of studies that are made just for the sake of studies, we don't need more of those. I remember about ten years ago, there was a big rural development research project which took three years to complete. It was a study on rural development and they came up with seven volumes. The main finding of the study was that, the Filipino farmer is poor! I almost threw the volumes on their faces. And then you will not believe when I tell you the recommendation was to expand the program and to continue to do more of the same. You know, I'm not exaggerating, these things happen. Now if that's the kind of research you are going to engage in, I have more important things to do.

Point two, I would hope that many more of the researches are done in consultation with us, because more than you, we know what we need. We have many problems which you researchers can help us with. I know that some of your researches are based on some actions you are already doing. But be careful, some of these kind of studies you are doing might not be relevant to what is actually happening nationwide. And therefore, we have to make certain priorities and I hope that we can at least agree on what these priorities are and then we can focus our efforts. In this way, I guarantee your findings will be utilized because these are the kinds of questions we are asking. This is my main complaint with so many university studies. I see a lot of them and many are irrelevant. Many are repeats of studies that have been done before. What I need are actual questions that are puzzling in our minds. And there are a thousand and one of them. Now, in fairness to you, as I'd said I know you have your own limitations.

Let's study what's wrong with the present FP program. I'm asking the questions. Is it a question of money? Is it a question of personnel? Is it a question of resources? Or is it a question of convenience, at least I know that I don't know the answer. This is the kind of questions I'm asking myself? Or, for instance, what is really the role of the church? I don't mean the role of the cardinal!

I'm asking about the situation in countryside or why is it I also get the flock in the city? What is the score? On the basis of this, is it really related to all of the things that we are talking about in terms of FP acceptance? I want to know what you researchers are doing? I want you to get a feel of the kinds of answers to some of the questions I am asking. And if this is not the kind of questions you are answering, then, we will have a problem with utilization of research results. I understand that the utilization rate of researches is only 5 percent. By any standard, that is a failure. Now, whose failure? It might be partly the DOH, but there are several items in an equation that you may just want to ask yourselves. What then can we do to improve our researches, so that they become worthwhile endeavours.

I did not come here to deliver a sermon, but, these are some of the thoughts that just came at the "sperm" of the moment. So, I still hope I deserve a standing "ovulation" from all of you. Thank you very much and good day!

Session I

Factors Affecting the Family Planning Program Drop-Out Rates of Bukidnon

Prof. Lita Sealza
Research Institute for Mindanao Culture
Xavier University

Background

This study has involved interviews with a randomly selected sample of 389 family planning (FP) acceptors from twenty barangays (picked by probability proportionate to size) in Bukidnon province. The respondents were currently married women who had either continued to use family planning since their initial acceptance (current users) or who had stopped using FP altogether (drop-outs).

Twenty health providers were also interviewed to obtain information about their experiences with providing family planning services. An inventory of facilities for family planning was conducted in all twenty clinics and actual observation of client-provider interaction was also carried out in seventeen of these clinic settings.

Findings from the present study may be expected to shed light on several aspects of the drop-out problem namely:

1. How extensive is the problem and how accurate are DOH records in this regard?

2. How do FP acceptors view their local FP clinic and the services offered therein?

3. What reasons are given by the drop-outs for their decision to stop using FP?

4. What are the factors associated with dropping out?

The Extent of the Drop-out Problem

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

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

Views and Experiences Regarding the Local FP Clinic

As FP acceptors, the respondents were in a good position to assess their local program. In all, only 9 percent said that they were dissatisfied with their visits to the clinic (see Table 1). Another 53 percent said they were "satisfied" while 38 percent claimed to be "very satisfied." Clients who were "dissatisfied" often reported unavailability of supplies as their reason. These respondents also tended to be critical of the local midwife for various reasons, e.g. that she is "not available", too "strict", or "unfair" in giving out medicines and supplies.

This same table shows that client dissatisfaction is strongly correlated with the drop-out phenomenon. To the extent that the program can create a larger pool of satisfied clients, so also will it be moving towards a solution of the drop-out problem.

Table 1. Satisfaction with Visits to FP Clinic by Family Planning Status of Woman.

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

Overall, a little less than ten percent of the respondents had never been given any lecture about FP. Another 61 percent had received a lecture about only one method. These statistics do not show the FP clients as being given a wide variety of choices. Despite the somewhat limited choices being accorded the respondents, 98 percent of those interviewed said they were allowed the freedom to adopt whatever FP method they desired. This is unfortunate since, again, an exposure to a wider variety of methods (thereby facilitating the goal of a full and informed choice) seems to be linked to a greater willingness to stay within the program, rather than dropping out.

Table 2. Family Planning Methods Learned by Family Planning Status of Woman

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

Most respondents (83 percent) felt that their FP trainor had been "friendly and approachable." They also gave favorable assessments with regard the trainors' ability to "clearly explain" the method, to show how to use it, and to explain its advantages. There was, however, less agreement with the idea that the trainors had dealt adequately with the method's disadvantages and potential side effects (Table 4).

As in the preceding cases, these data show that improved quality of care can play a positive role in overcoming the drop-out problem. Current users were significantly more likely to rate their FP trainor as "friendly and approachable" than were the drop-outs. They were also more likely to have been given full information about the advantages of the method and its possible side effects. This latter dimension is a particularly important one since many studies have cited side effects as a major reason for deciding to drop out. It would seem that efforts to warn clients about some of the minor (but potentially disturbing) side effects that can accompany such methods as the pill and the IUD could help to assure women that the feelings they have experienced are neither abnormal nor an adequate reason for dropping out.

Table 3. Respondents' Description of their FP Trainor by Family Planning Status.

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

Table 4. Client-Provider Interaction During Training by Family Planning Status of Woman.

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

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

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

1. There should be a permanent supply of contraceptives on hand.

2. There is a need for an intensive FP information campaign (e.g. seminars, house-to-house visits).

3. The midwives and motivators should develop friendly relations with local residents.

4. FP acceptors could be mobilized to teach/motivate other potential clients.

5. Free medicines should be provided by the local clinic.

6. Midwives/motivators should follow up the FP acceptors to monitor their progress.

Reasons for Dropping Out

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

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

Factors Related to Dropping Out

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

Client Factors

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

1. A lower level of educational attainment,

2. A lower rating on a scale of household economic status (ownership of consumer items),

3. A smaller likelihood of having been employed during the past year,

4. A greater number of previous pregnancies, and

5. Less favorable attitudes toward FP.

Table 5. Selected Characteristics by Family Planning Status of Woman.

	FP Status		
	Current User	Drop Out	Chi square Values
Educational Attainment (% with high school education)	34.9	18.3	18.59, p< .002
Employment (% working)	40.5	23.4	12.07, p< .002
Economic Status (% with 3 or more consumer goods)	20.1	7.5	9.72, p< .01
Number of Previous Pregnancies (% with 3 or lower pregnancies)	52.0	38.3	11.51, p< .01
Attitudes towards FP*			
Wife (% who thinks it is very good)	94.4	93.3	.18 n.s.
Husband (% who thinks it is very good)	97.7	93.9	3.54, p< .05

* Separate items also assessed attitudes toward two specific FP methods (pills and IUD). Significant differentials in the expected direction were found for three out of the resulting four comparisons.

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

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

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

Table 6. Percent of All Those Who Started on Condom, Pills and IUD Who Later:

	Condom	Pills	IUD
Stayed on condom/pills/ IUD	18.8	49.7	91.7
Dropped Out	37.8	34.3	0.0
Switched	29.7	12.1	8.3
Never Used	13.5	3.9	-

It is also interesting to note that the clients who were expected to return to the clinic every one or two months for a new supply of contraceptives were less likely to stay with the program than were those who were required to return on a less frequent basis. This finding may be noted in Table 7.

Table 7. Frequency of Visiting the FP Clinic by Family Planning Status of Woman.

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

Program Factors

We have already noted how the provision of improved services ("quality of care") was found to be associated with lower levels of dropping out. This was demonstrated for the question on rating the FP trainor as "friendly and approachable", for the item on client satisfaction, for the data on whether or not the client had been provided with information on the method's advantages and potential side effects, and for the strategy of orienting clients to more than just a single type of FP method. In each of these cases the drop-outs had been accorded less in terms of quality of care than had the current users.

A summary index of client-provider interaction was formed from various items listed in Table 4. As shown in the bottom row of that table, we can again see a significant difference between the current users and the drop-outs on this measure. In general, the drop-outs had experienced shorter and less satisfactory interactions with their trainors than did the current users.

Interviews with FP Service Providers

Most service providers were experienced in the provision of family planning. A good number of them had both theoretical and practical training in providing contraceptive pills and condoms. However, only 40 percent had been trained for IUD insertion and removal.

Several service providers also asserted that some local government executives are not very supportive of the family planning program.

Facilities and Services in the Health Clinics

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

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

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

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

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

Health Provider-Client Interaction

Most health providers were observed to be friendly and approachable. Discussion of possible side effects was rarely carried out during the consultation. This supported the earlier contention of the clients concerning the infrequent discussion of side effects.

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

Program Implications

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

1. The FP drop-out phenomenon continues to be prevasive in Bukidnon, although levels are perhaps not quite as high as is sometimes believed. The major problem in this regard appears to be the widespread belief that the various FP methods (especially pills) cause harmful or disturbing side effects.

2. A large majority of FP acceptors claim to be satisfied with the current program. Most also perceive the FP personnel as competent and friendly. Sustaining proficiency and favorableattitudes of personnel towards work would prove advantageous to the program.

3. Some programmatic weaknesses were also uncovered, however. Acceptors were generally not given an orientation on a wide variety of FP methods. Discussions of the side effects issue were often missing. Home visits by program personnel are rare.

4. Respondents gave several suggestions for improving the program, focusing in particular upon improvements in the logistics system and a more intensive educational/motivational campaign.

5. The drop-out problem appears to be most prevalent among poorer and less educated women, housewives (i.e. those not gainfully employed), those with many previous pregnacies and with less favorable attitudes toward FP. Strengthened efforts to reach out to these groups will be needed.

6. Campaigns to bring about more favorable opinions toward FP should focus on husbands as well as on the wife.

7. Increased used of the IUD should help to bring about declines in the drop-out problem. However, efforts to convince more women to use this method should not run counter to the goal of free and informed choice of method by the client.

8. Greater emphasis on high quality FP services (quality of care) will help to reduce FP drop-out rates. Providers should be competent and friendly, and concerned as well with fulfilling client expectations. They should offer a wider variety of FP choices, bringing out in a clear and objective fashion the advantages, disadvantages, and possible side effects of each method.

9. A number of local government executives are not supportive of the FP program. Convincing them of the importance of the program should be given priority.

10. Some FP clinics are not well equipped. An effort to upgrade these facilities will help improve the delivery of services.

11. Some FP services providers have not yet been trained. For example, about fifty percent of the clinics in Bukidnon are not prepared to provide IUD insertion and removal services. Providing the staff with appropriate training for this will be a help.

Remarks of the Family Planning Program Manager

DR. EDITH ABOCEJO
Family Planning Coordinator, DOH Region 10

Good morning. Since 1990 particularly we thought that we were doing fine in the implementation of the FP program in Bukidnon, only to realize that we were faced with several operational problems. One of the major problems that we faced is the extent of the program drop-outs. We are thanking the Population Council and Ms. Lita Sealza of RIMCU for assisting the Region in studying this situation. The region participated fully in the study from conceptualization which was done in Davao City up to research utilization and dissimination (with a utilization workshop held in Cagayan de Oro a few months ago). The results of the study have really pushed us program managers to strengthen and re-direct or re-focus our strategies in the implementation of the FP program. As a matter of fact, we utilized "quality of care" as one of the key factors in making our clients continue to use the method for longer periods of time and also for improving client satisfaction. So, what we did was we utilized fully the FP clinical standards and the manual as a guide for our FP service providers on their day to day operations in the clinic. We also, as far as training is concerned, prioritized those areas with low or no access to FP services. The same was true for the allocation of instruments and equipments. We also prioritized this in areas where there is low FP services. And as far as contraceptives are concerned, the logistics system is now in place in the region. We have realized that there are still some barangays with zero level of contraceptives, so we have seen to it that all contraceptives are in place even at the barangay level.

With the devolution, there is already less mobility of our health workers especially in the follow-up of clients. So we re-activated and mobilized community-based workers to help us in the follow-up as well as in the recruitment of clients. Now, part of the Quality of Care is the improvement of IEC and counselling. We have therefore emphasized during trainings and monitorings the importance of informing the clients about side effects, complications, advantages and disadvantages, how to counteract misconceptions, as well as the so-called Cafeteria Approach. We also expanded our IEC campaign among male organizations like cooperatives.

As far as monitoring is concerned, we realized the importance of the visibility of our coordinators and supervisors in the facilities. This will be the venue for consultation and dialogue among the clients, the service providers and the program managers. Also, we did on-the-job coaching, meaning monitoring. We provide technical assistance and make corrections if there are any. Moreover, we used the Quality of Care Assessment checklist and we have already conducted orientations among LGUs. But this time, as a follow-up, we did program reviews with the LGUs. We gave them feedback and updates on the FP program. Luckily, these documents have convinced some of the LGUs to fully support the

program not only in the logistic management but in the total management of the program at their level considering that during the devolution they have now become the managers of the program.

What about our future plans? If there will be an opportunity, we will select an area where we can implement these interventions. For instance, we will maintain existing strategies plus we will put up NFP centers and introduce DMPA. We will also mobilize community-based volunteers and designate them as our Barangay FP coordinators. We will institutionalize the Circle of SMART. (A SMART circle is an organization of women acceptors whom we mobilize as advocates of the program). We can also provide instruments, equipment and other supplies; and sustain existing coordination with partner agencies and LGUs. We would then hope that, after implementation, we will be able to identify strategies which will really help us keep our clients, make them stay longer with the program and most especially increase their satisfaction with the program. Thank you.

Session I

A Diagnostic Study of the Implementation of the Department of Health Training Course for Family Planning Providers in Region II and Cordillera Administrative Region

Steven Rood, Ph.D.
Cordillera Studies Center
University of the Philippines-Baguio

Marcelo Raquepo, Ph.D.
Cagayan State University

Mary Ann Ladia
Cordillera Studies Center
University of the Philippines-Baguio

A. Background

This particular research project is one of several operations research studies undertaken in the Philippines under the "Family Planning Operations Research and Training" (FPORT) Program. One of the aims of FPORT is to strengthen the capacity of local researchers to undertake operations research by working in close collaboration with family planning program managers. During the first workshop researchers and program managers from Northern Luzon chose the FP Training Program as the focus of their study.

The training courses are undertaken by the Department of Health as it situates its family planning program in more general health services. 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," came about after several meetings among researchers and health personnel. These meetings, which followed the OR workshops, were held in order to define clearly the research questions that would be relevant to the Department of Health in implementing its training programs. This process was necessary in order to insure that the perspectives and concerns of the program managers and the DOH Training personnel (who are the potential users of the data) could be properly addressed.

In the initial meetings, researchers and Department of Health personnel (both from the Central Office and Region II) brainstormed on a number of different ideas. In the end it was decided to focus on a tentative topic: The Basic/Comprehensive Family Planning Course for Physicians, Nurses, and Midwives. Discussions centered on Judith Bruce's client-centered "Quality of Care" framework as it affects family planning operations. It was also decided 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 obvious.

A preliminary research proposal was prepared, and then discussed in two subsequent meetings (one in Manila and the other in Tuguegarao). In addition to the researchers and Department of Health personnel who had been at earlier meetings, these meetings included one of the authors of the family planning training modules.

It was during the second set of meetings that the decision was made 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).

B. Research Design/Methodology

The Research Questions

Based on the discussions outlined above, it was decided that the general objective of the study is to observe and describe the conduct of the training courses in our two regions. 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 posed (see Attachment 1).

The first set of questions revolves around the conduct of the trainings and their outcomes. It should be noted in this regard that we in 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.

The next set of questions has to do with course content and effects. We were interested in a detailed analysis by the trainees of various aspects of the training. In addition, given the continued concern by the Department of Health in improving the trainings, we wondered what improvements could be suggested in the courses as actually implemented. Finally, we wished to know whether attendance at trainings increased commitment to the family planning program, and perhaps reducing thereby personnel turnover.

The third set of questions, on trainee selection, reflects the concern that, under the devolved set-up local governments would not send personnel who met DOH criteria, but would follow a different set of selection 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 and in which 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 new devolved set-up, the practice 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,
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 related to the family planning field worker. So, the research team examined value questions in all trainings. Finally, for the practicum phase of the Basic/Comprehensive course, we are interested in the client's reactions, as well as clinic conditions, in order to judge the quality of care being provided.

Research Methods

The team observed trainings (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/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 observed the didactic phase by sitting-in throughout this classroom experience. The research team had copies of the training manuals, and were therefore able to organize this observations with regard to the actual conduct of the training as opposed to the ideal training regimen.

In addition, a questionnaire was developed which was administered to all trainees at the beginning and after the end of the training. The sections of the questionnaires are given in Attachment 2. As can be seen, some of the questions were repeated, 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 as articulated by Judith Bruce, and their 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 ("End of Training Questionnaire").

During the training, we also administered a questionnaire to obtain the trainees' perceptions as to how they were selected, and what were the benefits and costs to them of attending the trainings.

As noted, during the practicum phase of the "Basic/Comprehensive Course in Family Planning" the research team observed the trainees as they worked in their preceptor areas. Three instruments were used at this time, namely:

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. The observations centered on the question of the Quality of Care that the clients were receiving, and the exit interview asked clients about their perceptions.

In order to capture some of the data about the newly devolved context of the family planning program, we first observed Family Planning Updates conducted by the DOH. However, these were sparsely attended, so we then made special trips to talk to local supervisors of all trainees in the courses. 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. This is probably a good place to reiterate our appreciation for the cooperation of these persons, inasmuch as our research would not have been possible without their assistance. Our observation of trainings, application of questionnaires, and discussions with the trainors inevitably taxed their busy schedules. Yet they graciously accommodated us, so that we might accomplish this research report.

C. Main Findings

One Basic/Comprehensive Course and two Interpersonal Communication Skills Courses were studied in Region II. Two Interpersonal Communication Skills (ICS) trainings and a Preceptors Course were observed in the Cordillera Administrative Region. (A Preceptors Course was observed in Region II as part of the pre-testing of questionnaires.)

Absenteeism and Drop-outs

There was no evidence of either absenteeism or drop-outs. The only absenteeism was caused by late notification of trainees. In short, fears about negative physician attitudes towards training as part of a "team" found no support in this research.

Course Contents and Effects

1. Trainees' Ratings

In the end of training questionnaire, trainees invariably rated the materials and handouts as excellent, the presentations by trainers as excellent, the training as very useful in their daily work, and the subject matter covered as somewhat broad. These findings hold for the didactic phases of all three types of courses: Basic/Compre, ICS, and Preceptors.
The differentiation come in the amount of time allotted for activities. The ICS was found to be somewhat too long, the Preceptors course a little too long, but the didactic phase of the Basic/Compre was rated as just right. Thus, while there might be scope for reducing the length of the ICS and Preceptors courses, based on the feelings of trainees, the Basic/Compre didactic phase ought not be shortened.

It is worth noting that trainees felt they should be consulted regarding their food and accommodation preferences.

2. Possible Modifications of Preceptors Course

During the implementation of the Basic/Compre and ICS trainings, we observed very few deviations from the training manuals. However, during the Preceptors course in Baguio we noted a certain amount of creativity on the part of trainors. When we documented this, and discussed it with the trainors, we arrived at the following recommendations:

1. The ICS should be a prerequisite for the Preceptors Course.

2. Core topics for the Preceptors Course should be the following:

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

3. Effect on Trainees' Commitment to FP Program

When we reflect that trainees have a generally high level of commitment to the family planning program to begin with (see trainee selection questions) we should not expect to find much scope for change. For instance, virtually one hundred percent of trainees say that it is important to have the ability to plan a family. However, agreement is not so unanimous on other aspects of the family planning program (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).

In general, there was clear evidence that the training had an impact on these attitudes. One reason verbalized for this was that trainees became more cautious due to emphasis on side-effects of family planning methods, which may have counter balanced any enthusiasm generated by the training.

Selection of Trainees

The selection of trainees was done through a variety of channels, with the trainees having little say in their own selection. None of the trainees cited the local government official who supervises them. Rather, it was the health personnel who were doing the selection. There was no evidence of favoritism in trainee selection.

There was no trainee in the Preceptors Course who mentioned the condition of their clinic as a basis for their selection. The condition of the clinic is used by the DOH to choose 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, the criterion does not seem very salient to the Preceptor trainees.

There were a variety of <u>costs</u> <u>and</u> <u>benefits</u> -- professional, economic, and personal -- cited by the trainees.

All trainees cited missed clients and work -- such a reaction was not limited to physicians.

Attitudes of Local Government Executives Toward Family Planning and Its Training Component

In their discussion with the research team, the local executives were found to be generally supportive of the family planning program, but not very aware of its health emphasis: "Family Planning Saves Lives". However, persistent complaints of health personnel cast some doubt on how concrete is the support of local government for health programs in general, and FP in particular.

Local executives are thus quite supportive of family planning. However, the researchers are not sure of the extent to which this verbal support is translated into actions.

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 the family planning program.

Values and Client-Centered Quality of Care

1. Social Values

It is well-known that there is a conflict between the government and the Roman Catholic Church about family planning. When asked directly about their stance in this controversy, trainees tend to split between those on the side of the government and those who are neutral. Few take the side of the church.

It may be, though, that positions on family planning issues are not so much tied up with religious beliefs, as with whether the general social values of the person are traditional or "modern." The trainees typically held values which would be called "modern" by sociologists.

The only exception to this generalization is in response to the item, "Health workers must have consideration of the individual needs of clients, even 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.

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.

2. Client-Centered Quality of Care

The researchers also focused in particular on the recently introduced "Quality of Care" framework by Judith Bruce. This framework attempts to foster a more client-oriented service provision. They found increased trainee adherence to "client- oriented 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.

It must be pointed out, though, that there is a certain amount of confusion between "Quality Assurance" as espoused by the Department of Health and the client-oriented "Quality of Care" espoused by Judith Bruce and her colleagues. Repeatedly, both in written and in oral communication, DOH personnel collapse client-oriented quality of care into mere 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 other five factors to consider: choice of methods, information, interpersonal relations, mechanisms for continuity, and appropriate constellation of services.

Continued emphasis on the client-oriented quality of care issues should sharpen the distinctions made in trainings between the narrower quality assurance and the more encompassing client-oriented quality of care.

We therefore recommend that an effort be made to teach health personnel to think in terms of real quality of care rather than mere quality assurance.

Practicum for the Basic/Comprehensive Course

In the Basic/Compre course we observed, the preceptor areas were given very little notice that trainees were coming. To add to this, trainees were doubled up, two to an area, which increased the pressure to find clients.

The Basic/Compre trainees satisfactorily completed the practicum requirements of IUD insertions and physical examinations.

Perhaps one of the most important findings of this study is that Basic/Compre trainees became confident in all situations to insert IUD after the seventh insertion. (See Table1.)

Our Client-provider observations indicated trainees' concern for client-centered quality of care, but medical asepsis required in handling patients was somewhat neglected. (See Table 2.)

In general, Preceptors clinic were inadequately equipped to provide an ideal clinic to practice. (See Table 3.) We suggest that health authorities create "model" family planning clinics each time a preceptor is trained.

In our exit interviews, we found that clients were generally satisfied about the services provided in the preceptor clinic. This was despite the lapses noted in Tables 3 and 4, which may indicate low expectations by clients.

D. Dissemination Activities

Separate Research Utilization Conferences were held in the Cordillera Administrative Region and Region II. Researchers and program managers from both Manila and the regional and local health offices attended. Suggestions from the Baguio RUC were taken into account for the RUC in Region II. Suggestions from both were also included in the final, full report.

Press releases were sent out in the regions, and carried in local papers.

Finally, brochures were printed in each region, highlighting for interested publics the main findings. Five hundred copies were produced in each region. These were sent to participants in the trainings, local health officials, local government officials, local bureaucracies, Congressmen and Senators, Manila offices and the like.

Attachment 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 course 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

Attachment 2. METHODS USED

---

1. Didactic Phase
INTERPERSONAL COMMUNICATION SKILLS (n = 71)
PRECEPTORS COURSE (n = 15)
BASIC/COMPREHENSIVE COURSE IN FAMILY PLANNING (n = 20)

OBSERVATION OF TRAINING BY RESEARCHERS
plus questionnaires

Pre-test	Post-test
A. Personal Information	A. End of Training
B. Family Planning Practice Questionnaire	
C. Attitudes of Personnel	B. Family Planning Practice
D. Service Delivery (Quality of Care)	C. Service Delivery (Quality of Care)
E. Social Values	D. Social Values

SELECTION QUESTIONNAIRE
--How/Who selected?
--Benefits and Costs of Training

---

2. Practicum Phase
BASIC/COMPREHENSIVE COURSE IN FAMILY PLANNING

Observation Guide (n = 60) for Client-Trainee Interaction

Exit Interview (n = 60) of Client

Clinic Inventory (n = 10)

---

3. In the Context of Devolution
Interviews (n = 31)
of Mayors and FP/Health Supervisors
Observations
of some FP Update Conferences

---

4. Expert Opinion on Training Issues
Focus-Group Discussions
with FP Trainees

Table 1. PERCENTAGE OF TRAINEES INDICATING THEIR LEVEL OF CONFIDENCE AFTER A NUMBER OF IUD INSERTIONS

	NUMBER OF INSERTIONS		
Confidence Level	Two	Five	Seven
Not Confident	85.00	-	-
Little Bit Confident	10.00	20.00	-
Confident with Few Exceptions	5.00	80.00	5.00
Confident in all Situations	-	-	95.00

Table 2. PERCENTAGE OF OBSERVATIONS IN WHICH CLIENT-CENTERED PROVISIONS WERE NOTED IN THE CLIENT-PROVIDER INTERACTION

NEW ACCEPTORS (n=17)	THE PROVIDER	REVISIT (n=23)
88	asked client's reproductive health	48
65	asked if client was breastfeeding	43
-	inquired if clients have problems with current method being used	61
59	took client's medical history	9
71	asked about date of last menstrual cycle	17
59	asked about unusual vaginal bleeding	4
41	asked about unusual discharge	4
65	asked about pelvic pain	9
41	took client's weight	4
65	took client's blood pressure	9
18	undertook laboratory screening for STDs	4
88	performed physical examination	4
76	performed pelvic examination	4
71	used a sterile speculum	4
47	informed client of what is involved in pelvic exam	4
35	washed hands before examination	0
76	used gloves to perform examination	4
100	informed client when to return for follow-up	57
82	told client what to do if she experiences problem	35
18	told client where to get for resupply	9
18	asked if client had a question	0
53	discussed other health issues	39
24	maternal nutrition	13
24	growth monitoring	-
24	immunization	-
-	children's illness	21
-	child nutrition	35

Table 3. PERCENTAGE OF RHU CLINICS OBSERVED TO HAVE PROVISIONS FOR QUALITY OF CARE

	(n=10) ITEMS	PERCENT
1.	Waiting Area	90
2.	Seating for all clients	80
3.	Toilets	80
4.	Auditory Privacy in the counselling room	20
5.	Visual privacy in the counselling room	60
6.	Separate room for physical examination	80
7.	Auditory privacy in the physical examination area	80
8.	Visual privacy in the physical examination area	80
9.	Clean examination area	10
10.	Adequate source of light in the examination area	70
11.	Adequate amount of water	60
12.	Inventory of FP commodities	100
13.	Storage of FP commodities according to expiry dates	100
14.	Adequate storage failities for contraceptives	80
15.	Separate client records	90
16.	Client addresses recorded in sufficient detail	70
17.	Well-ordered client record system	50
18.	Daily FP register	60

Table 4. SUMMARY OF MAIN FINDINGS

Physician Drop-out is not a problem
- so, "Team Approach to Training" can work

Trainees find courses too long, except Basic/Compre Didactic
- note: Preceptors is being shortened

Client-centered Quality of Care is being absorbed
- this despite only being explicit in Preceptors Course
- some slippage back into technical "Quality Assurance"

In the Practicum, current emphasis on 15 IUDs inserted is inappropriate
- See Table 3.
- pressures on new acceptors
  71% of observed new acceptors were IUD
  as compared to only 26% of previous month's

However, evaluators for "Competency Basing" may not be available
- limited number of trainors (i.e. to judge comperence for inserting IUDs)
- quotas as an information-saving device

Natural Family Planning is de-emphasized by trainors
- trainees do not feel competent to advise clients
- some clients would like to know more about this

Clients expressed overall satisfaction with services
- this despite lapses (Tables 4 and 5)
- perhaps this indicates low expectations

Remarks of the Family Planning Program Manager

MRS. CARMELITA TAGUBA
Family Planning Coordinator, DOH Region 2
FP Program Manager

I would like to inform the body that I was not part of the team that conceptualized this study, but I am here to share my own perspective as program manager. As a matter of fact it was Dr. TeresitaCastillo, of FPS, Dr. Rey Frugoso of FPS Training, and Mrs. Presentacion Nocenas who collaborated closely with the team of Dr. Rood and Dr. Raquepo. I first became aware of the study when the researchers came to the office to request for our presence during the conduct of trainings from October to December 1993. We were assured however, that this will not in any way evaluate us as trainors. My participation in the study was therefore more of providing the researchers with the copy of the manuals or of the modules that are used during trainings, providing them with the schedule and participation in the focus group discussions. During the conduct of this study, Dr. Raquepo and his team worked with us and followed up closely the results of the study.

Initial findings revealed that, as provincial trainors, there is need to provide technical assistance in terms of monitoring the trainees during the practicum phase and to seek administrative support from the local government units in upgrading the facilities of the preceptor areas. As a result of this study, we have done something. First, on the selection of participants. One basis of selection of participants should be the commitment of these participants to implement the program and the value they place on family planning. This will have to hold true also for participants who came in as replacements of those originally identified for reasons only the local government executives know. An interview is now conducted for those who come in as a replacement. For early notification of participants and preceptors what was done was, at the end of the year we prepared a list of possible participants and preceptors. A notification for their participation in the trainings was then given one month ahead of the schedule. In addition to this, the participants are reminded a week ahead of the training. The third change that we have done is on the preparation of the practicum site and the training venue.

Training schedules are synchronized with other activities in such a way that provincial trainors who are at the same time coordinators of other health programs can follow up or monitor the trainings and the trainees. On monitoring of trainees, the provincial trainors are advised to monitor them not only during the practicum phase but also during the internship period. They are also tasked to follow up the requirements of the internship phase and to

submit a list of clients who have been inserted with IUD which will serve as guide for them in accreditation with the Professional Regulations Commission.

We also sought the support of the local government units and we noticed some improvements. An examination room, which was previously situated in a dental room, was relocated to a separate room, thereby providing more privacy. A similar move was done in three other preceptor areas in Isabela. With this, there was great improvement in the examination room. Supplies were also given by the LGUs which includes the examining tables and some gloves and reagents although these were minimal. These, however, still did not meet all the needs of the preceptor areas. The regional office also provided lights and some medicines for FP-related complications. At present, preceptors and some of the trained health workers now come voluntarily to the regional office to ask for these supplies. In one instance a preceptor approached the Director for a microscope and she was granted one. This reflects their increasing awareness of their role as preceptors. The preceptors who were not able to have an update on "Quality of Care" as a topic in their preceptor's course were given a copy of the checklist on Quality Assurance so they may have an idea of what an ideal clinic set up should look like.

We have come out with some more plans but these will never materialize unless we get the decision from central office or the Family Planning Service. Our first plan would be to maintain coordination with the LGUs especially in seeking administrative support for training and monitoring training activities. The second plan is the inclusion of the clinic condition and local government support as a selection criteria for the preceptor area. This is needed to improve the quality of training during the practicum phase because this is the area where we are weak. We could not really meet the requirements that are needed in an ideal preceptor area. The third plan is to have a training on Natural Family Planning with participants coming from both the private and public sectors. Hopefully this will settle the differences between the Catholic Church and the government. Fourth, is to have the topic of ethics or Quality of Care as a major course content in the basic comprehensive course. And this again will entail a longer "didactic" phase to extend to 7 or 8 days, and then to lessen the requirements for IUD insertions. The fifth plan is to provide additional supply and reagents to preceptor areas which can be answered by central office. And the last is, to have a one to one trainee-trainor ratio. For a course that has 20 participants in the basic comprehensive training, there is a need to increase the number of preceptor areas and a need also to increase the funding for this training. In conclusion, I am grateful for having been included in this study because this has improved my management skills as a trainor. Thank you very much.

Reactions to Session I

Dr. Trinidad Osteria
Director, Social Science Research Center
De La Salle University

I will first discuss the second paper, the OR adopted in the diagnostic study of the implementation of the DOH training in Region II-Cordillera. The paper focuses on the basic comprehensive family planning course for physicians, nurses and midwives using the client-centered Quality of Care framework in family planning operations. The emphasis is on the process of training to increase the likelihood of basing program interventions on the research findings. Hence, the research has two major components: First, the training course and its process; and second, the Quality of Care framework as utilized in family planning service delivery. For the first aspect, the researchers viewed the overall training strategy as a system that absorbs inputs in terms of the content and format according to the conceived plan or design and process them to produce outputs mainly in terms of skills acquisition and development. Hence, there are significant areas in research delineation. There is the training program per se. Secondly, there is the training mode or process. Finally, the training inputs must produce the expected outputs in terms of meeting the demand for family planning services. Operations Research in this context is concerned with the identification of the family planning needs, the training process, and alternative modes that will bring about the optimum output in terms of increasing acceptance, retention in the program, and eventual fertility decline.

Analysis requires that the relationship be made explicit and defined in causal terms, that is, how does the training process lead to the desired outcomes, e.g. skills acquisitions, competency, increased client's orientation to the Quality of Care Framework, what is the relationship between the providers' task specification and the training requirements? Thirdly, what are the training components that need to be modified based on the results of the study? When the researchers begin to examine the training component of the family planning service delivery, they were confronted with a large number of variables affecting the system. The training variables can be dichotomized into those that are controllable, i.e. the mode, the venue, the format, the duration, the content, and those that are uncontrollable which in this case are resources and the clients' characteristics. Therefore, the selection of an optimum training modality is a function of the interaction of these two sets of variables. In analyzing the training process, there are several questions that come to mind. First, what are the basis for determining the providers' task given the results of the study and how could these be linked to the training needs? Second, what mechanisms are in place for integrating the major findings of the research into the modified training program? Third, how can a balance be achieved between the providers' concerns and the clients needs? Fourth, how can priorities be set in defining the content of the training program within the resource milieu of the system? Fifth, what data collection modes could be undertaken to monitor and

evaluate the providers' training, given the shift towards a local government sponsorship and the emphasis on the Quality of Care framework? And lastly, how can some of the major findings of the research, that is the lack of sustenance in the provision of quality services as we see in Table II of the study be addressed? The results revealed the difference between the initial visit and the revisits, the differential perceptions between quality assurance and quality of care, and the prescriptions of 15 IUD insertions before the declaration of competency. How can these be addressed in subsequent programs? In assessing the training program per se, one can go beyond the trainee's perceptions by examining the congruence in training content skills and objectives. In talking of Quality of Care, areas for consideration include knowledge and attitudes of women of the communities, adaptability to the local needs and circumstances, and the prospects of women's participation on the design of the training programs. Finally, in assessing the Quality of Care, one goes beyond the clinic based provision of clients services by determining how clients expressed needs serve as the basis for offering specific methods. Likewise, age, contraceptive choice, lactation status, health profile, and parity could serve as the basis for choice. In fact, the training program could be viewed as one of the inputs to generate the Quality of Service expected using the six elements specified by Bruce. The major findings of this study can be transformed into an analytical framework that specifies the components of the training program, their effects on service provision, clients satisfaction, reduction of drop-outs, and fertility decline. The program issues that emerge from research results are: First, a need for closer look at the training program to determine how specific components can be prioritized? Second, more explicit Quality of Care inputs and how these can be incorporated into service delivery scheme; Third, finding alternatives to competency assessment given the lack of evaluators as specified in the research; and fourth, going beyond clients' satisfaction by translating attitudes to practice as reflected in increased acceptance, improved continuation and fertility decline.

The second paper, entitled "Factors Affecting FP Drop-out Rates in Bukidnon" addresses four major issues. First, the level of accuracy in the of DOH records; second, the perceptions of FP acceptors of local clinics and the services offered; third, reasons given for termination of use; and fourth, factors associated with the use termination. The questions evolving from the results of these study are: First, to what extent would the client constraining factors e.g. low education and low socio-economic status be subordinated if the Quality of Care elements are strengthened in the Family Planning service delivery scheme?; and research results revealed that program factors which contain some of these elements lead to continuation of use of the methods. How can these components be adequately integrated within the program structure of family planning in the area? We can see the programmatic factors, the client-provider interaction, level of technical competence, facilities, and services. In terms of program revision, there is a need to put the disparate components of services together to assess the effects of changes made in one aspect of the research structure. What I'm advocating is a wholistic approach in viewing the program. Even if we have the results of the study, we should look at the integral components of Family Planning service delivery. On the basis of the findings, the strategy may need to be adjusted to accommodate the recommendations derived therein, such as, improvement of staff attitudes, increased home

visits, method orientation of clients, improved IEC campaign, and reaching the hard core group. Given the multiplicity of concerns, there is a need to merge the resulting information both in the training and implementation of programs. A change in training mode requires a change in the implementation as well as the supervision schemes. The program planner must look into the various determinants and ensure that family planning as a whole, will continue to function, to increase use continuation of specific methods, minimize drop-outs and subsequently reduce fertility. These can be described in a graphic manner and each of the components determinants can be analyzed to identify significant operational issues. For example, how can the client provider interaction be maximized, given the clinic load and the time input of the service providers? There are limitations in the technical competence of the providers. In transforming the results to operational inputs, specific variables can be grouped for analysis. For example, those that pertain to the program can be clustered, e.g. providers, trainings, supplies and facilities.

It is possible to identify areas that are expected to have the greatest effects in reducing termination of use. There is likewise a need to identify the logical sequence of decisions to terminate the use of a specific method and determine the entry points of such interventions. To reduce drop-outs, one must determine the FP services that need to be provided before deciding how the personnel can be trained. As in the review of the previous paper, there are both uncontrollable as well as controllable variables in the drop-out problem. Therefore, use continuation has to be maximized through the manipulation of decision variables which seem to be closely related to the six elements of the Bruce framework. With the multiplicity of determinants, a model could be developed. There are analytical and conceptual models that fit the problem of use continuation of specific methods. There is a need to use them to find the best or optimal solution to the problem. Alternative service delivery packages made up of different combinations of the principal decision variables, e.g. frequency of contact, competence and exposure to IEC materials can be developed. To generate the packages will require a number of approaches which can either be qualitative or quantitative. One is the so called oval diagramming that shows in a graphic way relationships among the variables with arrows showing the directions of causal relationships and pluses or minuses which show whether the effect is negative or positive. There is also a qualitative approach by using nominal group techniques of consensus building both by the program personnel and researchers for each variable and the verification of such relationships. Common decision variables would have then to be linked as Anrudh Jain of the Population Council stated "If the program's mission statement is clarified and defined in terms of helping individuals meet this reproductive needs, and the emphasis measured in terms of the extent to which these have been achieved, then program strategies adopted by the program managers would lead to improvements not only in the Quality of Care but in the achievement of societal goals of fertility reduction through increased use effectiveness of methods and the decline of the drop-out rates. THANK YOU.

Reactions to Session I

Dr. Ralph Curiano
Training Director, FPS-DOH
Reactions to Session I

When I read the papers of this conference, I tried to make some comments to prepare for this morning's dissertation. However, it seems what I read in the papers were slightly different from what was presented today. Possibly it is really different if you hear it from somebody than just by reading it. I have to now reconsider some of my comments, so bear with me if they are somewhat mixed up. After hearing my co-reactor, I think I may have much less to say nowabout the papers. Nevertheless, I'll be commenting on the practical side of it, whether this be on training or on client-provider relationship. First on the DOH training. Their research emphasizes more on the process of the training rather than on the outcome which I think is somewhat ambiguous. If emphasis is placed on the process of the training, we should also be equally concerned with the outcome of the program.

Just to cite an example, when we had an evaluation on a particular project, we had a good presentation of the reports, logistics, etc. We also had a good number of trainings conducted, a lot of manuals developed and yet the Secretary was not happy about it. He said, that it's not the number of manuals or the number of trainings conducted that counts but it all boils down to CPR (Contraceptive Prevalence Rate). So we had here a project which had a good process, which had all the support, and yet the outcome was not that satisfactory. (Compared to other Southeast Asian Countries, we are far behind especially in terms of CPR). So I think emphasis on the process must be given equal attention as with the outcome. As far as the evaluation of the training program as a whole, we need a good evaluation of the trainees, of the clients, and the service outlets. Well, I think also that the trainors have been somewhat neglected. Trainors have to also be given as much importance as the trainees. What is their motivation as trainors?. The same way as the trainees ask "What will I get after these trainings?" Whether it be financial, educational or whatever.

I would like to cite an example. Trainees were initially monitored; then they were monitored again on a revisit, this time by the research team. Initially, it was reported that for new trainees, 35 percent of them washed their hands before an examination. On the revisit, it was zero. So, we may say that we have a good process but not a good outcome.

With regard to the Mindanao drop-out rates, the providers were approachable, good, have the right knowledge, etc. So the outcome is good in terms of acceptance but there is also a

high drop out rate. What might have contributed to this effect? I think we have neglected one Filipino character, especially in the provinces, that we

Filipinos are not frank. If you ask a question, we won't tell you what we really mean. I think this was a crucial factor in the case of the Mindanao drop-outs.

With regard to the IUD insertion requirements in the perceptors course, there was a very good evaluation as far as number of insertions, how the patients feel and provider confidence. What the researchers fail to mention are complications of IUD insertions, especially those arising from new providers and how this affects the attitude of the trainees.

Now, let me proceed to discuss changes with Local Government Code (i.e. devolution) as exemplified by the different support of the LGUs on the FP program. In the case of Bukidnon, I don't think that they have a problem. The LGU is supportive of the FP program. But we have to look into areas where there is negative support from the LGUs. On the side of training, as I said earlier, we have evaluated the trainees, the clients, the service outlets but how about the trainors? Personally, I would say that we are lacking trainors from the central office; we also lack physician trainors. As health care providers, with the advent of the injectables (DMPA) there are many more questions about ethics, doubts about side effects, etc. which our nurses and midwives may not be able to answer. This is especially true in connection with the controversy surrounding DMPA. How much more when Norplant is introduced?

One more thing, it's good to know that in Region II, there is a positive outlook (as shown in low number of absenteeism) as far as training of physicians are concerned. This may not be true however, for the other regions. What we encountered was that physicians are usually number one in absenteeism. Based on the fact that they usually already know what is being taught, what they want is just a little refresher course or an update on new developments. There is the other issue of trainors who are mostly nurses. Sometimes it seems that the physician-trainees are just trying to know or to test what the nurse-trainors know. Now, inspite of the fact that trainors have been given standard answers to all possible theoretical and practical questions; new questions always come up and hence, the nurses need more support. So in training, what I suggest is that we have more physician-trainors I hope we could do that, so we would be more effective in addressing the needs of the program. Good day.

Open Forum
Session I

Rica Aquino, USAID: I'd like to address this question to Mrs. Carmelita Taguba. I'd just like to understand the comment you raised regarding the need for additional funds for training. There never seems to be an end to this in terms of how much to allocate. I'd like to understand what you mean by "more is needed" in contrast to what is already in the program, as far as financial resources are concerned.

Carmelita Taguba: The funding will be for the preceptor areas because there is need to reduce the ratio of trainee per preceptor area.

Rica A.: Okay, now we understand. Rencee (of UNFPA) is here with me and we have both discussed certain cost increases as far as training is concerned. I think that particular issue we are now addressing that particular issue.

David Alt, FP Logistic Advisor: This is related to Rica's comments about your concerns regarding adequacy of funding. I think it was Steven Rood who made the comment that trainees already come committed and therefore we don't see any measurable difference in their levels of commitment.

What I want to ask also is: has anyone looked at trainees who have gone through the basic comprehensive course and see how many of them never ever insert a single IUD after they got home. What I'm finding as we go around the field and look at consumptions of contraceptives is, a lot of these trained personnel never use their training. I don't know why they are opposed to it. I don't know if it has been noticed that providers would never have enough insertions on a regular basis to have confidence or whatever. I think some really good operations research on what people do in their own facilities after they go home is very important and likewise for all the DMPA training, because for instance, maybe a lot of people don't want to do IUD insertions or don't want to have DMPA training but we call them in for training. Maybe we should ask people to volunteer to come to the training or rate on the scale on how much they would like to be trained in DMPA injections or IUD insertions? This relates back to the budget and financing questions because one-fourth or one-third of the people that we are training never use that training. And if we can identify who these people are ahead of time, then let's not train them. Then we use our resources a little bit more intelligently. Thank you.

Dr. Ralph Curiano: First on the IUD insertions, it's good to know all these questions but only if you have good follow-up of these trainees. You have to make sure that you have enough personnel to do this. We cannot do this in the level of the central office so we have to tap the regional or provincial personnel. In as much as we are doing this as an

accreditation process, we have to train more personnel to become members of the accreditation process. We also have to go there on top of our busy schedule. For example, there was already a request from Region II regarding accreditation and up to now we haven't done that. With regard to the DMPA, the DMPA was available last May 1994, so the training started last March and the vials were available at the pilot areas in May. And we made a monitoring of the DMPA usage last July. Who did the monitoring? We again, and when we did that last July, no one was left at the office, and that was one week (i.e. monitoring the DMPA of five LGUs). So I think we need more personnel in terms of these things because it is always just us from the training section who have to do all these. We are doing all the trainings and we also have to monitor even if there are only a few of us in the FPS training section.

Dr. Edith Abocejo: May I say something on trainings? Region X had trained several persons -nurses and midwives on the basic comprehensive course and actually what we are doing in the region is that, we emphasize that the basic comprehensive course is not for them to become specialists in IUD insertion. It's more on the total delivery of family planning services from clinic management to provision of methods and logistics management. So what we did, as far as IUD insertion is concerned, since we only have a few clinics that were given instruments for IUD insertion, the nurses or midwives who graduated from the course were asked to call the midwives who had first finished the training to visit the main centers where the IUD insertions take place.

Nellie Antigua, AVSC: I would like to share some experiences regarding the training process. I know this discussion does not concern training in surgical sterilization. I had experienced conducting trainings in surgical sterilization in the 1970s and we evaluated our five year program. One of the results we found out was that most of the trainees really do not practice the course upon their return to the institution. One of the reasons we found is because the trainees were simply sent for training on a compulsory basis. And so sometimes they are not even prepared to accept the method, because they are personally against the method. And so, we tried to check on this. In the present training program what we do is, before sending people for training we go to the site itself, interview the trainees and then get the commitment of the trainees and their supervisor that upon the completion of the training, these trainees will have the time available to practice what they learned. It seems that this has helped the program, although we still have to evaluate the results. This is just to share what we have done.

Winnie Alvarez, Institute for Social Studies and Action: This is not actually a question but just a comment. I see the importance of training in different methods including on Natural Family Planning. I would like to underscore the fact that, in our experience, no one institute has combined these trainings with gender sensitivity. In our experience when we conduct sexuality workshops among workers, they begin to understand and they begin to adopt a broader perspective in the delivery of FP services. Hence, we see more and more, that we should adopt a framework that is more sensitive to women because we have found out that if women think they are really being empowered and not just told to use a certain

FP method, they themselves see its importance. If there is something in it for them also, like what I said -- empowerment, if ever they would see that then they tend to stick more to the method.

Rencee Tayzon, UNFPA: I'd like to raise two concerns, the first one is really an answer to Ralph's (Curiano) statement or comment a while ago on "number of personnel" because at least for now, we have added an assistant FP coordinator and Edith Abocejo can confirm this. FP coordinators are also supposed to monitor, so I think the training unit could request them to assist the Central Office. I mean the assistant FP coordinators could do the monitoring for the region. And I think under our next country program we will be hiring an additional four personnel for eight regions.

Still on the outcome, Ralph was saying we should look at results, and I think for example, in case of these trainings there has been very little attention paid to "complications". I think this has been raised two years ago when we had our tripartite meeting and there has been no research on this area. Lately, we've had information that there has been quite a number of complications (I think for Region 7), whihc is a reflection on the training and the confidence in service providers. This is an area to be addressed both on the side of research and training.

Regarding the monitoring of the preceptors on IUD insertions and the basic comprehensive practicum, it's good that the regional FP coordinator will do such monitoring, but wouldn't it be better if the FP coordinators monitor other regions instead of their own?

Jet Riparip, John Snow Inc: Actually I have both a question and a comment. I'd like to know whether given the number of training programs already done and a big number of trainees or participants who had undergone all of these training courses, will the Department makes some sort of mapping where these people are, so that future training programs will not be duplicated and therefore the money available will spread out more evenly. Second, I would like to suggest that in monitoring, it is very important that they be unannounced because I think, it defeats the purpose of monitoring when everybody knows that you are coming and therefore the clinics look nicer, the instruments better cleaned and everything else! So I'd like to suggest that we do random and unannounced monitoring. Thank you!

Ruby Fernandez, JHPIEGO: This is just a sharing which I would like the DOH to benefit from. I'm with JAPIEGO, working with the schools of nursing and midwifery all over the country. Right now, these are the two groups that are actually trying to adopt a competency based type of training which we had hoped to share with the DOH. We have ten reproductive health centers all over the country serving as the training sites for the faculty of nursing and midwifery and because these two groups are strong advocates for the competency based training, I think we would like the DOH to learn from these two groups. Secondly, these two groups are expanding to make their trainings more humanistic. Quality of care comes into these humanistic type of trainings. So, we practice first among pelvic models and when trainees are ready and have passed the skills checklist, then they go to the clients. We don't have a special session on quality of care because in each step of the training

it is emphasized and built-in the program. So I would like to invite the DOH to learn from the experience of these two strong groups of organizations who are already working within these competency-based trainings.

Steven Rood: I have a several points that I will make. I'm sorry if I left the impression that we didn't evaluate the trainors in our research. We did evaluate the trainors, they just came up so excellent, it wasn't very interesting in terms of OR. I mean the trainors are highly motivated, well qualified, in fact, one of their major complaints is that they don't have enough extra reference materials that they could use. They even asked to photocopy the materials.

My comment therefore goes back to the question of empowerment because I think that is a very important point. First, Judith Bruce does in fact have an article about the questions of quality of care perspective, and I think it's an excellent article, so it could be investigated. Secondly, I'm a strong advocate in my other work of decentralization. I'm a political scientist and I think, decentralizing health services to the local area is the best way to empower people. I think it would be a disaster if the health services will not be fully devolved.

Lita Sealza, RIMCU: I would like to thank the reactors for their very good responses. But I would like to comment on the statement of Dr. Curiano regarding the support of the local government executives. When we did our dissemination conference in Region X several local government executives were invited to the session. However, only one came which indicates, in one way or another, the interest of the local government executives on these issues in our region. Unfortunately, only one mayor came during the session, and one of his comments during the open forum was "I don't think I need family planning in my place because I need people, because that would determine my municipal allocation." So, working on the commitment of the local government executives, I think, is still a priority in our region.

Session II

A Study on Factors Leading to Continued Company Support to An Industry-Based Family Planning Program

Josephine Cabigon, Ph.D.
Demographic Research and Development Foundation
University of the Philippines-Population Institute

Emma Magsino
Philippine Center for Population and Development

A. Brief Background

This report presents the results of a qualitative study aimed at uncovering the factors that are likely to lead to varying degrees of continued company support of the industry-based RP/FP-MCH program implemented by PCPD in the Philippines after PCPD has withdrawn its programmatic inputs. Its ultimate objective is to identify for policy makers and FP program managers factors influencing and inhibiting the company's decision to sustain such RP/FP-MCH activities in the workplace.

PCPD has implemented this program in three cycles among companies that have shown interest in setting it up and consented to collaborate for two to three years. While PCPD's inputs in the project differ in each cycle, they are directed towards institutionalization of this program within the participating companies. Institutionalization refers to the company sustaining the RP/FP-MCH activities initiated by PCPD. PCPD provided similar programmatic inputs to all companies within each cycle. These are: **for the 1985-87 cycle** - (1) mobilization and training of in-plant volunteers, (2) monthly information, education and communication (IEC) activities, (3) weekly PCPD visits to the company, (4) establishment of a referral system and (5) research and evaluation activities; **for the 1987-90 cycle** - in addition to the above five activities, (1) provision of FP equipment, (2) cost-sharing, (3) establishment and training of the RP/FP-MCH team composing of the liaison officer, clinic staff and volunteers, (4) orientation of labor unions, (5) institutionalization planning workshop of liaison officers and (6) cost-benefit analysis of the projects; and **for present cycle** - in addition to the first and second cycle activities, (1) financial contribution of ₱ 10,000 per company for IEC planning and implementation, (2) program orientation for top-level and middle management, (3) participative planning and inter-company planning workshop, and (4) area coordination meetings of PCPD companies, government and non-government agencies.

Ideally, all participating companies under a given cycle will continue the RP/FP-MCH program after the end of the contract period with PCPD. However, according to a PCPD evaluation conducted immediately after the project ended, not all of the companies in the first and second cycles have been able to do so. Only two of the 24 1985-87 and four of the 18 second cycle companies still in operation were implementing all the four program components, namely service delivery (SD), information, education and communication (IEC), training and mobilization of in-plant volunteers (IPVs) according to PCPD evaluation framework. Meanwhile, only one company under the 1985-87 cycle and three under the 1987-90 cycle were sustaining the SD, IEC and IPVs components. On the other hand, six companies under the first cycle and four companies under the second cycle continued only the SD and IPVs components while 15 and 7 companies under the first and second cycles, respectively, were maintaining only the SD component.

It is important to go back to these companies under the first and second cycles together with the program implementor to find answers to the following questions:

1. Why were all program components maintained by only a few companies and why were one, two or three components dropped by other companies?

2. How useful is the PCPD evaluation framework for determining "successful institutionalization", i.e. the more program components initiated by PCPD, the more successful is the institutionalization?

With the 60 1990-present companies still in their initial, second and third year of project contract with PCPD, problems inevitably arise in the process of project implementation.

Operation research (OR) is one way to address the two questions raised earlier and to minimize problems with the present cycle of companies. With the involvement of the PCPD project implementor in this OR study, its results are vital in attaining a more effective planning and implementation of the RP/FP-MCH program in the workplace.

B. Methodology

Forty-six companies were purposively and then randomly selected for the study. For all three cycles of companies, the type of business (manufacturing, semi-conductor, garment, hotel, restaurant, department store and agri-industrial) was the main criterion for purposive selection so that one or some companies from each type had to be covered for the study to gain diverse insights. Among the first and second cycles of companies, the status of a company in maintaining the RP/FP-MCH components according to PCPD evaluation framework was another important consideration. All operating companies under the earlier cycles were combined as grouped under the PCPD evaluation framework discussed earlier. If the number of combined companies was less or equal to six under each institutionalization status, one was randomly excluded for the study; if the number was greater than six, the companies covered were randomly selected but considering the criterion of representation of the type of business. The resulting number of study companies are as follows:

1985-87 and 1987-90 cycles (n = 19)

5 --- 3 manufacturing, 1 semi-conductor and 1 garment, continuing SD, IEC, training and IPVs program components

3 --- 2 semi-conductor and 1 garment, maintaining SD, IEC and IPVs program components

4 --- 2 manufacturing and 2 garment, sustaining SD and IPVs program components

7 --- 5 manufacturing and 2 hotels, continuing only the SD program component

<u>1990-present cycle</u> (n = 27)

A. Metro-Manila and Southern Tagalog Regions (purposively and randomly chosen)

17 --- 8 manufacturing, 3 semi-conductor, 3 garment, 1 agri-industrial, 1 restaurant, 1 department store

B. Mindanao regions. At the later stage of the OR study, and for the purpose of gaining richer insights it was decided by the program implementor and researcher to include all of the 10 participating companies as they are quite different from the Metro-Manila and Southern Tagalog companies (3 manufacturing, 6 agri-industrial and 1 department store.)

Given the homogeneity of the companies belonging to each type of business and falling under each status category of the PCPD evaluation framework, it was expected that the information to be generated would be similar for each group of business type and status of implementation for the first and second cycles. It was anticipated that more enriching insights would be gained if the number of companies to be studied would be small and manageable. The main reason for this is the qualitative nature of the study involving in-depth interviews with company owners or managers of their immediate subordinates, liaison officers, company nurses and volunteer workers and Focus Group Discussions (FGDs) among industrial workers.

C. Main Findings

In going over the results of in-depth interviews and FGDs with the first and second cycles of participating companies the following emerge as common factors leading towards a successful institutionalization of the RP/FP-MCH program in the workplace:

1. Determination and commitment of management to participate in and pursue the program.

a. having an explicit and definite policy with regard to the health and welfare benefits of the workers and their dependents owing to the high awareness of the benefits namely, cooperation, high productivity, quality of work and less absenteeism;

b. allocating some budget (either separate or incorporated in the Personnel or Human Resource Development budget) for the RP/FP-MCH program;

c. incorporating the functions and responsibilities of the RP/FP-MCH team into their job descriptions and evaluations for promotion; the IPVs eventually becoming members of the team; and

d. making available free in-plant RP/FP-MCH services and supplies on a 24-hour basis.

2. Commitment and dedication of the RP/FP-MCH team and enthusiastic participation of beneficiaries for a common and clear goal.

a. determination of the team to properly address family-related problems or workers' worries and anxieties resulting in reduced absenteeism and tardiness related to pregnancy; post-delivery absences and tardiness and accident proneness and finally into improved workers' productivity;

b. high utilization of RP/FP-MCH services by most of the industrial workers, mostly females and even employees in male dominated companies tending to avail of such services not necessarily for themselves but for their dependents, particularly their wives and children resulting from the pressing economic difficulties they have been experiencing; and

c. provision of quality services by the company clinic staff.

3. Sustenance of commitment of all concerned through incentives and realization of the benefits of the program both for management and employees.

a. allowing the use of time and resources by top management to support the RP/FP-MCH program as the need arises; and

b. encouragement from management for the RP/FP-MCH team to implement the program activities on a regular basis.

4. Absence of serious economic setbacks.

Other influencing factors which were unique in only one or two of cases are as follows:

1. Determination and commitment of management to participate in and pursue the program.
a. concise and encouraging remarks from management on matters relating to FP/MCH;

b. welcoming into company premises any project or activity related to the upliftment of the individual workers (e.g. resource person, private, public and international agencies);

c. facilitating referrals outside company premises;

d. continuing the evaluation and search for innovative ways of improving the quality of life of industrial workers; and

e. extending the RP/FP-MCH program to communities located at the company peripheries.

2. Commitment and dedication of the clinic staff and IPVs and who eventually became members of the RP/FP-MCH team.

a. implementation of well-planned activities on schedule;

b. willingness to reach clients by trying several means or gaining friendship and cooperation; and

c. persevering RP/FP-MCH team in informing potential beneficiaries about the services by the company clinic staff.

3. Sustenance of commitment of all concerned through incentives and realization of the benefits of the program both for management and employees.

a. provision of incentives, in cash or in kind by top management for the RP/FP-MCH team (e.g. gift certificates, plaque, sending the team for training on official time outside of the region where the company is located), and for the industrial workers availing of the free services of the program.

In-depth interviews and FGDs with the third cycle of participating also reveal the above facilitating factors plus the following:

1. Ingenuity of the program implementors in tackling implementation problems.

a. resourcefulness of liaison officers in generating support from suppliers to sponsor some of the RP/FP-MCH activities and from the company physicians and company canteen management in implementing some of these actvities;

b. condensing and reproducing the IEC materials provided by PCPD in such a way that after they are read by workers, lessons are learned;

c. formation of sub-committees (e.g. health and safety committee) to assist under-staffed clinics;

d. ingenuity of RP/FP-MCH team in making workers go out of their way to participate in the activites conducted after working hours without overtime pay (e.g. initial compulsary attendance and a slogan in every pay slip which is different per day); and

e. liaison officer who perseveres in winning management commitment and support.

2. Participative planning and implementation.

a. active involvement of both labor and management in in-plant IEC;

b. making industrial workers suggest to top management the type of activities they want to be implemented and top management to respond promptly and accordingly; and

c. peer consultations or informal chats particularly over breaktimes on RP/FP-MCH matters.

The factors commonly cited by the respondents from the first and second cycle of participating companies which had prevented them from sustaining all the RP/FP-MCH activities initiated are the following:

1. Time constraint, this problem was common to all participating companies per cycle;

2. Financial and technical incapability to sustain the program because of economic loss thus resulting into the discontinuation of the IPVs, IEC and trainings with the company;

3. Lack of genuine commitment of management which led to the death of the all of the program components except SD in most of the companies.

4. Lack of monitoring system; and

5. High turn-over rate.

Some hindering factors towards institutionalization as observed with some companies are:

1. Nature of the establishment, most of the 1985-87 and 1987-90 garment companies are lagging behind those in manufacturing and semi-conductors in sustaining the RP/FP-MCH activities.

2. Traditional and typical culture of the workforce (i.e. economic survival as top priority of workers at the expense of health and opposing views on the use of artificial birth control among the workers.

Although most companies which participated in the first and second cycles were not able to maintain all four program components, it is encouraging to note that the SD component remained. However, the quality dimension varied greatly among companies. From the workers perspective, the personal dimension of service was very encouraging in some instances but very discouraging in others. Even in some of those companies evaluated by PCPD as having continued all the SD, IEC, training and IPVs, there was no guarantee that

such companies were more successful in institutionalization than those continuing only one, two or three components. The quality of care of FP in most of these companies is still far from fulfilling all the six ingredients noted by Bruce (1990) in her discussion of quality of care, namely: (1) choice of methods, (2) information given to clients, (3) technical competence, (4) interpersonal relations, (5) mechanisms to encourage continuity and (6) appropriate constellation of services. The qualitative information from the FGDs appears to indicate that improvements can stull be made on these aspects for better FP.

Program Implementation Problems Uncovered and Immediately Acted Upon By PCPD

1. In one company, the nurse required that the referral slip be signed by the kaugnay before any client could obtain pills. More often than not, clients who belong to the third shift could not find their kaugnay who is at the supervisory level. The result is that these clients miss taking the pill, and thus get pregnant. Right after the FGD, the PCPD co-investigator discussed this problem with the LO and action was immediately taken. A feedback mechanism and more trainings for kaugnays were negotiated.

2. The rising incidence of abortion, particularly among young workers in one company. This was confirmed during the FGD together with discussions with the PCPD project officer. Suggestions on how to reach these women were generated such as sending an HRD memo on compulsory attendance and orientation of production line managers about the program to solve poor attendance during lectures, seminars or film showings. Immediate actions included: (a) hiring an obstetrician-gynecologist to follow-up abortion and pregnancy cases in the company on a weekly basis; (b) holding a meeting between the PCPD project officer and nurses to devise ways of monitoring such cases; (c) an orientation by PCPD to update top and middle management on the status of the program; and (d) strengthening of small group discussions and one-on-one personal communications.

3. The sudden shortage of contraceptive supplies in one company under RPPII located in Taytay, Rizal. This company used to have a continuous supply for a long period of time. This was discovered only after this company joined the revitalization phase. There has been a high demand but no supply thus exposing such users to higher risk of pregnancy. The implementation of the Local Government Code caused the change in the system of contraceptive distribution by the DOH. All areas covered by any region should obtain the supply from such region. A regional distribution center does not give supplies to any recipient outside its jurisdiction. This company, which used to obtain such supplies at the nearest distribution center located in Metro Manila, now had to wait for the supplies from the distribution center in Region IV which was located much farther than the former source. Aggravating the problem is the fact that the regional distribution center is the one delivering the supplies to the requesting clinic every six months. Six months have passed but this company clinic has not

received any supply hence making it unable to respond to the high demand. The PCPD project officer and the company nurse even had to go to this center but unfortunately failed to obtain any supply because the one in-charge was on field work. Action taken was to invite the Regional Health Officer in the area coordinating meeting. The following day, the distribution team delivered supplies.

The Value of OR from the Program Implementor Perspective

A. Three areas in which this OR study has helped PCPD.

1. the coverage of the agri-industries in Mindanao. It is the first time for PCPD to implement the RP/FP- MCH program in agri-industries. This OR study gave PCPD insights:

    a. about the culture (e.g. prevailing beliefs and attitudes of management and workers towards modern contraceptions and the RP/FP-MCH program, language common to most workers, norms and behaviors at both the management and workforce levels) of these companies;

    b. on how to operationalize the IEC activities (i.e. when and where IEC activities can be held); and

    c. importance of involving the support of the community leaders.

2. the data gathered during the FGDs were used as guides during company planning and monthly team meetings. First- hand data from the workers during the FGDs have made management more open to suggestions.

3. the value of FGDs has generated the interest of PCPD in undertaking these regularly with future PCPD projects as they provide immediate data which enable program implementors to act quickly. FGDs have been found to be a quick means for employees or workers to ventilate their comments on the RP/FP-MCH program and team.

B. Uncovering these operational problems and immediately solving them, enriching experiences, prompt utilization of research findings and realization of the value of OR are important outcomes of an OR undertaken in a collaborative way between the program implementor and researcher.

Recommendations

1. In order to correct the misconception that responsible parenthood simply means family planning or birth control, training modules should include value formation at the different stages of the family life cycle (from early courtship to marriage, having children, and rearing the children on how to prepare them in every stage of the family cycle).

2. Training outputs should be echoed to employees immediately after the training.

3. Kaugnays should be recruited from each level of the workforce hierarchy.

4. Appropriate IEC strategies that responds to the inability of most employees to participate even during breaktimes should be planned. Examples are short film showings not exceeding 30 minutes or one-on-one communications during breaktimes.

5. Training on team-building should be made at the earlier stage of the contract period and henceforth be made as a regular activity.

6. Sectoral targeting within a given company even if a very small sector is reached at the first time; the lists of potential sectoral targets to come from the RP/FP-MCH team and PCPD to negotiate with management to allow this particular sector to participate in any PCPD IEC activity to be done.

7. There is a need for PCPD to design the training programs for each of the three types of team members in such a way that there are some overlapping of basic topics that will enable whichever team member is left in the company to continue the program.

8. The spirit of teamwork and helping one another are of vital importance. For example, the one at the higher level allows the one at his or her lower level to perform a more demanding job under his or supervision for the best training or learning for the team members is to let them do the job.

9. Recognition of the accomplishments of the RP/FP-MCH team in terms of incentives or tokens.

10. Commendable initiatives of LOs (e.g. formation of ad hoc committees) to be strengthened and sustained.

11. PCPD inputs which are the same for all participating companies may be provided in accordance with the prevailing economic status and culture of a given participating company. It may be on a staggered basis and timed when production demand is not on its peak. However, a close linkage with management through the RP/FP-MCH team should be maintained through a persistent and regular visit of a PCPD staff to the company to discuss operational problems during the contract period.

12. More intensive orientation or seminar of senior and line managers on the RP/FP-MCH program.

13. Gradual withdrawal or extension of the PCPD technical and financial assistance until such companies are ready to sustain the program.

14. Topics to include those that correct the "I don't care" attitude of some workers on their health.

15. To reduce cost, time and effort for the implementation of future projects, rigid criteria for a company to avail of the project may be helpful. For example, a brief screening process through a survey of the prevailing RP/FP-MCH needs of the beneficiaries and commitment to the RP/FP-MCH program of management and workforce may be important.

16. The undertaking of OR in a collaborative manner between the program implementor and researcher.

17. The addition of "quality dimension" of service delivery in assessing successful institutionalization in the research and evaluation component of the RP/FP-MCH program.

D. Dissemination Activities

A local research utilization took place last 26 August 1994 at the Hyatt Regency Manila, Pasay, Metro Manila. Other forms of dissemination have been: (1) the company planning, (2) monthly team meetings, and area coordination meetings among PCPD, companies, other government and non-government agencies.

Reactions to Session II

Dr. Michael Costello
Director, Research Institute for Mindanao Culture, Xavier University

There are several versions of Murphy's Law. One of these is that everything turns out to be more complicated than you thought it would be at first. This seems to be the case with the study of Dr. Cabigon and Ms. Magsino. The main -- or perhaps I should say the original -- concern here is project sustainability, i.e. "continued company support ... after PCPD has withdrawn its programmatic inputs." This study problem would seem at first to suggest a pair of fairly clear-cut dichotomies, as could be used for setting up a comparative study design.

And what are these dichotomies? This first is a comparison between companies which are still in the PCPD support phase vs. those who have completed the cycle. The second deals with the contrast between those companies who go on supporting the program after their "graduation" and those who decide to scrap it.

It turns out that the actual situation is not so simple. For one thing, companies can re-enroll in the program, should they so desire. In fact, they are very nearly encouraged to do this since the level of inputs offered in each new cycle kept increasing quite noticeably. Who wouldn't want to get free equipment or trainings, a cost-sharing agreement, ten thousand pesos for an IEC program, and the like?

It also turns out that companies have made various degrees of commitment, ranging from full implementation (all four program components) down to only a minimal effort (service delivery only). In fact, and as near as I can figure out, none of the companies either dropped out completely or went on to fully graduate, if by this latter term we mean taking on full fiscal responsibility for the full-scale program. Instead of a nice sharp contrast between the "haves" and the "have nots", the "ins" and the "outs", we must deal instead with a gradient of program commitments and a rather ambiguous one at that. (Why ambiguous? Because "the quality dimension varied greatly among companies". So two companies which have been classified as having the same level of commitment may really be quite different after all).

At any rate, and as my daughter would say, "its all rather confusing". Perhaps my first suggestion to the authors, in fact, is that they try one more time to spell out all the intricacies of this situation for uninitiated readers such as myself. (It really wasn't until I had dinner

with Dr. Cabigon last night that some of the subtleties mentioned above began to dawn on me).

The study comes to a lot of conclusions, most of which seems to be quite useful and sensible. I couldn't help wishing, though, that we could see a little more clearly the empirical foundations for all these ideas. Some flavor of this does come through in the final study report but I'd still like to see more of this, both in that document and in the paper which was presented today. Even just a few tables or charts would be a help here -- e.g. by contrasting quotations from managers in companies which ended up giving only a minimal commitment with those which have signed up for most or all of the program components. Perhaps the first group of quotes could be placed on the left-hand column of a big table while the second group is listed down on the right.

Or again, if the authors feel hesitant about a cross-sectional comparison, an alternative would be to use the case study approach with a longtitudinal twist. A key question here would be to document exactly what happened once the three-year cycle came to an end. Were the services maintained or gradually phased out? Was re-enrolment considered as an option? When, how, why, were these decision made? One gets a few hints of all this in the paper but the richness of detail found in a full-blown case study is missing.

Of course, we do have the data from the in-depth interviews and the FGDs and these are quite fruitful in their own way. A word of caution, though, may be in order. Most big companies are not (as one Vice President claimed about his own firm) "one big family". No. There are managers and there are workers and their perspectives are not only distinct but sometimes in opposition to one another. Perhaps this could have come out a little more clearly in the report. For example, when the study concludes that the workers have an "I don't care" attitude about health, is that what <u>they</u> say, or what management says about them? When a manager "teases" a worker for getting pregnant, isn't that a subtle form of social control? And doesn't it hint at an economic motive on management's part for the birth limitation campaign? How will that fit with the goal of quality of care? How do women workers feel about such pressures, especially when they come from male managers? And will it really be possible to get critical opinions from workers in an FGD conducted on company grounds as compared to, say, an in-depth interview in a private, neutral setting?

Let me go back to my earlier comments about "graduating" and re-enrolling" in the program. Dr. Cabigon was telling me last night that all the companies which are fully implementing the program are re-enrollees. In one sense, this is good, since it shows program follow-up for a deepening of the original commitment. But there also seems to be a certain element of dependency here. Again, it is noteworthy that there doesn't seem to be any full-fledged graduate. It does make one wonder if the companies are re-enrolling in the program because they believe in it or because they are attracted by all these new incentives. And if the latter reason is the true one, then what has happened to the original goal of sustainability?

Are the higher inputs implied by each new cycle having some unintented consequences? After all, each new addition to the program makes the option of full company support after full PCPD withdrawal that much less attractive. Perhaps it would be better to just do a good job on service delivery and leave it at that. If nothing else, you might get a few real graduates, maybe even some honor students. And this approach, too, would address the question of cost effectiveness, which I believe is often a problem in programs of this sort.

Perhaps we should even go further and ask if there is a sort of mutual dependency built into the program. Companies need inputs but so also do program managers need clients. Does this mean that they, too, are encouraging re-enrolments, whether consciously or not?

These are all speculations on my part, and perhaps they are somewhat wide of the mark. But if nothing else, I do feel that the study would be a better one, and the sustainability issue would have been addressed more directly, if these sorts of questions had been raised by the authors.

I don't want to be misconstrued here. We have all heard the presentation and there can be no doubt that there is a lot of food for thought in the paper, even as it stands right now. There are twenty or thirty good and practical suggestions for program managers to be found here and that is a good deal more than one is likely to get from most research studies. And it is especially impressive to see that a number of program changes have already been undertaken in response to the study's findings, even while several others are still in the works.

And yet one does get the feeling that somehow the forest has been lost for all the trees. Sustainability was the original concern and it remains an important one. The authors have done a good job but they could still go a bit deeper. In particular, I would suggest the need for a real coming to terms with the sustainability issue, particularly if the study is still to retain some relevance when the industrialized scenario of Philippines 2000 come to pass. Thank you.

Reactions to Session II

Marissa Reyes
Vice President, PCPD

I am Marissa Reyes and I'm with PCPD. I guess after listening to Dr. Costello, we have to make some clarifications. Dr. Costello was saying something about re-enrollment, I think, I'd like to go back to that and its cost effectiveness. If you are offered a free program of course everybody wants a free program, especially companies which are always very sensitive to pesos and centavos. First, I'd like to start by saying that the three cycles have very different inputs. We went along and made clearer definitions of what we thought were necessary ingredients to increase the sustainability of the program.

When we started this particular program, most of the inputs were for having increased contraceptive prevalence rate. So if you'll notice the inputs were essentially training of clinic personnel, so that they will be able to provide family planning service; training of the volunteers so that they will be able to give information; and regular IEC activities to motivate and to inform the potential clients in the companies. Because of this we thought that there are certain functions that are required for a sustainable program after PCPD phases out, and one of these is to get the company management to coordinate the program and to see that initiatives are sustained even after phase out. So, in the second cycle, we had negotiated with company management for them to assign a specific person to coordinate the program, so that this person can make sure that the planned activities for that company will happen after we phase out. This is the essential ingredient that was added in Phase II. I must confess that we were piloting this particular program from which we had very much to learn. In the second cycle we had learned some lessons already which we tried to respond to. Hence, in the second cycle the new ingredient was appointment of a liaison officer to coordinate the program. What was missing was that it was only towards the later part that we were able to do this when we had an institutionalization planning session with the whole team. So I guess it came too late, because they were not used or they didn't have skills to do this participative planning process.

USAID gave us the opportunity to correct our mistakes in the first and second cycle. We thought that for sustainability to happen, one must have certain good prognosis for institutional-ization. After PCPD phases out, we need certain ingredients in the company. What are these? One, there must be an organization within the company that has specific duties and responsibilities with planning implementation and assessment of the program. And this was crystalized through the organization of a Responsible Parenthood-Maternal and Child Health team within the company which had specific duties and responsibilities.

Because of the assessment functions of these people in the PRMCH team, certain training efforts were then focused on.

For example the liaison officer is supposed to coordinate the program. Usually these are Personnel Officers whose skills are really in psychological testing for incoming officers. They do not have the skills to manage and implement a program. So we had to train these liaison officers in the third cycle. A second ingredient in the training which is very critical, is the training of trainors in the company. Why? When in the first and second cycle our own staff were doing the training of the volunteer motivators, as you know in companies, there is high staff turnover. There is no mechanism for re-training new people or upgrading the training. So we thought that this has to be institutionalized in the company and it cannot be PCPD. So their own people in the third cycle are being given trainors' training so that they can do the initial training and then they can do the upgrading too. And who are being trained to do these? The clinic personnel because they have the RP-MCH skills already. Hence, they have to be trained now to transfer this information and skills to volunteer motivators.

A third important ingredient which we had learned and which we had tried to implement is participative planning. Because in the past, it has been basically a management decision to do a particular program, and then they tell the volunteers, "this is what you are supposed to do", etc. In the participative planning process, you have the workers working together with representatives from management and the clinic personnel to have their common understanding of what their objectives are for that particular company, i.e. what are the things that they'll do to attain such objectives.

What we are trying to do is to institutionalize the skills within the company to make sure that when we phase out, the skills remain and the program continues. What we have tried to ensure is that there's always a representative from top management who can say yes or no to the program that they are planning. In the past, we were asking for an in-kind counterpart. But when we started requiring them to give cash from day one of the program, to show their commitment, we ensure they are going to put their money where their mouth is. This forms part of the institutionalization.

I thought that the research study would have been improved if it tried to analyze per cycle whether the inputs in the second cycle increased institutionalization compared to the inputs in the first cycle. Also, whether the prognosis is better for the third cycle companies as compared to the first and second cycle companies, because of the kind of inputs that were added to the program. As a program manager, I feel that this information would be very useful for me to know whether we are at the right tract in terms of our own analysis of how the program is going.

We feel strongly, that the measure of success of this particular program is really in the companies that institutionalize. Those that use their own funds, their skills, the organization, the system for accessing other organizations to help them. For example, most of these

companies are in manufacturing. They do not know how to access, for example, resource speakers who can train their people on maternal and child health. But in the process of institutionalizing the program, they are given access to other organizations who can provide certain inputs that they can not find in their company.

I guess, the real opportunity in working with corporations is that, once they are convinced that this is good for them as a corporation, they have the funds to actually invest in such a program. They are able to provide the facilities, manpower, etc. That is why we are encouraged to continue working with these sector because of the opportunity that we see. So that once you install the program in the company even after you phase out, they can continue providing information and education to their workers.

As a reaction to the paper, I'd like to further suggest that perhaps, the analysis can be broken down per cycle to see whether the new inputs have really contributed to increasing the institutionalization of the program.

By the way, I also noticed that, when we say they are not doing IEC anymore, I think for the most part we are thinking of organized IEC activities (film showing, lectures, demonstrations) but we failed to consider whether these companies have IEC activities in the form of one-on-one interpersonal counselling which I think from the studies mentioned earlier is a very important component for the program. I think we missed that when we said there are no organized IEC activities. So I guess it is important to find out whether this interpersonal communication is going on. I mean because of the current situation in the participating companies where the prevalence rate is much higher compared to the national prevalence rate where our drop-out rate is less than 10 percent. The program is quite effective in making sure that those who accept family planning are fully motivated, I mean, highly motivated because they do not drop-out right away.

So, I guess I will stop here and work with our researcher on how to analyze the data to make it, you know, still more useful, more focused for our particular needs.

Open Forum
Session II

Grace Migallos, SOMARC: I'd like to address this question to Marissa Reyes. It's not really a question. There are a couple of suggestions I would like to give regarding sustainability. I would like to suggest that, in screening prospective company participants, perhaps it would be best if we include as part of the criteria, a commitment from the companies to provide commercially purchased contraceptives after a successful pilot because I believe they continue to get free commodities from the DOH. I think private companies should be capable of funding their own contraceptive requirements especially if they are convinced that the program is good for their company in terms of profitability and productivity. Corollary with this, I think that the DOH list of companies currently receiving free commodities should also be reviewed because I believe that there are certain companies who continue to get free commodities and they are very profitable ones with a reputation of providing generous employment benefits to their employees. An example to this would be PLDT. I think the list should be reviewed, so that the more deserving and the more needy companies will be served.

Marissa Reyes: Well, PLDT is not a participating company. But for the participating companies, that's a very good suggestion but we must also think of the earning capacity of the employees. Some companies may just pass on the cost to their employees. On the other hand, we have companies like Johnson and Johnson where the acceptors are getting their commodities from private providers and they do not depend on free contraceptives from the DOH. There are some companies that buy their contraceptives for their employees, but this cannot be a requirement for all. If the companies believe that this increases productivity and efficiency and the benefits of running a program goes back to the company perhaps it can be a criteria to be able to provide for free products or subsidized products. I know that Nestle does this. So maybe it can be duplicated in some other companies.

Jet Riparip, JSI: I have been privileged to work with this project, in its first cycle as project director, and in its second cycle as a funding agency. I'm quite familiar with the project and there are two points I'd like to raise. One is that I think one of the reasons why a program like this must continue is because it provides access to the workers. When we, for example look at the situation of the worker, she goes to work at seven in the morning and goes out at five or six, by that time the government clinics are closed. And making available the services right there, I think is the reason why there is a very low drop-out rate. My second point is the sustainability issue. I think it might be useful to find out the definition of sustainability from the point of view of management. In working with these companies there are many things that are realities to them. For example, one of the things that they cannot do is to train the volunteers on family planning. The reason is that they do not have a big HRD and they are in the business of production or manufacturing (i.e. that they don't

know anything about family planning). But if it is made available to them or if they have access and know how much it will cost, they are interested. Again, let me cite two companies. Under our second cycle, the Philippine Refining Co. was actually willing to continue paying for the program but the project ended and they were not provided the opportunity to continue accessing PCPD technical assistance. Second, was INTEL again the personnel manager was willing to continue paying because under the second cycle of PCPD they will charge P 8,000 per year, for the third and fourth year they have to pay more but then there was the issue of continuing on their own because availability of technical assistance from PCPD stopped. So, I think apart from the fact that there are many realities, it is important for PCPD to know to what extent the definition of sustainability is from the point of view of a manager. And second, what can PCPD do to continue providing technical assistance for a fee because I believe some companies would be willing to do this as they don't have IEC materials for FP. But if a group like PCPD would continue providing services without this issue of re-enrolling to be able to get free assistance then I think it might be pretty useful for the continuation of the program.

Marissa Reyes: Just one comment on re-enrolling for free assistance. I think this is not very clear, when we refered to re-enrollments, which was for a particular input which is the training of trainors and the training of the liaison officers. But everything else the companies will have to pay for. So, you know it's not like they're being given a total package for free, they have to give a lot of cash inputs for them to avail of certain services.

Mario Taguiwalo, UP School of Economics: I have comments on both the study as well as the program. Apparently, the program defined was established from a perspective of making accessible family planning services in the workplace as an alternative, as a supplement, as an augmentation to services made available in the community. It was never meant to be a self-contained effort. However, I would just like to caution Marissa pointing out higher CPR and lower drop-out rates because your clients are really the better clients. If you look at the factors in the Bukidnon study about determinants of drop-outs you will see that your clients are really people who don't belong here. In the Bukidnon study, they said that clients most likely to drop-out are those with lower educational attainment, lower rating in terms of household economic status, smaller likelihood of having been employed, greater number of previous pregnancies and less favorable attitudes. I think your clients are something that do not fall under this. So you cannot really cite higher CPR and lower drop-out as principally the result of your interventions. It may be something to do with the endowment of your clients in the first place. You have better-off client. So don't raise that.

On the other hand, you could always say that every little step in the national program is an addition. Because, if politics is the art of addition, program execution is also the art of addition. Every little thing helps. So I think we should not take all these comments as critical of the program but basically of attempting to try to understand the potential of this approach as a possible way of expanding its coverage. I think there are many issues that Dr. Costello raised. Number one, from a program perspective there are a lot of justifications for making in-plant services available and there's a lot of justification in supporting subsidies

to make that available. However, we have to define exactly from an economic perspective which are the most worthy of the clientele and the most worthy of the targets for in-plant subsidies because we do not have enough money to provide subsidies to all the companies in order to start up.

Session III

Factors that Contribute to the Performance of BSPOs and BHWs in the Delivery of Family Planning Services in Iloilo City

Prof. Fely David
Social Science Research Institute
Central Philippine University

Prof. Fely Chin
Social Science Research Institute
Central Philippine University

INTRODUCTION

Background and Rationale of the Study

In 1992, when the Population Council established the Family Planning Operations Research and Training Program in the Philippines, it brought together program managers and regional researchers to identify problem areas which may benefit from operations research. From Region VI, the City Population Office (CPO) in collaboration with the Social Science Research Institute (SSRI) of Central Philippine University (CPU) in Iloilo City identified poor performance of volunteer family planning (FP) workers as one of the reasons for the declining trend of FP accomplishment in the city.

The CPO noted that, despite the problems encountered by the city's FP programs, the network of BSPOs remained intact and functional; however, the performance of many volunteers were observed to have deteriorated. While some remained active and performed well, others became complacent and unproductive.

The City Health Office (CHO) also has a network of community volunteer workers who assist its health teams in the provision of Maternal and Child Health (MCH) care which includes FP. Like the BSPOs' performance, the BHWs' FP accomplishments have also been perceived as having declined. What factors contribute to the volunteers' poor and varying performance, was the questions the CPO and the CHO wanted to answer. This prompted SSRI and the CHO to conduct a diagnostic study on the problem.

Among the possible reasons for the decline are: lack of training, lack or inadequate supervision, lack of knowledge about FP, heavy workload, poor relationship with supervisors, dissatisfaction with their incentives and/or other benefits received, and lack of interest or commitment and unavailability or lack of FP supply.

Immediate Objective of the Study

The SSRI in collaboration with the CPO conducted this diagnostic study in 1993 to determine and compare the FP activities and performance of BSPOs and BHWs and to determine what factors influence their FP performance.

Ultimate Objective of the Study

The results of this investigation can help FP program managers, service providers, and policy makers improve FP program planning and implementation. An understanding of

population/FP situation can help them take appropriate actions to address emerging FP program concerns.

Methodology

This diagnostic study utilized a combination of quantitative and qualitative approaches. Using systematic sampling with a random start, a sample of 106 BSPOs and 106 BHWs was selected for interview from a population of 474 FP volunteer volunteer workers in Iloilo City. Qualitative techniques included in-depth interviews of 29 key informants consisting of health and population officers, FP coordinators, nurses, physicians, midwives, barangay Nutritions Scholars and local officials; 13 Focus Group Discussions (FGD) participated in by 92 FP workers and clients; and four observations of field and clinic activities of the volunteers.

FINDINGS

The Profile of the FP Volunteers Workers

The BSPO and BHWs in Iloilo City were mostly female (98 percent), 46 years old on the average, married (84 percent and 83 percent, respectively), and high school educated (82 percent). The married ones had an average of 4.7 children. Slightly more than half (58.6 percent) of the volunteers were gainfully working at the time of the study wish most of these being engaged in sales/trading/small scale business on a part time basis (BSPO, 41.94 percent; BHWs 46.77 percent). On the average, those working were earning a monthly average of P1,501.50 and P1,369.65, respectively. Their monthly household incomes averaged P4,460.52, and P3,613, respectively.

Attendance in FP Training

Only a few of the BSPOs and BHWs had attended any formal training, but most of them had undergone informal trainings/orientations on their duties and responsibilities from their supervisors. All the trained BSPOs, but only 19 of the 31 trained BHWs reported that FP was one of the topics taken up in the training they attended.

The BSPOs' and the BHWs' Actual Work

The majority of the BSPOs were performing their prescribed FP tasks which include: "resupplying of contraceptives" (82.0 percent), "follow-up of defaulters/drop-outs" (80.2

percent), and "referrals of MCRAs" (70 percent). The BSPOs were also involved in data collection, home visits, and pre-natal referrals.

The BHWs were assisting the clinic health team provide MCH care (97 percent), which include immunization, weighing of children, and pre- and post-natal counseling. Their FP tasks included: 1) motivating MCRAs to practice FP (72.6 percent) and 2) counseling them on FP (55.7 percent). A few were involved in making referrals, follow-up of defaulters and resupply of contraceptives. Some volunteers, mostly BSPOs were also involved in community projects/programs.

Incentives and Other Benefits Received by the Volunteers

The Iloilo City government provides the volunteers a monthly incentive of P200.00 each. Some volunteers holding dual roles (both as BSPOs and BHWs) were receiving the allowance for both positions. Most of them expressed contentment with their monthly incentive, but admittedly welcome an increase. The discontented ones felt that their allowance is not enough to meet their expenses. This sentiment was shared by their supervisors, the nurses, the midwives and the local officials. The monthly incentives have been perceived as a motivating factor in the volunteers' FP performance, but the delay in the release and the fact that some volunteers (those with dual roles) receive more than the others have negatively influenced performance.

The volunteers also received other benefits, which include: free supplies and some clothing, free education, free hospital services, livelihood projects, money and insurance.

Supervision

In 1993, the 168 BSPOs of Iloilo City were being supervised by 13 PPOs, while the 360 BHWs were supervised by more or less 60 PHNs or RHMs. The majority of both BSPOs and the BHWs confirmed that they were indeed being directly supervised by their respective supervisors (92.5 percent and 95.3 percent respectively). Almost all of the BSPOs were reportedly visited by their PPOs the month prior to interview, each visit averaging 1.77 hours. Slightly more than half of the BSPOs and the BHWs met with their supervisors (64.8 percent and 50.5 percent, respectively) the week before. The rare volunteer-supervisor interactions was attributed to the supervisors' work overload and many office-based responsibilities. Nevertheless, volunteers still positively appraised their supervisors in terms of "approachability", "supportiveness", "helpfulness", "flexibility", "consideration", "dedication in their job" and "knowledge of their job". (see Table 4.)

The BSPOs' and the BHWs' Interest and Commitment and Satisfaction with their Work

Based on length of service, most of the BSPOs and BHWs of Iloilo are interested and committed to their volunteer work, most of them having been in active service for more than five years. Comparatively, however, the BSPOs have served longer than the BHWs (9.88 years vs 7.01 years on the average). Furthermore, the majority of the both groups expressed a desire to continue working (98.6 percent) as volunteers. They are reportedly satisfied and contented with their volunteer work, and gave themselves favorable ratings in both aspects.

Source of Family Planning Supplies

The majority of the volunteers reportedly obtain FP supplies from the CPO or the PPOs. It was learned that the CPO got supplies from the CHO and in some cases from FPOP clinics whose source is the DOH or the CHO. Many BSPOs reprted however, that they find it difficult to get supplies from the CHO or health clinics and perceived that some CHO personnel are antagonistic towards them. This relationship problem between the CHO and CPO volunteers and personnel was perceived to have adversely affected the FP volunteer workers' performance. Aware of this, the CHO and CPO officers and staff have initiated dialogues and team building activities to address this problem and to improve FP program implementation.

The BSPOs' and BHWs' FP Knowledge, Attitudes and Practices

The volunteers' knowledge about family planning was gauged in terms of their agreement or disagreement to five statements used to measure knowledge. Based on their scores, both the BSPOs and the BHWs were found to have "good" knowledge about family planning. Most of them knew about the most common misconceptions about FP and the effect of frequent pregnancies on a mother's health.

The volunteers' attitude towards FP planning, as measured by their responses to five attitude-related statements was assessed as open and favorable especially in the use of contraceptives and birth spacing. The majority of the BSPOs and BHWs (96 percent and 93.4, respectively) believe in birth spacing and "feel comfortable talking about contraceptives".

The majority (73 percent and 73.7 percent, respectively) of the married volunteers have practiced FP. The number of current FP users, however, is much lower. Counting out those who are already beyond reproductive age, only slightly more than one-third of the married ones (37.7 percent of the BSPOs and 36.4 percent of the BHWs) were currently practicing FP at the time of the study. Among those who had ever used FP, the most common FP

methods were the pill (31.1 percent for both), IUD and natural family planning (NFP). Among the current users, however, the most common methods practiced were ligation, NFP, and pills.

BSPOs' and BHWs' FP Performance

Performance in the delivery of FP services in this study refers to the number of FP clients motivated, referred, followed-up, counseled and provided FP supplies by the volunteers. Originally, it was intended to be measured in terms of accomplishments relative to targets, but this was not possible because the volunteers did not have targets the year before the survey.

Based on the index of performance, the volunteers were found to have varying FP performance. On the average, the volunteers were able to serve about 11 clients a week within the month prior to interview. The BSPOs notably registered a better FP accomplishment (12.09) than the BHWs (9.36). The BSPOs spent an average of 5 hours a week on FP functions, in their three-day week volunteer work, while BHWs spent an average of 3 hours per week on FP activities during the same period.

Ninety of the 106 BSPOs and only 77 of the 106 BHWs were able to motivate potential or current FP users during the previous month, the BSPOs averaging 13 clients, while the BHWs, 6 clients. Referral of FP clients to health clinics were made by 75 BSPOs and 45 BHWs, the BSPOs averaging 5 clients, while the BHWs, 6 clients. The data further show that while most (85) of the BSPOs were able to follow-up FP clients, only 50 of the BHWs were able to do so, the former with an average of 6, and the latter, 5.

Ninety-two of the BSPOs, but only 59 of the BHWs were able to counsel clients. The BSPOs had 11 on the average, the BHWs only 6. There were also more BSPOs than BHWs who were able to provide FP supplies to their clients (88 and 14, respectively), the former having served an average of 21 contraceptive users, the BHWs, 14 users.

Factors Influencing Volunteers' FP Performance

As earlier hypothesized, FP performance of the volunteers may be influenced by a number of factors. The correlation analysis revealed that among the factors found to have significant influence on the volunteers' FP performance were: attendance in FP training, amount of time spent by volunteers on FP activities, volunteer's interest and commitment to his/her work, and involvement in community/livelihood activities. The data show that volunteers' attendance in FP training is significantly related with the number of FP clients they had followed-up ($r = .24$), counseled ($r = .22$), and provided FP supplies ($r = .35$). This means that those who had attended FP training performed better than those who had not. The amount of time spent by the volunteers on FP activities also significantly impinges on their

FP performance as shown by the significant correlation between the predictor variable and the number of FP clients motivated (r = .21), referred (r =.14), followed-up (r = .19), counseled (r = .19), and provided FP supplies (r = .24).

The volunteers' interest and commitment to their work as gauged by their length of active service as volunteers was found to significantly contribute to the improvement of their FP performance as indicated by the significant correlation values between the FP performance and number of MCRAs referred (r =.18), followed-up (r= .14), counseled (r = .16), and provided FP supplies (r = .28).

The data also support the hypothesis that involvement in community projects by the volunteers would improve their FP performance as demonstrated by significant correlations between the predictor variable and the number of FP clients referred (r = .19), followed-up (r = .15), counseled (r = .13), and provided FP supplies (r = .27) by the volunteers.

Another factor found to be a significantly related with FP performance was number of meetings with supervisors. Significant relationships in this case were only found for two indicators, namely number of FP clients referred and number of clients followed-up.

The hypothesis that the number or type of position/s held by the volunteers has significant bearing on their performance finds support in this study. The data show that the BSPOs performed better than the BHWs, and volunteers who served as both a BSPO and a BHW also performed better than the BHWs.

The BSPOs and the BHWs as Viewed by the Community and other FP Workers

Community folk acknowledged the important contribution of the BSPOs and the BHWs in the promotion of health and FP in the barangays. They recognized that the volunteers have helped disseminate FP information, motivate and follow-up FP users, advise mothers on FP, and distribute FP supplies. Most of them know the BSPOs and the BHWs in their community, but admitted that there are many in the community who are not familiar with the local volunteers. They also reported that some volunteers were inactive and not performing their FP tasks.

They expect the volunteers to constantly interact with the people, especially with the mothers and their children. For them an effective BSPO/BHW is one who: conducts home visits, is concerned about her clients, committed to her job, has good public relations, is active in health or FP information campaigns, and is helpful to the clients.

The FP workers, particularly the CHO and the CPO field/clinic personnel in Iloilo City, recognized the BSPOs and BHWs as their partners in health and FP promotion. They favorably rated the BSPOs' and the BHWs' performance on their FP functions but expect the

BSPOs to perform more FP tasks than the BHWs. They shared the view that effective volunteers are those who are active, sincere in their work, persistent, approachable, industrious, patient and hardworking. They opined that the volunteers should also be able to visually detect "warning signs" among FP clients for immediate referral. For them an effective volunteer is one who is concerned with clients, committed, has good relations with the community, is active and helpful.

CONCLUSIONS

1. While the delivery of FP services is a major function of the BSPOs, this is only one of the many responsibilities of the BHWs. More BSPOs than BHWs handle referrals, follow-ups and resupplying of current FP users with contraceptives.

2. Close supervision and monitoring of the health volunteers by their supervisors was perceived to help improve volunteers' FP performance. This enables the supervisor to follow-up the progress of the volunteers' work and to assist the volunteers in addressing whatever problems/difficulties they may encounter.

3. Although the quantitative analysis did not show a significant correlation between FP performance and relationship with supervisors, this has been unanimously recognized by the volunteers themselves and the FP workers as an important ingredient in improving the delivery of FP services.

4. The volunteers' incentive was perceived as a motivating factor for FP volunteers to perform well. However, the delay in its release, and the fact that some volunteers (who are both BSPOs and BHWs) receive more than the others bred indifference among them, and admittedly influenced their performance.

5. The data support the hypothesis that the volunteers' FP performance is significantly influenced by various personal and external factors, such as attendance at trainings, amount of time spent on FP tasks, supervision, and volunteers' interest and commitment to their work.

6. Volunteers trained on FP tend to perform better than those who had not undergone training.

7. The amount of time spent by volunteers on their FP tasks also positively affects their performance which indicates that the more time a volunteer spends on his/her work, the better his/her performance.

8. Supervision is proven as an important component of FP program implementation. The closer the volunteers are supervised and the more time the supervisor spends with them, the better the performance of the volunmteers.

9. Despite the fact that husbands play a major role in family decision-making, their participation in FP programs is very minimal. Moreover, like many other programs, Iloilo City's FP program, is still very female-oriented.

Program Implications and Recommendations

1. A training that will address the immediate knowledge and skills needs of the volunteers should be conducted. Before any training is conducted, however, a training needs assessment should be done, including a review of this study's findings so that the specific training needs of the volunteers can be properly addressed.

2. The perceived poor relationship between some CPO and CHO personnel and between their respective volunteers and its admitted negative influence on FP performance suggests the inclusion in the proposed training of a reorientation on the roles and responsibilities of all those involved in the FP program.

3. To allow the PPOs more time to monitor, guide and assist their BSPOs, the number of PPOs must be increased and the coverage of each supervisor be reduced.

4. There is a need for the immediate resolution of conflicts and strained relationships between some CPO and CHO personnel and volunteers. The present initiative to bridge the gap and resolve the problems through a coordinative system that defines their respective roles and tasks must be pursued and given the chance to work. This will require regular consultation and dialogue between the CPO and the CHO.

5. There is also a need to train the volunteers on some simple visual diagnostic procedures to enable them to recognize "warning signs" or symptoms that would require immediate termination of contraceptive use or immediate referral of a client to a clinic.

6. There is a need to identify and define common indicators of FP performance which both offices should use in their performance evaluation.

7. The fact that husbands often make the final decision in FP practice makes their involvement in FP programs more imperative, both as targets and motivators. The CHO and CPO can start this by recruiting male BSPOs and BHWs.

8. Since volunteer work needs time, interest and commitment, these should be given priority among the criteria to be considered in the recruitment and selection of volunteers.

Session III

A Diagnostic Study on the Implementation of the Department of Health Volunteer Workers Program

Prof. Marlina Lacuesta
Social Research Office
Ateneo de Davao University

Prof. Segundina Sarangani
Department of Sociology
Mindanao State University

Napoleon Amoyen
Social Research Office
Ateneo de Davao University

I. Background

This study was conceived as a result of the Family Planning Operations Research Training Workshops held in Tagaytay City (October 1992) and Davao City (January 1993). In a small group discussion, the program managers of Davao and Lanao provinces emphasized the problem of turnover among Barangay Health Workers (BHWs). This phenomenon was especially noted for the case of the Lanao provinces. The BHWs being the link between the health center and the community are expected to be visible in the community to assist in the delivery of essential health services including family planning. Previous studies have shown, however, that although BHWs come from the communities where they serve, they seem to be poorly known among clients and are least preferred as health providers.

Reaching out to the countryside and utilizing its local resources are major concerns of the government. As such, the DOH launched the Barangay Health Volunteer Workers program. These volunteer workers do not receive any compensation, although in general they are given some "incentives". They are especially needed in the remote areas where there are no established health centers. As government resources are limited, the BHWs play an important role in the implementation of priority health programs, such as family planning.

With the implementation of greater autonomy for the local government units (LGUs), it has become doubly important to provide a database on the field experiences of the volunteer health workers. The reason is obvious: the LGUs are principally responsible for carrying out the health program in the countryside, as this function is now devolved to them.

The Study

This report is therefore an attempt along this direction. It summarizes the major findings of field experiences as based on a survey of 200 Barangay Health Workers (BHWs) from the provinces of Davao and Lanao. The study concentrated on the involvement of these BHWs in the government's family planning program rather than in all health-related areas. The objectives of the study are to:

- □ provide information on the characteristics of BHWs
- □ determine their training needs
- □ identify factors that affect their performance
- □ suggest policy options to the DOH

Given the DOH efforts to promote community-managed health care and with the Local Government Code in place, the study is timely and significant. It will hopefully provide informed actions toward enhancing the quality of family planning program in the rural areas. The study will also give some indication on the partnership between the DOH and the local

governments, the latter now exercising more powers under the new code. One area of concern is to know how the DOH health care program, specifically its family planning program is affected by the "devolution" process.

Hypotheses

Apart from describing the BHWs, this study wishes to test a set of hypotheses on the performance of the BHWs. More specifically, *BHW performance (measured by counting the number of family planning services actually delivered) is believed to be a function of the following variables: BHW's training/formal education, sex, age, incentives, working relations with midwives and other health practitioners, length of stay in the community, personal experience in the use of FP methods, work motivation, and availability of BHWs,* among others.

II. Research Design/Methodology

Study areas and sampling

Four provinces are covered by this study: Davao del Sur, Davao del Norte, Lanao del Sur, and Lanao del Norte. These provinces represent "high" and "low" performance areas according to the 1990 DOH report. The two Lanaos, where a large Muslim population is found, also serve as a test case in the government's family planning program. Five municipalities were randomly chosen from each of these provinces, in which 24 sample barangays were selected. Two hundred volunteer health workers or BHWs were then chosen at random, or an average of 50 per province. In addition, 300 clients were chosen for interview.

Instrumentation

A survey schedule was prepared and administered to gather the desired data from Davao and Lanao. Pre-field visits were done in the survey sites to conceptualize the interview instrument. Project interviewers were then hired and trained. With the help of the supervisors, modified focus interviews were conducted. The instrument was finalized through discussions with the workers and interviewers.

III. Main Findings

The findings are presented next, by sections, to portray the BHWs and their work in their respective communities.

Social and demographic characteristics

From the data, the BHWs may be characterized as follows (see Table 1):

- **BHWS ARE MIDDLE-AGED**. They have an average age of 39.6 years, with the Davao respondents being somewhat older (mean = 41.4) than the Lanao BHWs (mean = 38).

- **ARE TYPICALLY FEMALES**. Nearly all cases (96 percent) are females. In Lanao, all of the BHW samples are female.

- **AND MARRIED**. While a great majority (89%) are married, slightly more than tenth (11%) are single. This is striking in view of the nature of work for which the BHWs are involved.

- **MARRIED BHWS HAVE 5 CHILDREN**. For those who are married, their average number of ever-born children is 5.3. As regards the number of living children, they average 4.8, with the Davao BHWs having fewer (4.7) than those from Lanao (4.9).

- **ARE MAINLY CATHOLICS**. As expected, the BHWs are divided by religion. Those from the Davao areas are nearly all Roman Catholics, while half of those from Lanao declared Islam as their religion.

- **HAVE HIGH LITERACY.** the BHWs generally have a high level of literacy judging from their formal education. In Davao, 77 percent have completed secondary or college education. In contrast, 65 percent of the BHWs from Lanao completed elementary education, with only about a third (31 %) reaching secondary or college level.

- **ARE LONG-TIME RESIDENTS.** Years of residence in the community has been found to be 26.4 years on the average, with those from Lanao registering longer residence (30 years) than those from Davao (22.8 years).

Table 1 - Summary Data on Characteristics of BHWs
(In percent, unless otherwise specified)

BHW Traits	Davao	Lanao	Total
Mean age	41.4	38.0	39.6
Sex			
Female	4.0	-	2.0
Male	3.0	19.0	11.0
Civil status			
Married	4.7	4.9	4.8
Single	0.0	50.0	25.0
Mean children	27.0	4.0	15.5
Religion			
Roman Cath	58.0	19.0	38.5
Islam	19.0	14.0	15.5
Others	-	2.0	2.0
Education	22.8	30.1	26.4
Primary	96.0	100.0	98.0
Secondary	97.0	81.0	89.0
Tertiary	73.0	46.0	59.5
Vocational	23.0	65.0	44.0
Mean residence			
TOTAL (N)	100	100	200

Economic Status

Interesting facts are gleaned from Table 2 showing the economic characteristics of the BHWs and their families.

● **BHWS NOT GAINFULLY EMPLOYED**. A majority (59.5 %) of the BHWs are *not* gainfully employed. They mostly do housekeeping work. Those who said they have jobs to do are largely involved in trade, illegal gambling ("last- three" ushers for the weekly sweepstakes draw), farm-related work and teaching.

● **BHW SPOUSES ARE FARMERS AND FISHERS**. Their spouses are not occupationally different either. However, joblessness is reported to be fewer (1.5 percent). Farming and fishing represents the largest occupational group (32 percent). Transportation, services, and construction workers make up a hefty 23 percent of the total. The professional and business groups consist of 9 and 4 percent, respectively.

● **ARE POOR.** Even as they are declared as having some form of jobs, the BHWs earn very low incomes -- their monthly average household income being ₱3,194. The Lanao BHWs, however, earn much more (₱3,489) than those from Davao (₱2,919). In any case, *both groups clearly fall below the poverty threshold of ₱5,000*.

Table 2 - Economic Status of BHWs
(In percent, unless otherwise specified)

Economic Status	Davao	Lanao	Total
Occupation of BHWs			
No work	-		
Housewife	58.0	12.0	6.0
Trading	11.0	49.0	53.5
Farm work	8.0	11.0	11.0
Others	2.0	4.0	6.0
		8.0	5.0
Mean family income	₱2,919	₱3,489	₱3,193
Primary source of income			
None	-	7.0	3.5
Services	37.0	43.0	40.0
Agriculture	36.0	16.0	26.0
Business/trad.	14.0	21.0	17.5
Others	12.0	13.0	13.0
TOTAL (N)	100	100	200

Knowledge and Use of FP

The crux of this study is on the BHWs' performance in the provision of family planning services to their clients. To begin with: How much do they know about what they preach?

The interviews on the BHWs probed into their knowledge of family planning (FP). When asked what methods they knew, their answers are given below:

- **BHWS KNOW FP**. The vast majority (80-90 percent) mentioned having heard about IUD, pills, rhythm and other birth control techniques. They also said that there are side effects in using some of these methods. As to their sources of FP information, they mentioned the midwives, doctors and nurses in town.

- **BUT FELT THEIR TRAINING INADEQUATE**. However, they admitted that their knowledge about FP is grossly inadequate, with more than two-thirds confirming this.

- **SOME BHWS ARE NOT CURRENT FP USERS.** The BHWs fall into two categories: users and non-users of FP methods. While majority (73.7 %) belong to the first group, about a fourth have never used these methods. Some among the non-users are single females, or are now beyond their reproductive ages. Furthermore, only about a third (70 out of 200) admitted to being current users, distributed as follows (Table 3):

Table 3: FP Methods Used by BHWs, Percent (N = 70)

Method used	Davao	Lanao	Total
Traditional*	31.2	22.7	24.3
Permanent	27.1	4.5	19.8
Pills	12.5	22.7	15.7
IUD	22.9	13.6	20.0
Condom	4.2	4.5	4.3
Combinations	2.1	9.1	2.8
Herbal	-	9.1	2.9
TOTAL (N)	48	22	70

*rhythm, withdrawal, LAM, abstinence

Attitudes Toward FP

- **BHWS APPROVE OF FP**. Except for one case in Lanao, everybody approves of family planning. In general, among the married their spouses also approve of FP. In Lanao, where conservatism was thought to be high, such an attitude is striking.

- **DESIRE RELATIVELY FEW CHILDREN.** Asked about their ideal number of children, the average number is 3.79 or 4. The BHWs from Davao indicated a lower ideal number of children (3.36) than the Lanao respondents (4.2).

- **BELIEVE IN CHILD SPACING.** The BHWs believe in good child spacing. They said that the gap between children should be about 3 or 4 years, the average being 3.79 years.

Selection and recruitment

How were the BHWs selected and recruited? How long have they been involved in the DOH volunteer program?

- **MIDWIVES RECRUITED BHWS.** From the survey, it was learned that the midwives principally recruited the BHWs, so said about two-thirds of the respondents. About a fourth claimed to have volunteered by themselves. A tenth said that the Barangay Captain recruited them for volunteer work. About an equal percentage mentioned that doctors, nurses and other practitioners induced them to volunteer.

- **BHWS HAVE WORKED 7 YEARS.** On the average, the BHWs have been working with DOH for about 7 or 8 years, with those from Davao mentioning a slightly longer period (7.6 years) as compared to the Lanao BHWs (7.3 years). More than two-thirds (69%) said they were recruited during 1981 to 1990.

As far as family planning is concerned, it was learned that they have been providing such service to the community for an average of 7.7 years. Again, the Davao BHWs mentioned longer involvement (8.1 years) than those from Lanao (7.0 years).

- **BHWS WERE NOT PREVIOUSLY INVOLVED.** Prior to their involvement with the DOH, half of the BHWs did not have any work background or community participation. Only about a fourth had a cognate job experience. For this minority, they said they were church leaders, health workers, BSPO or outreach workers of POPCOM before. This means that half of them are new to the job.

- **BHWS WERE RECRUITED DUE TO THEIR AVAILABILITY.** They said that the main reason why they were recruited was their "availability" as volunteer

worker (58.5%). Others mentioned that they were "active" (47%), and "influential" (12%).

● **BHWS PERCEIVED THEIR ROLE IN VARIED WAYS.** As to their precise role as BHWs, the respondents believed that they were there primarily to assist the Health Center in its general activities (64%). They also thought that they were to "motivate" clients to adopt family planning (39.6%). Others believed that they should conduct surveys (24.9%), disseminate information (9.6%), campaign on use of herbal medicines (7.6$), make referrals (5.6%), and resupply pills (5.6%), among others. The role that they play seems an open one. Note that even the DOH manual for Volunteer Health Workers allows them flexibility in selecting the roles that they should perform (Table 4).

Incentives and Motivation

● **BHWS EXPECTED TO BE PAID.** While the BHWs as volunteers do not receive any compensation for their work, a hefty majority (88.4%) do expect cash benefits. Others would perhaps be content with receiving the FP kit (27.1%) and medical assistance (20.6%).

● **THOUGHT THAT MONEY AND SUPPLIES WERE IMPORTANT.** Among those who expressed dissatisfaction (N = 56), financial support was cited as the most critical reason, followed by inadequate supplies and conflict with their need to seek their livelihood.

● **BUT SAID THEY WOULD WORK EVEN WITHOUT INCENTIVES.** Asked whether *not* receiving incentives would discourage them from working, a full 93 percent felt otherwise. They said they would go on with their work, citing the desire to help their own communities and their continued commitment.

● **BHWS CLAIMED THEY SPEND 1-2 DAYS AS VOLUNTEERS.** An indication of the commitment of the BHWs is their willingness to work. Although they are volunteers, more than two-thirds reported spending 1-2 days per week in the field, with about 15 percent saying they work from 3 to 4 days. About the same number (70%) said they spent 1-2 days per week in the Health Center (Table 5).

Table 4 - Recruitment, and Perceived Role of BHWs

Role, Recruitment	Davao	Lanao	Total
BHW Recruiters			
Midwife	59.0	70.0	64.5
Volunteered	19.0	8.0	13.5
Bar. Captain	13.0	8.0	10.5
Nurses/doctors	3.0	13.0	8.0
Other BHWs	7.0	1.0	4.0
NGO workers	3.0	0.0	1.5
Others	2.0	5.0	2.5
Why recruited	58.0	64.0	58.5
Available	37.0	57.0	47.0
Active	4.0	20.0	12.0
Influential	8.0	13.0	10.5
Inquisitive	19.0	7.0	13.0
Others			
Perceived role	70.0	57.7	64.0
Assist Health Center	44.0	35.1	39.6
Motivate clients	42.0	7.2	24.9
Conduct survey	11.0	8.0	9.6
Disseminate info	10.0	5.2	7.6
Campaign for herbs	3.0	7.2	5.6
Referral	6.0	0.0	5.6
Resupply of pills	18.0	1.0	9.6
Others			
TOTAL (N)	100	100	200

Table 5 - Time (Days) Spent as Volunteers (in percent)

Time/days spent	Davao	Lanao	Total
Time spent in field			
0 day	0	22.0	11.0
1-2 days	69.0	69.0	69.0
3-4	25.0	5.0	15.0
5 & more	6.0	4.0	5.0
Time spent in Health Center			
0 day	31.0	12.0	6.5
1-2 days	62.0	78.0	70.0
3-4	6.0	5.0	5.5
5 & more	1.0	5.0	3.0
TOTAL (N)	100	100	200

Training

Training is an important component of the BHW's total field experience. How widely and extensively trained are these workers? Here are the data:

- **BHWs SAID THEY HAD BEEN TRAINED FOR THE JOB.** About two-thirds said that they had been trained for the job. However, only about a fourth (23.3%) admitted having a specific training on family planning. But a larger number said that FP had been incorporated in a broader training on health care (Table 6).

- **BUT FELT THEIR TRAINING WAS INADEQUATE.** More than half (54.9%) said that their training was adequate, although variations occur in the two study sites. More among the Lanao cases (68.6%) reported that their training was adequate than among the Davao BHWs (39.7%).

The BHWs had attended said training in various periods, with 70 percent reporting that they did so during the last four years.

Table 6 - Training Received by BHWs (in percent)

Training	Davao	Lanao	Total
Attended training			
Yes	63.0	70.0	66.5
No	37.0	30.0	33.5
Type of training first attended			
Solely on FP	25.4	21.4	23.3
Part of MCH	27.0	75.7	52.6
Part of PHC	44.4	-	21.1
Others	3.2	2.9	3.0
Perception of adequacy			
Adequate	39.7	68.6	54.9
Not adequate	60.3	31.4	45.1
TOTAL (N)	100	100	200

Supervision

● **MIDWIVES SUPERVISE BHWS.** Majority of the BHWs are under the direct supervision of the midwives, and only a few said they work closely with the DOH nurses. The midwives meet with them regularly, at least in the Davao area, where field visits and monthly meetings are said to be more regular.

● **BHWs COULD NOT ATTEND MEETINGS OFTEN.** The BHWs, expressed some problems in attending frequent meetings. It appears that as the meetings become regular and consistent, they find these activities somewhat demanding of time and money. Economically hard up, the BHWs would find this a problem.

● **BHWs SUBMITTED AT LEAST THREE TYPES OF REPORTS.** The BHWs said they submitted clients' records (78%), records of their daily activities (28%), and accomplishment reports (8%). In Lanao 22% claimed they were not required to submit any report, except to record the clients' background and type of FP used. This is significant because data on resupply are needed to monitor supply distribution and FP related activities of BHWs.

● **EXPECTATIONS OF A GOOD SUPERVISOR.** Relationship with the supervisors (midwives) is an important matter. The BHWs expect their supervisors to be more concerned about their own situation. They need greater autonomy from supervision, although they certainly welcome expressions of support and warmth from their supervisors. Good supervisors are perceived as those who:

- maintain favorable relationships with the BHWs
- give constant encouragement
- are trustworthy
- are respectable, and open.

On the other hand, they dislike supervisors who:

- practice favoritism
- delay action on their requests
- do not initiate planning, and
- those who display tantrums, among others.

BHW Performance

The foregoing sections adequately describe the profile and activities of the BHWs under study. A central concept about which we shall say something is BHW *performance*, measured by the number of family planning services the BHWs rejprted themselves as having delivered during the preceding year. Each service is assigned a score of 1; then, all points are counted for each BHW.

The overall average number of services provided to the clients was 4. These services were: motivating clients to practice FP (93%), referring them to the health centers (92%), accompanying clients (88%), and disseminating information on family planning (49%). Using the number of FP services to gauge performance, data show that BHW's performance in Davao was low, while the Lanao BHW scored high.

Because of the diverse cultural backgrounds, separate regression analyses were run for the data by geographical location. For the Davao sample, we can say this:

● **HIGH PERFORMANCE IS INFLUENCED BY HIGH EDUCATION, LONG RESIDENCE IN THE COMMUNITY, BHWS RECEIVED INCENTIVES, WERE SATISFIED WITH JOB, AND AVAILABLE MOST OF THE TIME.** Or, listed another way, the regression equation tells us that high-performing BHWs are due to these:

□ Education - high education, high performance
□ Residence - long residence, high performance
□ Incentives - more incentives, high performance

□ Job satisfaction - more satisfied, higher performance
□ Availability of BHW - more available, higher performance

On the other hand, for the Lanao BHWs -

● **HIGH PERFORMANCE IS COMMON AMONG MUSLIMS, MORE YEARS OF WORK, YOUNG BHWS, BHWS HAVE GOOD RELATIONS WITH SUPERVISORS, AND ARE AVAILABLE MOST OF THE TIME.** The regression yielded these findings:

□ Religion - Muslim BHWs, higher performance
□ Years of work - longer experience, higher performance
□ Age - younger, higher performance
□ Relationship - positive relations with midwives, high performance
□ Availability - more available, higher performance

Clearly, the variables are not uniform. Note the variables common to both groups: availability of BHWs and residence/years of work as BHWs. Stated another way, these are conditions that can be manipulated by policy uniformly. For those variables unique to a location, something may be done about them in the particular setting where they seem important (e.g. religion). Being Muslim is unique to the Lanao areas due to cultural sensitivity. The program manager advised to consider this trait in the selection process.

Clients View the BHWs

Three hundred clients from the Davao and Lanao areas were independently interviewed to validate some of the data obtained from the BHWs. Here are some results.

CLIENTS ARE AWARE OF THE BHWs. About two-thirds of the clients said they knew about the BHWs in their areas. In Davao, many more (82%) said so. A vast majority (86%) corroborated their presence in the community.

PERCEIVED THE BHW SERVICES AS ADEQUATE. Asked about the FP services rendered by BHWs, they said that these were adequate, citing at least three such services (motivation, referral, resupply of pills). They also mentioned that the BHWs are approachable. Majority (63.5%) confirmed the influence of the BHWs in FP practice and said they are satisfied with the services they received from them.

BUT ABOUT HALF DID NOT CONSULT THE BHWs. While more than half (58.6%) approached the BHWs, the rest did not. The latter went directly to the Health Centers nearby.

IV. Recommendations

From the data, certain policy suggestions are in order:

■ **ADEQUATE AND UNIFORM INCENTIVES BE GIVEN TO BHWs**. The LGU should make it a standard policy to include these incentives in its annual budget. From field observations, it has been noted that proper motivation spells a world of difference in the effective delivery of FP services. There is no substitute for it. Discussions with health personnel and DOH management also confirm the importance of adequately motivated BHWs. The types of incentives to be given the BHWs may include:

- free transportation and meals to Health Centers during meetings;
- medical/hospitalization subsidy of the BHWs and their immediate family; and
- office supplies for record-keeping and monitoring (notebook, ballpens, etc.)

Providing incentives, or increasing them if already in place, presumably insures the availability of the BHWs, thereby enhancing their delivery of FP services.

■ **FURTHER TRAINING OF BHWs,** particularly on family planning. The training may include monitoring procedures, clarification of FP roles, and motivational strategies. Balance in the timing and duration of the training, however, is important considering that the BHWs also attend to their livelihood and family chores.

■ **INTRODUCE A RECORD-KEEPING SYSTEM** to the BHWs for monitoring client's family planning practices, schedule of procurement and distribution of FP supplies.

■ **ALLOW BHWs TO RESUPPLY PILLS AND CONDOMS** to make them easily accessible to the community where they work. Under the present setup, only the nurses and other authorized health personnel can dispense these.

■ **REDEFINE AND CLARIFY BHW ROLES,** particularly in the delivery of FP services. As models of family planning, they should possess knowledge and skills about its practice. Single BHWs are *not* credible counsellors of FP.

■ **TRAIN MIDWIVES.** Since the nurses and midwives working with DOH are the best known contacts of BHWs, they should be requested to make regular visits to the latter. During the visit, they can re-orient the BHWs on certain tasks. A trainor's training for these DOH personnel may also be developed to provide them with appropriate skills, especially those relating to human management, so they may effectively deal with the BHWs.

■ **GET LGU OFFICIALS DEEPLY INVOLVED**. Field data suggest some problems in the implementation of the health care program due to lack of participation by the LGUs. Local officials should be deeply involved in the program to assure its success.

■ **RE-EVALUATE PRIMARY HEALTH CARE.** The Primary Health Care strategy should be re-evaluated in terms of its applicability and timeliness.

■ **RESEARCH UTILIZATION.** Research utilization workshops were held in Davo City and Iligan City to bring to the attention of program managers and other interested individuals in the academe and NGOs the highlights of the study. Some of the inputs obtained from these activities are as follows:

1. The DOH family planning workers suggested a review of the primary health care strategy to clarify the role and functions of BHWs, as well as the guidelines on recruitment and selection of volunteers;

2. Program managers strongly recomended and planned for the training of BHWs. Only BHWs designated to resupply pills and condoms will be trained. (Apparently not all BHWs are allowed to resupply pills and condoms.) Role clarifications and record keeping will be part of the training.

3. The governor of Davao del Norte endorsed the allotment of incentives for BHWs and assured all concerned that this will come from the Provincial budget.

4. The provincial administrator of Davao del Sur recommended the recruitment of male BHWs to help recruit male clients. He also supported the need to strengthen the incentive system for volunteers.

Reactions to Session III

Dr. Aurora Perez
Director, Office of Research Coordination
University of the Philippines-Population Institute

1. The study entitled "A Diagnostic Study on the Implementation of the DOH Health Volunteer Workers Program" is an illustration of operations research that draws on linkages between individual characteristics and areal characteristics to produce a desired outcome, e.g. good BHW work performance. The researchers ought to be congratulated for their initial work. the focus of this paper, however, is on the individual characteristics of the BHWs that can contribute to good performance, to the neglect of other crucial factors.

2. I was happy to note that there were some attempts to look into program effort variables such as supervision of BHWs by midwives, for most of them and by DOH nurses, for a few of them, as well as training. But my disappointment lies in the exclusion of these variables in the regression analysis as presented in Table 7, despite the recognition that in the Davao area, considered the better-performing area, field visits by the midwives were more popular (as reported).

If benefits from operations research are to be maximized, program managers need to have information on the effects of supervisory visits of DOH program workers on the work performance of BHWs. This aspect was not sufficiently dealt with in the paper. Reinforcement by supervisors of the basic knowledge of community-based volunteer workers is important and essential to good worker performance. It can also fill in the training needs of the BHWs identified by the study. Some supervisory approaches found to be associated with better worker performance are joint home visits with workers to observe their interaction with clients and discussion of clients' problems with the workers. These two approaches could suppliment the regular meetings, which, according to the study, the BHWs could not attend. The recommendation on free transportation and meal subsidy ties in quite well with the above-mentioned supervisory approaches.

3. I have some reservations about the measurement of worker performance. I think this needs further scrutiny. Without the description of the types of FP service actually delivered (which could range from motivation work to referral work to follow-up work), one wonders whether uniformly assigninng a score of one for each service actually delivered and cummulating the scores is the best way of measuring worker performance. Besides, I find it difficult to evaluate a BHWs performance when the BHW appears "confused" withs his/her many roles, reinforced by the flexibility in taking on roles contained in the DOH manual.

4. While some incentives, such as the suggested medical and hospitalization subsidy of the BHWs and their families, can encourage better worker performance, this approach needs some rethinking on some imported aspects.

(A) Are incentives selective? In other words, would incentives attract BHWs with less motivation? The usual finding is that incentives seem to draw in the poorer, less educated population and those with less motivation.

(B) Will incentives work? Incentives only work well when there is a fully established FP delivery system already available. Given the finding that "among those who expressed dissatisfaction, financial support was cited as the most crucial, followed by inadequate supplies, and conflict with their seeking livelihood", motivation arising from incentives may only increase frustration and dissatisfaction among BHWs in situations where inadequate supplies are a contraint on actual service delivery.

5. The above concerns for incentives and worker dissatisfaction further underscores the need to incorporate program effort variables into any diagnostic study of program implementation, as what this study attempts to do. This is clearly brought out by the call of local government to the program made by the researchers.

6. Finally, I would have wanted to see more discussion on the effects of gender on worker performance. If the FP program in serious in encouraging male participation in achieving program objectives, it becomes important to now begin recruiting male BHWs and to help them become good BHWs.

Reactions to Session III

Emily Maramba
Planning Officer, Family Planning Service, DOH

In studying the volunteers (i.e. BHWs and BSPOs), we are now getting closer to what devolution really is. For me, the spirit of a real devolution does not stop at the LGUs but really goes down to the community level. So there is only one way that we can achieve this, and it is through participation. I'm not going into any of the analysis which includes regression tables, etc. I'm here as a program planner. Unlike Vida Acosta who, after she heard all those findings, went out and did something; for us at the central office, all we can really do is toy around with these concepts and try to come up with standards that can be carried out nationwide.

Obviously there is a need to rethink the concept of the BHWs and maybe the BSPOs as well. Although both studies covered only two provinces and one city, I think I will be correct in assuming the same studies hold true with the rest of the country as far as the performance and the characteristics of the BHWs are concerned. So there is a need to rethink the concept of the volunteer workers. For one, what is their role? There seems to be a lot of confusion on what their role is. And the confusion, I think is not only with the BHWs and the BSPOs themselves, but also with those who supervise them. Maybe even in the higher levels -- the regional level and the national level. We are not one on what we want them to do or what we think their role is. So, there is need to spell this out. I think there is a paper in the DOH about how the BHWs are supposed to be the vital link to the communities. However, from these two studies, it seems this is not happening. Most of the BHWs see themselves as assistants in the health centers. So, somewhere along the line, the lofty concept of their being a vital link or change agent within the communities is not always true. In many cases they are assistants of the midwives. Sometimes they even act/think they are midwives. So, we have to rethink this in the central office and down the line.

I also would like to give my reactions to the performance indicators used in the study. I do not blame the researchers. But I think that it was unfair to rate the voluteers in terms of number of motivations, referrals, etc. Moreover, it was unfair to compare the BSPOs and the BHWs in terms of performance because for one, the BSPOs are really more focused on family planning. So I think there is a need to rethink these performance indicators not only for research purposes but for the program itself.

Maybe also there is a need to look at what we envision the BHW program to be twenty years from now. Will they still be there as BHWs? Will they still be: assistants to midwives; bringing in children for immunization; bringing in clients for motivation; etc. Maybe there

should be some vision towards what we hope to happen by that time when we have developed the volunteer concept to its full.

So, there's a lot of rethinking to be done about this and I hope Vida can share more of her experiences within the region. Then there is also one interesting thing that I noted. There was one finding that said the number of positions held by one volunteer (i.e. those holding both positions of BSPO and BHW) affected the performance of others. Maybe that's true but I believe those holding dual positions should to be paid for it.

I also think we should rethink our criteria for recruitment of volunteers. If you noted, the study said most of them were recruited because they were available. Is that a good enough criteria? Maybe we should set up some criteria. If we see them as workers or assistants we don't need as much criteria, but if we want to look at them as our links to the community, as community leaders then we have to have some criteria, and maybe even some income. A worker or a volunteer (who lacks basic needs) cannot be expected to do much volunteer work.

I would like to question when it was reported that volunteers spend one or two hours a week on the program. I do not believe they really mean that. The true volunteers from the community spend more time and not just on service delivery but on motivation. The volunteers can motivate while they are at the market, in the sari sari store, etc. They can motivate while they are doing whatever it is they are busy with.

The next issue I'd like to discuss is the supervisors. The studies showed that the more time spent by the supervisors with the volunteers was able to affect volunteer performance. I think we have to rethink this too. The midwives/supervisors are doing so many things already.

With regard to incentives, most people expect incentives to come in the form of cash of course, but there are other ways of looking at it. I would like to look at incentives as some help to them in making what they are supposed to do lighter in terms of say, travel allowance, per diem, etc. So incentives I think, should come in other forms.

In reading the studies they brought out more questions than answers. I certainly hope there will be more studies to follow. Thank you.

Open Forum
Session III

Nellie Antigua, AVSC. Emily is right, these studies have raised more questions. But before that, I think the studies are important even so much as to focus our attention on BHWs. What is their real role?

Now, my questions is on the process of the study. Was there evidence that these volunteers contribute to the family planning program? Are there figures (in the clinics) to show their contribution to the FP program?

And my second question, are there plans to continue to utilize these volunteers in the recruitment of FP clients or in their referral network? If so, are there plans to re-orient them and train them along these lines? There was mention about the role of BHWs in Iloilo for counselling, so I'm quite concerned regarding how they counsel because they are also motivators and I think most of us know that if they are motivators, they cannot be counsellors. So, if they are trained as motivators they are trained maybe to refer their motivated clients to counsellors in the clinic sites or in the hospitals. Now, at present AVSC is in the process of developing a program for assistants in Iloilo City. I'm interested in the activity of the BHWs in Iloilo whether we need to have an orientation program for them and if this is recommended by the City Population Office or the City Health Office. We are willing to sponsor this orientation program for BHWs in Iloilo City.

David Alt, FPS Logistics Advisor: Let me answer two of the questions that were raised. First is a reaction to the statement that the studies raised questions. I think that's a very good reaction because I think scientific studies should really attain that kind of level wherein after finding answers to certain questions, other questions should also be raised. That is why we always have a section on recommendations for further investigation. Regarding the next question, has the study yielded information with regards to the contribution of volunteers to family planning program. The graph that I presented showed there was enough contribution if family planning program involves motivation, referrals, follow-up, counselling and re-supply as defined by the Family Planning program. In Iloilo they had identified these functions. Regarding counselling, I agree that volunteers may not have sufficient knowledge with regards to counselling and I am glad that among the five functions, this has the lowest figure. The highest was motivation particularly for the BHWs. The BSPOs by the way, I've learned, have been trained in counselling formally. But counselling here is definitely not the counselling done by the nurses and midwives but just simply advising them on simple things. What they do not know, they usually refer to the CPO or the CHO personnel.

Dr. Nick Baronda: Are the BSPOs and BHWs helping the Family Planning Program? Without them I think we will have no clients. To be frank, in my city, I think only 5 to 10

percent of FP motivation is being done by our regular personnel. Doctors provide FP service but they will never motivate, they will tell the BHWs and BSPOs to do this. Hence, we have improved services but we have not increased our IEC. Why is it that people do not go to the services? Are we not selling these? Or maybe nobody is telling them that this is the case? So, that is how important the BSPOs and BHWs are to the Family Planning Program, is at least in Iloilo City.

Emily Maramba: I would like to comment on the BHWs' contribution to the Family Planning program. If you are going to ask for statistics, maybe it would be difficult for us to get statistics. As you have noted, one of the findings of the study is that there was an attempt to get specific data on the performance of the BHW, in terms of number of referrals, etc. We will not be able to find any data or record specifically on their contributions because they are not required to document the things that they have done, especially as they are not paid well, and they have no targets. Now, qualitatively when you ask them regarding contribution they will say they have accompanied clients to the clinics, they have referred clients, they have motivated clients, etc. But to quantify specifically how much contribution, this we cannot do. Another thing, we try to find out what we meant by contribution. Is it in terms of use of contraceptives, or is it in terms of fertility. So, its a question to be raised which takes another study to find out.

Segundina Sarangani: I was hoping the Autonomous Region of Mindanao (ARM) Provincial Health Officer (PHO) as well as the PHO of Region 12 are with us this afternoon to give light on the present status of the FP program as well as the volunteer program, but unfortunately they are not here. Anyway, I would just like to share with you the contributions of the BHWs in terms of the FP program in ARM as well as in Lanao Norte or Region 12. From our discussions with the DOH personnel, midwives, BHWs as well as the PHO, I have gathered that, though the prevalent rate of FP in ARM is low, I have the feeling that the BHWs in the area are doing their jobs, in spite of socio- cultural factors that are in some way hindering them. But I noted in the findings specifically in the regression part, you will note that performance in Lanao is very much associated with Muslim workers. So, it is somewhat encouraging to note that they are now starting to sell the idea. That is why in our local Research Utilization Conference, one of the suggested action plans was to establish an IEC center where materials from the national level will be translated into the local dialect for BHWs to use particularly in reaching the men (the husbands), in informing them on what the program is all about. And another thing is, even in Iloilo the most commonly used method is Natural Family Planning. So I think that's a fact that we have to face and according to Dr. Saber who is the present Provincial Health Officer in Lanao del Sur, he is bent on stressing that particular program because that is what the clients want. So I guess the training needs of the BHWs have to be met.

Anonymous: I started the conduct of the trainings of the program entitled "IEC course for Community Health Volunteer Workers (CHVW)". We are doing away with "motivation", rather it is education. Also we may not state it as "counselling" because it needs skills and in-depth study, and they are not prepared to do that. But the volunteers are prepared to

provide FP information and to focus on the idea that there should be no coercion in the promotion of the program.

Dr. Edith Abocejo: This is not a question but I would just like to ask some sharing from the Iloilo group. This morning I was discussing about drop-out rates in Bukidnon and one of the interventions that we plan is to mobilize or re-activate community based workers. Now, one of the functions that was identified by us was on resupply. We all know that the DOH has a new logistics system. Contraceptives are now delivered from the central office through Care Philippines, shipped directly to the provinces and through the provincial delivery teams. These are then delivered to the RHUs and then to the Barangay Health Stations, through the midwives. This means that the last personnel distributed to are the midwives. But in your discussion, I do not know if I heard it right, but I am not familiar how the BSPOs come into the picture, especially in terms of this new logistic system because what we know is that only the midwives are allowed to dispense contraceptives. I would like to ask if the BSPOs are allowed to dispense pills? Where do they get their supplies? Where do they submit reports? And is there a possibility of duplication because as far as we are concerned, the strategy that we are thinking about is for the midwives to give to whoever is the community-based worker. None of the community-based workers are allowed to dispense without enlisting their clients with the midwives. We would now like to ask for some sharing from the Iloilo group.

Dr. Nick Baronda: The initial giving of pills is done by the nurse or the doctor in the clinic. The clients are referred by the BSPOs. That is our referral system. Resupplying will be done by the BSPOs. They are allowed to resupply.

Dr. Abocejo: Where do the BSPOs submit their reports?

Dr. Baronda: The reports are being consolidated in the Barangay Health Stations or in the District Health Stations and then the City Population Office cordinates and sends these out. It is not the City Health Office which prepares the family planning report, it is now the City Population Office. The report comes from our Barangay Health Stations, or from the districts. There is no duplication because it is only the City Health Office which records, and then the City Population Officers collects or collates the reports, write them up and then sends them to the Regional Health Office.

Dr. Abocejo: Okay, because I think we have a different set up.

Marlina Lacuesta: I was trying to recall the data and we found out that in the resupply of pills and condoms the BHWs are not really given that responsibility. They are told to refer to the midwives.

Anonymous: I think what you are describing is the actual practice and I think probably in the provinces where you are doing operations research this is what they told you.

David Alt: I thought I heard Professor Lacuesta say that, under the present set up, only the nurses and midwives can supply the pills and condoms. I've been spending the last two years trying to correct that misimpression. Every province and city, and every region of the Philippines is now under the contraceptive distribution and logistic management information system. In all of our trainings, we show overhead slides with eleven points that talk about the main features of this system. And one is the encouragement of community-based volunteer workers to resupply contraceptives. So people who don't see that, hear that and get it, that means they are biased against volunteer workers doing this role. So let me make that absolutely clear. There are two ways the volunteer workers can get these contraceptives. In some provinces and cities, they merge the networks such that volunteer workers whether BSPOs recruited originally by the population offices or whether BHWs recruited by the health offices, they still go to the midwife for supplies. They basically get their products from her and tell her who is getting it. In some places like Iloilo City the Population Office is still active and you still have that network but the city makes one combined report. So, if people tell you resupply by volunteers are not allowed, that is false. Thank you.

Anonymous (male): If BHWs tend not to fulfill their resupply role, that's too bad in my opinion and in the Secretary's opinion because he has made it clear that he wants the program to be closer to the households. On the other hand, for the BSPOs who were originally recruited by the population offices, that was one of their major functions, to resupply. What I'm saying is the central office encourages the use of volunteer workers including BHWs to resupply pills and to supply condoms and in a lot of cases also supply Oresol. And we encourage it because it's easier for people to continue. This morning's research showed that we get tight about the supply and I think it was clear that drop-out rates are higher among those clients who are forced to go back every time to the health facility to get their supply.

Marlina Lacuesta: I would like to add to that during the Research Utilization in Davao, I think even in Iligan, the program managers agreed that they are going to allow the BHWs to resupply and that is why they felt that it should be part of the training. Thank you.

Rica Aquino, USAID: The importance of the volunteers in family planning work seems to emphasize that volunteers are institutions themselves as far as the program is concerned. My comment is a thought for the DOH and this was somewhat mentioned by Emily when she said, there must be a definition of the recruitment process because if we recognize them as an institution, there must be certain defined roles that they should be having as far as implementing the program is concerned. And that's when you match them with who are to be recruited to perform that role. Maybe that's something that DOH should spell out. I see volunteers' tasks being determined by whoever is their so-called supervisor or entity that they are linked with. If you see the program as a whole maybe their functions and their profiles should really be identified. This also leads to the concerns that there should be some program standards as far as their involvement is concerned. And specifically in the area of training which is something very close to my heart. Plus the fact that there's a big chunk of resources that has always been going to training. And this is a concern not only for USAID

but for the other donors as well. I speak for them because we regularly meet and compare notes and costings. Some months back we also had a program communicators' course for volunteers funded through ADF. We seemed to be having different sets of trainings but actually the intent is the same. If we are to really look at volunteers as an institution maybe that particular aspect should also be standardized, i.e. what to give them and how to give it to them. Thank you.

Angel Montes, Family Planning Organization of the Philippines: I would like to share something, something related to Dr. Antigua's and Ms. Aquino's comments. Primarily, FPOP has been existing for more that 25 years and we can say that we are ahead as far as mobilizing community volunteers are concerned. We have been implementing our community based program since the mid-1970s. Most of the recommendations raised by the presentors have already been done by FPOP. We have given incentives to some of our community health distributors (CHD). We have developed systems for CBD and we have placed certain accountabilities. Also, we allow our CBDs to resupply contraceptives. We have some male CBDs. But one emerging issue within FPOP is the question of multiple personalities of CBDs. Multiple personalities in terms of CBDs who are also BHWs, Barangay Nutrition Scholars, BSPOs and even Barangay Tanods. This arrangement seems to be beneficial because of complimentarity of efforts but in some areas we get reports of conflicts of interest. Maybe future research could answer this. Thank you.

Fely David: In Iloilo City we found that concern. In fact, to answer that, I would also address the issue raised by Miss Maramba about position. When we talked about effect of position on performance, what we really meant in our study was the dual position versus single position. In Iloilo City some of our BSPOs are also BHWs. With regard to the advantage of this, I think it has an advantage because our correlation analysis showed that those who were performing both functions had better performance in terms of the indicators we used. However the negative effect of this dual position is the conflict it brings regarding allowances. Thus, those who are both BSPOs and BHWs were receiving double compensation of P400 instead of the usual P200. And this made some volunteers envious of their collegues.

Josie Cabigon: I just want to point out one technical issue in Fely David's report. This is to remind you about the correlation analysis. Some of the variables are qualitative, answerable by yes or no. Correlation, that means the Pearson Correlation is only useful if both are measured at interval level. So the analysis should take that into consideration. That means those variables correlated, one is qualitative, has to be measured not using the Pearson Correlations, so that your result would be more useful in the end.

Fely David: Yes, we took that into consideration. We knew that from the very beginning. We did cross-tabulations and for the nominal variables we used chi-square. In addition to that we also treated the yes or no questions. For instance, training and no training. So those with training, we gave them a score of 1 and those without training we gave them zero (0).

And we treated that, as interval variable. So, I think we knew the limitations so we used both test, the chi-square which is a crosstabulation.

Female (Anonymous): This is not a question, it is a comment. We talk of the training needs of BHWs because both the NGOs and Government rely so much on them. My concern is the gender aspect of all this. For example, women who are already overworked in their own homes still take on volunteer work in the community. So we speak of double burden even triple burden. Hence, I'd like to suggest that we look into the whole issue the motivation behind why women volunteer to become BHWs. I know of a study which shows that the reasons are not really "altruistic". Instead many factors influence women to become volunteers. They say that as women with low education, this is one way for them to prove that they can make a difference in their community. It is also a way to get out of their homes and avoid the drudgery of housework. Hence, we should probably not focus too much on monetary incentives, because for all we know, its not really the money that they are after but probably, for example, social recognition, acceptance in the community, etc. I have encountered BHWs who said they would appreciate receiving a "certificate of recognition" in acknowledgment of their contribution and importance in the community. That's all.

Synthesis

Dr. Alejandro Herrin
Professor, School of Economics, University of the Philippines

I'll start by referring to two common themes that people have refered to today. One is that research should be utilized and I think the Secretary (Dr. Flavier) was also urging that rather strongly. Then we ask, utilize for what? We need to utilize research in order to improve the effectiveness of our programs, in order to increase the efficiency of the way in which we do things. And of course to achieve a certain equity in certain areas especially in family planning where people who have less access could eventually have similar access as others.

The other common theme recurring, is the need for users and researchers to interact. And then of course, interact on what? What are they supposed to talk about? Well, I think the Secretary and others, during the open forum provided basic answers, namely, we need to talk about the questions that need to be answered. Usually this comes from the users themselves sensing what the problem might be, and which needs a little bit more information on: what is the nature of the problem? how does it manifest itself in various way? and what can be done about it? The researchers' experience can also offer a different perspective of what the problem is, based on past experience and past research. So, they can help even in the formulation of the question and other things that we need information on. But it's not only a question of interacting on the basis of the questions, but also interacting on how to get the answers. So researchers have to share their methodology, they too have to show how they are going to go about getting the answers, discussing these with the users, in such a way that users understand. And how to get the information so that later on, once the information is available, they know what it means. Once the data comes in, what do they really mean? And what is it that we need to act on? I think that's also important. If there is no interaction, each one might have different interpretations, and the interpretation of the researcher might not be the one that is acceptable to the user.

This morning, I gave a presentation to the Department of Health where the two under-secretaries were there. I presented the data that we got by synthesizing various results from studies on health. What we did was look at the tables, look at the data and see what they mean, and, sure enough, the people there who had more experience on what is happening in the field offered rather interesting insights on what they mean in terms of what is actually happening in the field, (e.g. issues regarding control of diarrhea, control on acute respiratory infections and so on). In fact, towards the end of the presentation they said that since a lot of the data dealt on maternal and child care andfamily planning, I should be presenting this to the service units of the Department of Health. So I said Yes! I'm going to do that this afternoon in the National Research Utilization Conference of the Population Council.

We need to answer/utilize research for what? And we need to interact on what? Actually this needs common understanding of the objectives of what we are doing here as well as the factors that affect the achievement of those objectives whether it's promotion of what we need to interact about, the substance of what research would be, or research utilization. Actually, research utilization sometimes requires a synthesis of research results as they come. So, it's a continuing process. You don't forget the past research that has been done either in your district or anywhere else but get the researches as they come and relate the findings to a larger body of knowledge. In the end, this larger body of knowledge which is used for decision making.

What I'll try to do is to make a synthesis and summary of three things. One, is to summarize the underlying framework by which you have conducted your research, i.e. operations research work. This is the framework that is probably not articulated as well during the discussion because you didn't have time. So I will try to summarize what you have said. The second, is to use this framework to summarize: the range of questions that the studies have asked; additional questions that the studies have generated; and more questions that come out of the open forum as claimed by the kind of notes that were kindly given to me by rapporteurs and friends. Although I wasn't here, more or less what happened was that there were interesting discussions especially on one particular paper. And then the third, which is actually I think what you had expected is simply to summarize the results of the findings. That's probably the easiest one but I'd like to do that within the perspective of the framework and to use examples from the findings. That is, to put in a larger perspective not only one study but actually all five studies.

Refer to Diagram. First, on the underlying framework that is useful for reviewing the kinds of questions that operations research on family planning is likely to ask. These are the potential questions that users are likely to ask. We can start with perhaps the overall objective. What is it that we want to achieve in terms of improving maternal and child care, family planning impact on fertility, and so on? There will be other factors that affect that. We'll just call it Box E (see diagram) where the proximate determinant of that will be the use of family planning. The use of family planning is in turn affected by many factors, other factors involving education (Box E) and so on. But the major proximate factor would also be the availability of services, and of the quality of access that people have for various kinds of family planning. So we have family planning services. Family planning services are something that we produce or you produce by combining manpower, family planning supplies, various kinds of information and so on. We have a set of inputs, the manpower supplies and so on to produce a specific set of services and we can think of these services as family planning services as well as information services, counselling services and so on. The inputs themselves in particular, the manpower, are also produced by the system through trainings and we have examples (i.e. those studies that deal with training). So the inputs

themselves are produced by the development of skills, attitudes and so on. And this is, I call this box, Production of Family Planning inputs. The production of this, the entire delivery system, and finance run by the general sets of resources are simply called Pesos (see Pesos Box). Unfortunately, we can not buy good health or family planning use or maternal child care. If we could, it would have been easy to apply pesos to family planning services and family planning use, or to buy maternal and child health care. We can only do that by giving the system, a series of production and a system of utilization of that set of production.

I have other arrows there, which say you can apply your pesos to affect maternal and child care or family planning use by affecting all the other determinants. But these are dotted lines meaning that we concentrated on the delivery system itself which is viewed as a series of inputs and outputs. The output here being the maternal and child care while the inputs are family planning use. Family planning use is also an output of which services is an input. Services is an output for which manpower, family planning and devices are inputs. Manpower, family planning manpower like the BHWs is an input but its also an output which is produced by our training programs, recruitment programs and so on.

So, that's the basic system of the underlying framework. (It was on the basis of reading your minds that I made the summary. Now, we use this framework, to summarize the kinds of quick questions about family planning operations. So there are many questions, some of them were not specifically asked but some of them, in fact most of them were asked by the studies themselves. Let us go through each one and through each of the links. The first link is between the use of family planning and the ultimate objective of improving maternal and child care. One of our concerns here might be on the use effectiveness of family planning, so it is not enough that people use family planning services. We also want to ensure what factors affect effectiveness. For example, we know that abstinence theoretically is the perfect contraceptive, in other words 100 percent effective, unfortunately nobody knows how to use it and so, use effectiveness is very low. Then we move on to the kinds of questions that were asked more specifically by the studies, that is on family planning use itself. What proportion use them? But more importantly, how many do not use them, and among those who use them what proportion eventually drop-out and what factors affect discontinuation. I think we identified through the studies some of these factors (e.g. fear of side effects, whether real or imagined).

Hence the questions is: what can be done to prepare couples for possible side effects and how can we help them cope with such side effects? Then we go to family planning services. What we are interested here are, what kind of mixed services provide not only the various methods but also the kinds of IEC compliments that go into each method and the quality of services provided. So the basic proposition here is that, greater family planning service use can be achieved if the services provided are those that adequately meet the informed preferences of couples in service outlets most convenient to them. So, first in the method mix and then secondly where they are available. If people want natural family planning, are we offering Natural Family Planning? If they want to get their supplies from the resupply points, BHWs, are we doing that? I've just learned a while ago that there is no policy that

prevents that, but it depends on practice. That is not always happening. There are several questions here. What services should be provided? What service outlets should be set-up to provide the services? What kind of information should be provided to prepare them for potential side effects? What motivational and communication methods should be used?

Whether interpersonal or mass media, somebody mentioned, maybe what we have to do rather than wait for people to come to the clinics is, house-to-house visit. What is the appropriate service mix? These services are of course produced by a set of inputs, manpower of various kinds and various kinds of contraceptives. Again we can state a proposition, that greater efficiency in the provision of services and even quality can be achieved by chosing the less costly combination of inputs. What should we use? Should we use doctors versus midwives, and offer specific types of family planning services we know that midwives are able to do? Physicians might be required to do IUD insertions but for other types of family planning methods the others can do the rest of the work. Should we rely more on clinic workers, or more on outreach workers? Should we rely more on paid workers or should we rely on volunteer workers? These kinds of decisions have to be made with the help of the studies presented here.

For example, I might as well say it now when we discuss the role of the volunteer health worker. We are actually referring to the input mix. Should volunteer health worker have a place in our system such that they are part of the inputs, and what would be their role? One of the things that was discussed was whether they could be resupply points and so on. And when we say that, we are in effect thinking that volunteer workers as resupply points is probably less expensive and perhaps more effective than if we simply rely on clinics as resupply points. As the findings from the Drop-Out study show, the further the supply point is, the less likely they will continue. So having volunteers as resupply points right there in the community might have some impact on use which in effect is a decision regarding how we combined our inputs for the production of quality health and family planning services.

Now for the Box on Production of Family Planning Inputs. The question here is, how do we produce the manpower that we need. First, on the providers themselves (physicians and nurses), who are supposed to provide a high level of service in cases like those which require medical consultations for IUD insertions. We have found, from the Baguio study, that you can actually reduce the training time, the practicum time, with the same level of effectiveness or at least confidence in people's ability to do things. So those are the kinds of questions that are involved in this Box. The whole issue is about what is the most effective and efficient way to produce the kind of manpower that we need to become inputs into the production of services. Then I have other things here: of course, the management issue is a recurring issue. We manage the inputs here, we manage the training there, and by management we mean those kinds of decisions that have something to do with logistics, have something to do with dealing with personnel, making sure that their morale is high. Then a lot of issues regarding supervision, a lot of issues regarding the extent to which people actually do their work, that they come on time, they don't have hang-overs when the

come, the schedules are convenient for the clients, the providers go as scheduled, etc. So when we say Wednesday afternoons are available for consultation, there are people there available for consultation. All of these are management issues. These might sound like "nitty gritty" but obviously they count a lot in terms of what actually happens in the system. And I have this issue about financing. I think one of the papers had something to do with this question. Can we expand the financing of family planning services beyond the usual government financing? Can we encourage or compel business enterprises to finance and provide FP services through their clinics and health system enterprises? One of the studies was to see the extent and ways this can be done, the factors that would facilitate this. The study dealt more on the operations of particular implementors.

What else did I miss? Focus, we didn't really discuss that except in passing. What this means is that it is not enough to have services. In order to increase family planning use, certain types of services have to be focused to specific clients rather than providing services across the board. For example, Natural Family Planning might have a focus on certain people due to their convictions. So, do they have access to training information on how to do that effectively? That means identifying people who need which kind of services and so on. So those are the kinds of questions that the users are likely to ask either from the standpoint of the operations of a clinic, or from the standpoint of the DOH management looking at the entire family planning operations.

Having summarized some of the key questions in family planning operations research which have been raised and which the studies have tried to answer, let me now try to very briefly to situate where some of these studies and results are.

Let's begin with the first study -- Factors Affecting Family Planning Drop-out. This study dealt with the factors affecting family planning use, factors like education, wealth, income and so on. But it also and therefore dealt with the whole issue of continuation. However, in dealing with that issue, it then went into the quality of services being offered, the conclusion being that the quality was better in terms of accessibility if users are not to go too often for resupply; where the provider was pleasant; etc. So these kinds of issues were addressed by that particular study. I also put it under management, I think one of the aspects of the study has something to do with, the quality of services, clinic hours, etc.

Two, the second study, I put it under training. This is a study on the implementation of training courses of family planning providers. The study focused on the production of family planning inputs, namely, the providers of services themselves. And here we are now all familiar with the results that they have mentioned this afternoon in terms of the skills that are produced and how the skills are produced at the least cost by modifying the training module.

Now, the third study, well, let me pass on the third and go first to the fourth. The fourth study is on factors affecting the performance of BSPOs and BHWs. Here, I put it under training on one hand because we deal with factors that affect performance. A part of that is

the kind of training that they have had, and I put it also under input mix, that's number four. This whole question on what is the role of BHWs, in effect, is like saying should they be our input to the production of family planning services of given quality, or should they perform other functions and so on. Even the time input of the workers, how much do we expect them to work? That is part of this whole question of input mix. Should we use more of their time rather than the time of the midwives or should we use less of their time and more of the midwives?

The fifth study is on the implementation of the volunteer workers program. Actually there are several aspects of the entire framework that are addressed here. One, of course, is training, so I put it under training. We talk about what are the characteristics of this kind of workers, the kind of family planning services that they deliver, do they know something, do they feel adequate? These are issues for us to think about. Should we train them some more and on what areas? How about their background characteristics, what are the things that we need to look for when we begin to train them? A lot of this has something also to do with management, so I put it under five. This whole issue whether we should pay them or not whether their motivation will be affected with or without monetary incentives is a whole issue of, I think, management. How do we manage our workers such that they would still be motivated without large monetary remuneration. Another issue on management is the issue of supervision. To what extent they are supervised by midwives, are they supervised properly? This whole question of the need to clarify what their role should be is also a management issue.

So, let me mention a little bit about the third study as already mentioned earlier. This deals with the extent that we expand financing of family planning beyond the usual government financing to see how private enterprises can also begin to finance and provide. I think this study dealt more with implementation rather than questions of what would be the minimum types of activities that we need in order to be able to bring a number of enterprises to the point where they are able to provide family planning services to their workers, and what would be the factors that would govern this. I think it's not enough to say, that those who were committed were the ones who continued. Well, why were they committed? What factors were responsible for strong commitment? Hence, we need to go a little bit deeper into the factors in the future it might be possible to do some kind of an experimental type of study where you divide prospective enterprises, some getting so many inputs depending on their characteristics and see which ones eventually continued, and which one did not. What minimum set of activities do we still need to do to get them to give the bigger share of the financing. I guess the way it is designed now is they give more non-monetary inputs.

This is just a mechanism showing what kinds of questions, kinds of results these five studies have come up with. It cuts across a wide range of issues that we normally think about in the full range of family planning operations. So it's not just one aspect but several. And it is important for us to look at the big picture especially when we begin to accumulate studies. So, now we have five. Later on it will be fifty.

Which of these issue will we concentrate on? And similarly for the users, which of these questions are the most problematic ones from the operational standpoint and which should be the object of the more intensive research?

There are several levels that we can look at. One, is from the clinic level, the provider level where we look at the entire set of operations and problems. But some are more problematic than others, and therefore, we have to do some operations research in order to get necessary information to be able to act. But that could just stop there at the level of the provider, at the level of the clinic or the hospital or the NGO or the community. What could actually happen as we accumulate experiences and studies at different levels? Eventually we can begin to see from a larger perspective. What might be common problems among many different institutions, many different providers, many different communities? And those common kinds of problems require additional research. This is at the level of policy-making rather than just pure operations and management.

I think I have said enough. These were some of the points that you mentioned that I could summarize including those that we have thought about but have not yet said. Thank you very much.

Closing Remarks

Dr. Rebecca Infantado
OIC, Family Planning Service, DOH

I have three concerns. One, the National Research Utilization Conference is done and everything has been said. I am afraid that my adding even a sentence would brand me as being repetitive. Two, I would wish to put some emphasis on the things I made mention of earlier. This is the setting up of Family Planning Operations Research and Training. And to put up a model which we hope would be maintained by constant dialogue between program managers and researchers. I have been silent since this morning because I believe, as the Secretary earlier said, "I came to listen", to learn and internalize the recommendations especially those that were given to the DOH. This is to try to improve our service delivery especially on those problems that have larger than local implications so that we could improve the family planning program.

The third, but not the least important, in behalf of the Population Council, especially Dr. Marilou Costello, the Department of Health would want to thank everybody from the presentors to the researchers, the reactors, the moderators, the emcees and the synthesizer, and all of us who have participated in this whole day's affair. I know we stayed the whole day because we are committed to the family planning program. Likewise, this shows our interest in research and its utilization. I know people who have common interests will see each other again. So, we will not say good-bye but good afternoon.

Appendix 1
List of Resource Persons

Opening Remarks

Dr. Juan Flavier
Secretary
Department of Health

Dr. Marilou Palabrica Costello
Host Country Advisor
The Population Council

Dr. Rebecca Infantado
Officer in Charge
Family Planning Service
Department of Health

Principal Investigators

Prof. Lita Sealza
Research Associate
Research Institute for Mindanao Culture
Xavier University, Cagayan de Oro City

Dr. Steven Rood
Director
Cordillera Studies Center
University of the Philippines-Baguio

Dr. Marcelo Raquepo
Professor
Cagayan State University, Tuguegarao

Dr. Josephina Cabigon
Research Associate
University of the Philippines Population Institute
Diliman, Metro Manila

Prof. Fely David
Director
Social Science Research Center

Central Philippine University, Iloilo City

Prof. Marlina Lacuesta
Professor
Ateneo de Davao University

Prof. Segundina Sarangani
Professor
Mindanao State University

FP Program Managers

Dr. Editha Abocejo
Family Planning Coordinator
Department of Health - Region X

Mrs. Carmelita Taguba
Family Planning Trainor
Regional Health Office 2, Tuguegarao

Ms Emma Magsino
Project Officer
Philippine Center for Population Development

Dr. Nick Baronda
City Health Officer
City Health Office, Iloilo City

Ms Elvira Acosta
Family Planning Coordinator
Department of Health - Region XI

Reactors

Dr. Trinidad Osteria
Director
Social Research Development Center
De La Salle University

Dr. Ralph Curiano
Training Unit, FPS
Department of Health

Dr. Michael Costello
Director
Research Institute for Mindanao Culture

Ms. Marissa Reyes
Vice President
Philippines Center for Population Development

Dr. Aurora Perez
Director
Office of Research Coordination
University of the Philippines

Ms. Emily Maramba
Planning Officer, FPS
Department of Health

Moderators/Hosts

Dr. Virginia Miralao
Philippine Social Science Council

Ms. Rowena Alvarez
Director
Institute for Social Studies and Action

Ms. Malou Sevilla
Technical Advisor
LGP/MSH Department of Health

Ms. Myra Arenas
Program Officer
The Population Council

Ms. Carmela Patron
Research Associate
DMPA Project, FPORT, The Population Council

Summary and Synthesis

Dr. Alejandro Herrin
Professor
School of Economics
University of the Philippines

Appendix 3
List of Participants

Dr. Mercedes Concepcion
Professor Emeritus
University of the Philippines

Dr. Emmanuel Voulgaropoulos
Chief, Office of Population,
Health and Nutrition
USAID

Bishop Javier Gil Montemayor
Executive Director
Family Planning Organization of the Philippines

Ms. Myrna Jarillas
Chief, Research Division
Natinal Commission on Women

Mr. Mario Taguiwalo
Project Director
UP Economics Foundation

Ms. Jet Riparip
Resident NGO Advisor
John Snow Inc.

Mr. Patrick Coleman
Senior Resident Advisor
Johns Hopkins University

Ms. Rencee Tayzon
Programme Officer
UNFPA

Mr. David Alt
FP Logistics Advisor
John Snow Inc./DOH

Mr. Mahlon Barash
Project Development Officer

USAID

Mr. A.C. Montes, Jr.
Chief, PEMISG
Family Planning Organization of the Philippines

Ms. Taryn Vian
Resident Advisor
FPOM-DOH-OSC

Ms. Nellie Antigua
Country Director
Association for Voluntary Surgical Contraception

Ms. Ruby Fernandez
Country Representative
JHPIEGO Corporation

Mr. John Dioquino
Country Representative
PROFIT
Mr. Ephraim Despabiladeras
Population Project Specialist
USAID

Ms Grace Migallos
Resident Advisor-SOMARC
Futures Group

Ms. Judy Taguiwalo
Executive Director
Center for Women's Resources

Dr. Pilar Ramos-Jimenez
Research Associate
SDRC, De la Salle University

Ma. Florina Dumlao
Executive Director
PPA-Health Research Network Project

Ms. Dorothy Ruth Leoncio
Medical Specialist II
FPS-DOH

Ms. Rowena Frogoso
Medical Specialist II
FPS-DOH

Ms. Rica Aquino
Project Specialist
USAID

Mr. Virgilio Aganon
Project Director - DMPA Monitoring
The Population Council

Ms. Cecilia Agrusa
Technical Advisor
Department of Health

Ms. Elizabeth Go
Statistician V
National Statistics Office

Mr. Jimmy Alojado
Sr. Project Officer
Philippine Federation for National Family Planning

Ms. Dolores Castillo
Provincial Health Officer
Davao Province

Ms. Mary Ann Ladia
Researech Associate
Cordillera Research Center
University of the Philippines-Baguio

Mr. Sandy Araneta
Reporter
Medical Observer

Appendix 4
Pictorial Documentation

Appendix 5