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EVALUATION OF  
THE USAID/PHILIPPINES  
POPULATION PLANNING III PROJECT

by

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GLOSSARY

AID/W	AID/Washington
ASEAN	Association of Southeast Asian Nations
BHS	Barangay (village) Health Station
BHW	Barangay (village) Health Worker
BNS	Barangay (village) Nutrition Scholar
BSP	Barangay (village) Service Point
BSPO	Barangay (village) Service Point Officer
BTL	Bilateral tubal ligation
CBR	Crude birth rate
COS	Community Outreach Service (GOP)
CPO	City Population Officer (GOP)
CPS	Contraceptive Prevalence Survey (GOP)
CRNI	Crude rate of natural increase
CRS	Cost Recovery Scheme (GOP)
DHS	Demographic and Health Survey (AID)
DPO	District Population Officer
DRDF	Demographic Research and Development Foundation (NGO)
FAR	Fixed amount reimbursement (AID)
FP	Family planning
FP/MCH	Family planning/maternal and child health
FPIA	Family Planning International Assistance
FPOP	Family Planning Organization of the Philippines (NGO)

FST	Field Support Team
FTOW	Full Time Outreach Worker
GDP	Gross domestic product
GMAG	Gabriel Medical Assistance Group (NGO)
GOP	Government of the Philippines
HRD	Human resource development
IBRD	International Bank for Reconstruction and Development
IBRD/IDA	International Bank for Reconstruction and Development/ International Development Association
IDA	International Development Association
IEC	Information, education, and communication
IMCH	Institute of Maternal and Child Health (NGO)
INC	Iglesia ni Cristo (NGO)
IPPF	International Planned Parenthood Federation
JICA	Japan International Cooperation Agency
KAPS	Knowledge, attitudes, practices, and skills
MCRA	Married couple of reproductive age
MECS	Ministry of Education, Culture and Sports (GOP)
MIS	Management information system
MOH	Ministry of Health (GOP)
MOLE	Ministry of Labor and Employment (GOP)
MSSD	Ministry of Social Services and Development (GOP)
NA	New acceptor (of a birth control method)
NCSO	National Census and Statistics Office (GOP)
NDS	National Demographic Survey (GOP)

NEDA	National Economic Development Authority (GOP)
NFE	Non-formal education sector
NFP	Natural family planning
NFPO	Natural Family Planning Office
NGO	Non-governmental organization
NNC	National Nutrition Council (GOP)
NRR	Net reproduction rate
PACD	Project assistance completion date (AID)
PCF	Population Center Foundation (NGO)
PHC	Primary health care
PHN	Population, Health and Nutrition (AID)
PHN-1	Population, Health and Nutrition Project-1 (POPCOM)
PHO	Public Health Officer
PIL	Project implementation letter (AID)
POPCOM	Philippine Commission on Population (GOP)
PP	Project Paper
PP II	Population Planning II (GOP/AID)
PP III	Population Planning III (GOP/AID)
PRECEDE	Predisposition, reinforcing and enabling causes in educational diagnosis and evaluation
PVO	Private voluntary organization
RCM	Reversible clinical method (of birth control)

RHO	Regional Health Office
RHU	Regional Health Unit
RP	Republic of the Philippines
RPC	Regional Population Coordinator
RPFS	Republic of the Philippines Fertility Survey
SDIS	Service delivery information system
SP 10	Special Project 10 (within PP III)
TBA	Traditional Birth Attendant
TFR	Total fertility rate
TMFR	Total marital fertility rate
UNFPA	United Nations Fund for Population Activities
U.P.	University of the Philippines
UPCPA	University of the Philippines College of Public Administration
UPPI	University of the Philippines Population Institute
VS	Voluntary sterilization
VSS	Voluntary surgical sterilization
WFS	World Fertility Survey

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The team members wish to express their appreciation to all parties for contributing their time, views, and experience to the assessment process. We shall not single out specific individuals but express particular appreciation to the central and regional officers of POPCOM and to the Manila staff of USAID. Their approach to the review process was very positive and constructive.

## EXECUTIVE SUMMARY

This evaluation of Population Planning III (PP III), the current bilaterally funded population program in the Philippines, was mandated in the original Project Paper. The need to assess progress at this time is particularly urgent both because the Government of the Philippines has not yet submitted a proposal for a follow-on project after 1986 and because it is generally recognized that progress in controlling population growth in the Philippines has been slow. This evaluation accepts the estimates, generated by others, that the crude rate of natural increase (CRNI) is currently around 2.8 percent, that the crude birth rate (CBR) is in the mid 30s, that prevalence of program methods is no more than 30 percent of all married couples of reproductive age (MCRA), and that the mean desired family size is still about four children.

PP III is currently achieving about half its targeted numbers of new acceptors and about half its targeted rate of increase in prevalence. These are significant achievements, because the targets have been set unrealistically high. The targets were based upon evidence of high achievement prior to PP III, which apparently was exaggerated, and also upon a goal of replacement fertility by the year 2000, a wholly unrealistic goal. The genuine achievements--an estimated annual increase of roughly one percent in prevalence of program methods and steady declines in total fertility rate (TFR)--have been almost completely offset for the past 10 years by declines in marriage age and duration of breastfeeding, and by an unfavorable age structure. Because there are so many young women in the Philippines, their fertility dominates the crude birth rate.

It would be a serious mistake to discard or dramatically restructure the core of the current community outreach program, particularly without careful pilot studies. The network of paid Full Time Outreach Workers (FTOWs) and Barangay (village) Service Point Officers (BSPOs) should be maintained and strengthened. In the long run, the outreach network will indeed become obsolete, as prevalence reaches high levels, as the motivational role is accomplished by friends and relatives in normal social contact, and as contraceptive technology and delivery are improved. But in the short run, effective personal motivation within the community is needed, particularly in those barangays where prevalence is low. This report offers numerous specific recommendations for improving the effectiveness of the basic structure.

The outreach system is currently endangered by three probable changes, each apparently motivated mainly by fiscal and organizational considerations, and not by decisions made on the basis of studies and analyses of impact in the field. These changes have been buttressed by theoretical arguments, but there is no empirical evidence that any of them will have a positive effect on levels of prevalence and fertility. It is likely that they will actually have a negative effect.

The first of these changes is the rapid transfer of all outreach costs to local governments. This has already produced a decline in the number of FTOWs and is likely to eliminate outreach almost completely in the poorest areas. There are advantages to local administration, but some kind of cost sharing or block grants will be necessary if outreach is to be sustained and to remain responsive to central government guidelines.

A second probable change is the proposed Cost Recovery Scheme (CRS), whereby users of condoms and pills must pay for supplies. The evaluation did not find a single individual outside of the central Philippine Commission on Population (POPCOM) staff who supported this approach at this time. CRS should be regarded as a long-term objective and be deferred.

The third change, proposed integration of population with health and nutrition, is a danger to the effectiveness of outreach. While there may be potential theoretical advantages of such an integration, it seems unlikely they will translate down to the field level. If a single volunteer barangay worker is to combine the functions of the current Barangay Health Worker (BHW), Barangay Nutrition Scholar (BNS), and BSPO, the health function will probably dominate and she will have little time to carry out the motivation, monitoring, and referral activities of the BSPO. At present, many BSPOs are also BHWs and/or BNSs, but one cannot assume that in general the BHW will have the time and the inclination to be an effective population worker. At the very least, an integrated PHN scheme should be field tested and should be phased in gradually.

The current POPCOM leadership is viewed very positively in this evaluation. Generally speaking, the central and regional offices seem to be managed efficiently. The effectiveness of the program as a whole, and of POPCOM in particular, however, is impaired by too broad a definition of POPCOM's functions. Some conflict has arisen and is likely to intensify over two related issues (see III.12, Some Organizational Issues).

The first issue is whether POPCOM is a coordinating or implementing agency. With virtually no exception, persons outside POPCOM view it as an implementing agency; this view is apparently correct, although one must also recognize that POPCOM coordinates the population activities of ministries, local governments, non-governmental organizations (NGO), etc. This issue is significant because there is role conflict when one agency has primary responsibility for the outreach program, including training, service delivery, logistics, management information systems (MIS), and so on, and also has an influence over the budgets of other organizations, particularly private ones, which may be regarded as its competitors. This role conflict must be acknowledged and not be regarded as just a matter of semantics. A review several years ago by the University of the Philippines College of Public Administration (UPCPA) also made the same observation. It is not healthy for POPCOM to have a kind of regulatory capacity over such NGOs as the Population Center Foundation, the Family Planning Organization of the Philippines (FPOP), and the Institute of Maternal and Child Health (IMCH)--all of which are important to the overall population program--and simultaneously to have elements of both symbiosis and competition with these organizations.

As a second and related issue, it is undesirable for POPCOM to have regulatory and gatekeeper responsibility over all basic and applied population research in the Philippines. This is a misuse of POPCOM staff, it leads to bias against certain kinds of research, and also leads to potential conflicts of interest.

Some planning and evaluation activities and authority over non-POPCOM budgets should be conducted externally to POPCOM. Detailed recommendations should be generated in another review, perhaps conducted by UCPA in behalf of the National Economic Development Authority (NEDA).

Perhaps the single most important reason fertility remains high in the Philippines is that the desired family size remains at about four children. The program has been oriented around supply: service delivery for those couples who want to terminate or to space childbearing. It is important that this emphasis continue. It should, however, be supplemented by another emphasis: demand generation. The demand for contraception must be increased, or equivalently, the demand for large families must be reduced.

Progress in this direction has been made during the past couple of years, but it should be given even higher priority. Vocal and continuing commitment from the political leadership is needed. Accommodation with Catholic and Islamic leaders is essential, as in the Responsible Parenthood Campaign.

The advantages of low fertility should be put in terms appropriate to various target groups. Thus, the national leadership should be made even more aware of the negative impact of high population growth on economic development. Local government leaders should become more aware of the negative impact of high growth in terms that are relevant for them--e.g. the impact on schools, housing, unemployment, water supply, etc. The thrust of information, education, and communication (IEC) should be on the advantages of fewer children at the level of the family--that is, for the parents and the children themselves. Young people must be convinced of the advantages of child spacing and of allocating limited resources to a smaller number of children. There should be sharp focus on an ideal family size of two children. Efforts along these lines are a strength of the present program, but should be intensified. A future program should specifically have the reduction of desired family size as one of its objectives.

USAID and other donor agencies should be receptive to government initiatives in the development of a successor program. In the past, USAID has perhaps been intrusive. It may now be more appropriate for USAID to be reactive rather than directive. Changes in the program, however, should be based on evidence that they will improve program effectiveness. Such evidence could come from field studies or from programs in other developing countries. Present planning is motivated by administrative and fiscal exigencies (e.g. local government funding and cost recovery) and/or by theoretical expectations (e.g. integrated outreach) rather than by evidence of potential positive impact.

The staff of the USAID mission has reached critically low numbers. The PHN Office should be reinforced by a replacement Population Officer and additional skilled Filipino staff. It is essential that sufficient staff be available so that all staff members can have greater familiarity with actual field activities than at present. USAID staff should actually have the possibility of serving as advisors--although low-key advisors--and not just as enforcers of fiscal and procurement regulations.

## I. INTRODUCTION AND BACKGROUND

### I.1 Purpose of the Assignment

This report presents the results of an evaluation of USAID's Population Planning III (PP III) Project in the Philippines (Project 49-0341). The evaluation was carried out between January 6-31, 1986 in the Philippines, with preparatory work and final report preparation in the U.S. The evaluation was conducted by a four-person team from the International Science and Technology Institute, Inc. under its centrally funded contract with AID. The members of the team were:

Dr. Thomas W. Pullum, Demographer and Team Leader  
Ms. Elizabeth Q. Bulatao, Sociologist  
Dr. Donald E. Morisky, Behavioral Scientist/Health Educator  
Mr. William R. Thomas 3d, Evaluation Specialist  
A brief description of the team members appears in Appendix B.

This report represents Phase II of a two-part evaluation. Phase I is being carried out by the College of Public Administration of the University of the Philippines (UPCPA) under the direction of Associate Professor Mila Reforma, under a contract between the Philippine Commission on Population (POPCOM) and the University. Phase I is an in-depth field investigation of seven processes of institutionalization of the population program, especially the outreach program in the field. Data collection in 12 provinces and in six cities has included the administration of standard questionnaires to four levels of population program staff, extensive interviews with clients and the collection of secondary data. The scope of work for Phase I is contained in Appendix A.

The report is directed toward both USAID and POPCOM. It is hoped that the observations will also be useful to other agencies in the Philippines, whether governmental or non-governmental, which are included in the formulation and implementation of population policy or research, and to various donor agencies other than USAID.

### I.2 Scope of Work

The scope of work contains a core scope and eight additional questions to be addressed. The complete scope of work for Phase II appears in Appendix A. The core covers three broad areas, namely:

- o Project input level timeliness and utilization, funding adequacy, and funding and monitoring requirements.

- o Project output level achievements, their continued importance, and priorities for the future.

o Reasons why there was little progress toward the project purpose and program goal, even though the project outputs were largely achieved.

The scope of work was developed jointly by the staff of USAID in Manila and officers of POPCOM.

### I.3 Methodology

The methodology used in this evaluation, which was principally empirical, was outlined in the terms of reference for the evaluation. It included:

o Review of background materials. Extensive background materials on PP III--many of which are analytic or evaluative in nature--are available. These were provided to, and utilized by, all members of the team.

o Interviews with personnel from the Mission, a variety of government agencies, non-governmental organizations (NGO) involved in population work and other knowledgeable personnel. A list of locations visited and persons interviewed is shown in Appendix C.

o Field observations. The second week was devoted to this activity. Team members visited four regions and met with personnel involved in, or connected with, the program at all levels down to and including the barangay (village).

o Finally, the writing of the conclusions and recommendations set forth in this report.

### I.4 The Setting

#### I.4.1 The Demographic Setting

The population of the Philippines has increased dramatically, from 27 million in 1960 to an estimated 54.8 million in 1985. The Philippines is the seventeenth most populated country in the world. With 180 persons per square kilometer it is also one of the most densely populated countries in the world, and is more densely populated than most countries in the region. Available forecasts suggest that by the year 2000, even with best efforts, the population will be over 75 million and growing at over 2.0 percent per year.

The last census of the Philippines, in May 1980, enumerated 48.1 million Filipinos, increasing at an average annual rate of 2.7 percent during the intercensal period 1975-1980. This meant that the population had approximately doubled since 1960 but was growing at a slower rate.

Between 1950-1960 and 1960-1970, the annual growth rate was unchanging at a high level of 3.0 percent. The intercensal rates of growth were 2.8 percent for 1970-1975 and 2.7 percent for 1975-1980. The most recent

estimate, from the 1983 National Demographic Survey (NDS), is that the population continues to grow at a rate of 2.8 percent per year.

#### I.4.2 The Economic and Social Setting

The social and economic implications of the current 2.8 percent growth rate are serious. Over the 30-year period from 1950 to 1980 the Philippines per capita gross domestic product (GDP) grew at 3.1 percent per year. In the 1950s the annual per capita growth rate was 3.5 percent, rivaling that of most countries in the region. Due largely to continued adherence to an import substitution strategy, the rate fell to 2.2 percent in the 1960s, the lowest among all non-Communist East and Southeast Asian countries. While performance was better in the 1970s (an annual rate of 3.4 percent), the Philippines' relative standing did not improve. As a result of these policies and of natural disasters, Philippine economic performance during the 1980s has progressively deteriorated.

The rate of growth in the economy has declined each year. In 1983 the rate fell below the rate of population growth, and in 1984 it was actually negative. Real per capita GDP in 1984 fell by 6.3 percent from 1983 and was practically at its 1980 level. Per capita income was below its 1979 level of \$625.

While some observers believe that the domestic recession bottomed out in 1984, no one is forecasting a rapid recovery. Because of this economic fact, and the extremely high rate of population growth, best estimates are that rates equivalent to the 1983 per capita GDP will not be reached again until at least 1997.

The actual role of population growth in Philippine development is also clearly demonstrated by the growing problem of unemployment and underemployment. In 1978 open unemployment was down to 5.2 percent--800,000 persons. By 1984 there were 1.2 million people unable to find work, and the number of underemployed persons had risen from 1.5 to 6.9 million. Thus, in 1984 there were 8.1 million people in the Philippines who were either looking for work or desiring more work--a staggering 40.8 percent of the total labor force.

It is not necessary for the purpose of the evaluation to dwell on the social and health consequences of the current rate of population growth, but two facts suffice to represent these problems. First, at a growth rate of 2.8 percent, schools must absorb 300,000 additional children each year. Second, it has been estimated that if all births occurred only among women aged 20 to 34 and all mothers had no more than four children, infant and maternal mortality would fall by about 11 percent.

## I.5 Predecessor Projects

Since 1967 USAID has provided about \$100 million in bilateral assistance to population programs in the Philippines. Through this long period of assistance USAID has provided funds for the design, institutional development, and implementation of the national family program, including substantial assistance for recurring local costs. AID support to the Philippines' population program began with assistance to the private sector in the late 1960s. Bilateral assistance to the government began in 1970 with Population Planning I, which helped to get the newly established Commission on Population (POPCOM) under way, and supported the growth of a clinic-based service delivery structure throughout the country. During the course of this first effort at national program support, the prevalence of contraceptive use rose swiftly from around 15 percent of married couples of reproductive age (MCRA) to about 25 percent. Prevalence then appeared to level off for several years during the mid-1970s. As a result of this plateauing phenomenon and a research finding that the probability of contraceptive use was in inverse proportion to distance from a family planning clinic or other source of contraceptive supply, the GOP decided in 1976 to launch a national population outreach program. Population Planning II (PP II) was the result of that decision. Its centerpiece was outreach, which, among other activities, involved training and deploying a cadre of Full-Time Outreach Workers (FTOWs) who in turn recruited and trained thousands of Barangay Service Point Officers (BSPOs) who served as the village (barangay) level source of oral pills and condoms for all eligible couples.

PP II was evaluated in 1978--at the end of its first operational year--and the evaluation provided significant inputs for the preparation in 1978-79 of a new program plan of action and USAID's Multi-Year Population Strategy for the Philippines. These documents, in turn, led to the preparation of the current AID-funded population project: Population Planning III (1981-1985). The 1978 evaluation identified as key program issues 1) the matter of local government financial support to the program; 2) coordination among implementing and participating agencies; 3) liquidity and liquidation; and 4) the mix of contraceptive methods (more vs. less effective methods) in the program.

## I.6 The Present Project

Population Planning III was authorized in August 1980 as a six-year project with a Project Assistance Completion Date (PACD) of December 31, 1986 and estimated life-of-project costs of \$151,047,000, including other donor assistance. On December 2, 1985, the Mission issued Project Implementation Letter (PIL) No. 25 proposing a selected extension of the PACD to June 1989 for contraceptives only. The PIL also proposed reprogramming \$2,225,000 of already obligated grant funds: \$225,000 to supplement the grant funding of local costs in CY 1986 within the original PACD and the balance of \$2 million to meet contraceptive requirements through June 1989.

Of the original total project funding of \$151,047,000 in the PP, 37.6 percent was to be financed by AID, 51.6 percent by the Government of the Philippines (GOP), and the remaining 11 percent by the World Bank. Details are shown in Table I.6-1 below.

Table I.6-1  
Forecast Life of Project Costs - Population Planning III  
(In \$000)

<u>Funding Source</u>	<u>Foreign Exchange</u>	<u>Local Costs</u>	<u>T o t a l</u>
AID-Appropriated Total	24,875	31,875	56,750
(Grant)	( 2,675)	(27,160)	(29,835)
(Loan)	(22,200)	( 4,715)	(26,915)
Government of the Philippines	-	77,972	77,972
(AID counterpart)	-	(65,580)	(65,580)
(World Bank/ counterpart)	-	(12,392)	(12,392)
World Bank (IBRD)	<u>7,725</u>	<u>8,600</u>	<u>16,325</u>
<b>T O T A L</b>	<b>32,600</b>	<b>118,447</b>	<b>151,047</b>

USAID foreign exchange funds were programmed primarily for contraceptives (\$20 million) with the balance planned for other commodities, consultants, participants and evaluation. Local currency costs to be financed by USAID were cost-sharing in all aspects of the project program, including outreach, field operations and clinic support (voluntary sterilizations); training and information, education, and communication (IEC); development research and evaluation; and logistics and the management information system (MIS). Of these, outreach was by far the largest category, requiring an expected 46 percent of total costs and 48 percent of AID grant funding.

The Project Paper (PP) provided that AID would pay for local costs under the Fixed Amount Reimbursement (FAR) method. Under FAR, costs are incurred by the GOP and then certified to AID, which reimburses the Government in accordance with an agreed cost-sharing formula. The formula in the PP provided for AID's share of local costs to decline from 45 percent in 1981 to 20 percent in 1985.

#### I.6.1 Project Goal and Purpose

The sector goal of PP III was to reduce the population growth rate from an estimated 2.3 percent in 1980, with a population level of about 48 million, to an estimated 2.0 percent in 1985, with a population level of 53 million. This goal was intended to support the long-term goal in the GOP Five Year Development Plan of 1978-1982: achieving replacement fertility or a net reproductive rate (NRR) of 1.0 percent by the year 2000. (This long term goal is no longer considered feasible, and the current somewhat optimistic but feasible target is a growth rate of 2.0 percent by the year 2000.)

In order to achieve the goal, the end-of-project (1985) purpose of PP III was an increase in the contraceptive prevalence rate among married couples of reproductive age (MCRA), from 43 percent in 1980 to 53 percent in 1985, and an increase in contraceptive use effectiveness from 81 percent in 1980 to 83.5 percent in 1985. To achieve the purpose, the PP envisaged seven categories of coordinated population services, which formed the basis for the planned project outputs. They were:

- o In-place qualified management and field personnel to serve population family planning program needs;
- o Adequate public and private clinic support and services;
- o Effective IEC;
- o Effective, reliable contraceptive supplies available to practicing couples;
- o Timely and accurate measures of program progress and fertility reduction;
- o Completed and utilized operations, development and policy research; and
- o An MIS.

Although the project has achieved most of its expected outputs, it has fallen far short of meeting its purpose, and the sector is far short of the goal stated in the PP. This anomaly, which is a key finding of the evaluation, is analyzed in Chapter II below.

#### I.7 Other Donor Assistance

In addition to the World Bank contribution to the project (See Section I.6), there has been substantial other donor assistance to population activities during the life of PP III. It includes:

- o The GOP-IDA (International Development Association) Population II project (around \$40 million 1980-84, but extended) supports improved IEC manuals, training for program professionals, research implementation of pilot strategies, improved MIS, and noncontraceptive commodities. Nearly \$24 million of the project is administered by the Ministry of Health (MOH).
- o The GOP-UNFPA (United Nations Fund for Population Activities) Program (authorized at around \$20 million 1980-86) supported IEC, training, NGO activities, an improved vital registration system, injectable contraceptives, upgraded management and policy analysis, and integrated family planning in under-served areas in Metro

Manila. Only about \$4 million of the funds for the project were utilized. About half of the remainder was withdrawn by UNFPA due to budget constraints. The rest was not programmed by the Philippine government.

- o The ASEAN (Association of Southeast Asian Nations) Population Program (around \$1.5 million 1984-87) supports human resource development, research, policy studies and IEC.
- o The GOP-JICA (Japan International Cooperating Agency) Integrated Family Planning/Maternal Child Health (FP/MCH) Project (around \$3 million during 1981-86) is a pilot project testing improved community-based family planning and maternal and child health activities in Benguet and Luzon, providing commodities, training, and technical assistance.

The three major donor assistance activities for population--USAID, IDA and UNFPA--are all coming to an end at the same time. In recognition of this fact, AID initiated a proposal in 1985 for a coordinated donor plan for subsequent population assistance. The World Bank has taken the leadership role for the activity and sent a Bank mission and a special consultant to the Philippines to conduct preparatory analysis and to assist the government in preparing a five-year population, health, and nutrition (PHN) Plan. UNFPA has financed a detailed needs assessment and is preparing a draft third-country program for the Philippines. The GOP is currently preparing a five-year population, health and nutrition action plan entitled PHN-1. When completed, PHN-1 will form the basis for a formal request for further donor assistance. A donor round table on population and health is tentatively scheduled for late February, depending on the status and quality of the PHN-1 plan at that time.

## I.8 Constraints

The team sought to produce a comprehensive and objective report. Three factors intervened in the data gathering process, however.

The first related to Phase I of the evaluation, being conducted by UPCPA (see Section I.1). It was originally intended that Phase I would be completed in time for the results to be incorporated into this evaluation. That, however, was not possible. The two phases are running concurrently and the results will become available at the same time. This is unfortunate. The field review in this evaluation has necessarily been limited, and the findings are largely impressionistic. This aspect of the evaluation would have been far stronger if the Phase II team had been able to draw on the much more comprehensive field work of Phase I.

Second, while perhaps inevitable, we were not always certain that persons interviewed were able to be fully frank. For example, during our brief visits to the provinces, it was never possible for us to interview lower echelons of the delivery or outreach hierarchy without the presence of the higher echelons. When we talked with a Barangay Service Point Officer (BSPO),

we were always in the presence of a Full Time Outreach Worker (FTOW). When we talked with an FTOW, a City Population Officer (CPO) was always present. When we talked with a CPO or Mayor, the Regional Population Coordinator (RPC) was always present. The social structure of these interactions, as well as the shortage of time, undoubtedly had the effect of minimizing any problems of cooperation or communication, etc.

Third, we realize that, in the field, only a few individuals fully understood that we were independent reviewers and had no actual authority within the program. A misunderstanding of our function may have acted as another barrier to complete frankness. Even in our interviews in Manila, every individual and agency with whom we met had certain vested interests.

## II. OBSERVATIONS AND FINDINGS

The structure of this chapter conforms generally to the division into major activities in the original Project Paper for Population Planning III. It also conforms, although less precisely, to the activities of POPCOM's administrative divisions.

### II.1 Demographic Impact and Research

Measurement of program progress and research on policy and operations, two closely related activities, represent approximately three percent of the total budget of PP III. Of this amount, about one-fourth was funded by GOP and virtually all of the remainder was grant rather than loan funds.

It has been impossible to identify and/or to study all of the relevant research produced as part of the project. Policies and practices sometimes seem not to be based on earlier research, and to have built-in evaluation components, but there may be some research of which the team is unaware.

Some research findings that are not directly a part of PP III, but refer to the 1970s or earlier, have, however, been included.

#### II.1.1 Measurement of Program Progress

The specified purposes of the project were to increase the prevalence among MCRA's from 43 percent in 1980 to 53 percent by 1985 and the overall efficiency of the method mix from 81 percent in 1980 to 83.5 percent by 1985. The goal was to reduce the crude birth rate (CBR) from 32 per thousand in 1980 to 28 per thousand by 1985. It is clear from the program's own figures on prevalence that the 1985 prevalence and efficiency targets had not been reached. The targeted CBR also has not been reached, partly because prevalence remained at a low level and partly for other reasons, such as changes in the age structure and apparent declines in age at marriage and duration of breastfeeding.

This chapter offers some possible reasons why the targets were not met. The present discussion will be limited to technical considerations involving target specification and measurement.

##### II.1.1.1 Program Goal

II.1.1.1.1 Choice of Target Variables. The program goal was stated in terms of the crude birth rate (CBR). Initially, the CBR may seem the ideal measurement of the impact of a family planning program, but in fact it is inappropriate for several reasons. In particular, the CBR is sensitive to changes in the age structure.

Paradoxically, from 1975 to 1980 (based on the 1978 RPFS and the 1983 NDS) the CBR increased by five percent while at the same time the total fertility rate (TFR) declined by four percent. The CBR rose simply because the age distribution changed; in 1980 a higher proportion of the population

was in the most fertile ages. The change in the age distribution had no relevance to the program, and it is inappropriate to express the goal of the program in terms of a measure that is affected by completely extraneous changes. Moreover, the CBR is sensitive to changes in the proportion of women who are married. PP III was not specifically intended to affect this proportion, although delayed marriage has more recently become a component of the Responsible Parenthood campaign.

POPCOM has set forth another ultimate target, the achievement of a NRR of 1.0 by the year 2000. The NRR is a better measure than the CBR, but it has the disadvantage of depending upon the pattern of mortality up to age 45 as well as upon the age-specific fertility rates. Therefore it also involves a confounding of program and non-program variables.

The TFR is a cross-sectional indicator of completed fertility like the NRR, and it is not affected by mortality levels and changes. Since the TFR gives the total number of births (sons plus daughters) and the NRR is defined in terms of daughters only, the TFR is probably better understood by non-demographers.

Several research reports have presented values of the Total Marital Fertility Rate (TMFR). This rate is the average number of children that a woman would have if she survived to age 45 and was continuously married between ages 15 and 45, based on prevailing age-specific marital fertility. Marital fertility rates are definitely of program interest, but their sum, the TMFR, is not a useful indicator. The average age at marriage in the Philippines is around 23, and a starting value of 15 is completely artificial. This criticism of the TMFR was made in the PP II impact assessment, but with no apparent effect.

To sum up, the most appropriate cross-sectional measures of fertility to indicate the program's impact are the NRR and the TFR; of the two, the TFR, is preferable. In the Philippines, replacement level fertility corresponds to a TFR of approximately 2.2--that is, an average of slightly over two children per woman.

II.1.1.1.2 Specification and Achievement of Target Values. The project goal, to reduce the CBR from 32 in 1980 and 28 by 1985, was reasonable, based on data which were available at the time the project was implemented. It was believed at that time that the CBR had declined from 39 in 1970 to 35 in 1975. The figure of 32 for 1980 was essentially an extrapolation from the 1970 and 1975 estimates. Actually, taking the 1970 and 1975 figures at face value, it would have been reasonable to set a target even lower than 28 for 1985. The earlier trend implied that continuation of the previous program would be sufficient to reduce the CBR by four points in five years.

At this time, as PP III is nearly completed, there is still no estimate of the CBR which extends beyond the start of the project--although the 1980 estimate, which comes from the 1983 NDS, is actually a five-year rate for

1978-82, centered on 1980. The estimate of a CBR of 36 for 1980 can be interpreted in various ways, of which the following is preferable.

Analyses by the Population Institute, University of the Philippines (UPPI) (1985; original sources given therein) shows that during the 1970s there were steady demographic influences upon the CBR: (a) to decrease it by reductions in marital fertility, (b) to increase it by changes in the age structure; and (c) to increase it by changes in the marriage pattern. If one sets aside the 1978 Republic of the Philippines Fertility Survey (RPFS) and looks only at the estimates for 1970 and 1980 based on the 1973 NDS and 1983 NDS, then the components of change are as follows:

- (a) decline of 7.4 points due to marital fertility
  - (b) increase of 2.7 points due to age structure
  - (c) increase of 1.8 points due to marriage pattern
- Net decline of 2.9 points.

Given that marital fertility has been the sole target of the program, at least until very recently, it is noteworthy that the CBR declined by an average of about three-quarters of a point per year throughout the 1970s as a whole. (The allocation of this decline to the first or last part of the decade is indeed problematic.) In this sense, a decline of approximately four points in five years did hold. During the same 10-year interval, the TFR, which is unaffected by non-program demographic changes, declined from 5.9 to 5.0, or by 15 percent.

This review of the specification of goal target value is summarized in two points. First, the target that was set will be impossible to assess until several years after the project ends. Second, the target was set without any recognition of the role of non-program factors. In view of these considerations, a certain amount of frustration and uncertainty over program progress was inevitable.

#### 11.1.1.2 Project Purpose

11.1.1.2.1 Choice of Target Variables. The project purpose was stated in terms of two variables: contraceptive prevalence, and the mean use-effectiveness or efficacy of the method mix. Prevalence is a cross-sectional measure: the percentage of MCRA's using any method, program or non-program.

Prevalence is a desirable indicator of program performance in the sense that it measures current or continuing use (i.e. stocks, rather than flows of users), which will have an impact on the number of births. On the other hand, there are some ways in which prevalence is an inadequate measure.

Prevalence is a crude rate, as is the CBR, and it is subject to compositional distortion. For example, it was observed above that the CBR apparently rose by five percent from 1975 to 1980 because the age composition became increasingly dominated by the age groups of young, highly fertile women.

Although this observation does not appear in local analyses, it is almost certain that the same age shift also served to depress the prevalence rates. Those age groups with high fertility are clearly the age groups with low prevalence. Therefore the main measure of program performance is subject to compositional effects which are completely outside the scope of the program.

The relationship between age and contraception has further importance, however, because the number of births averted by a year of continuous use, say, depends very much upon a woman's age. The 1975 and 1980 age-specific marital fertility rates show a steady and nearly linear decline in fertility with age (after 20-24). A married woman aged 15-19 or 20-24 will expect approximately .41 births per year; by ages 40-44 she can expect less than one-fourth that number, only .09 births. Yet the prevalence figures (and the new acceptor figures) produced by the program do not differentiate by age and the expected demographic impact. Program officers and workers at all levels should recognize that the age mix of users is far more important than the method mix.

Other weaknesses, or at least potential reasons for slippage between the specified program purpose and goal, concern the method mix. A major question is the following: Why is prevalence calculated to include non-program methods? There is a paradox in present practice. A traditional non-clinical method, rhythm (without temperature charts), is regularly included in prevalence measures and is recognized as a valid method in BSPO records, etc.; but at the same time the program does not support this method. It would be more consistent simply to include program methods in the prevalence measures. If the more sophisticated form of Natural Family Planning (NFP) is given a significant place in the program, as it should be, then it should be included in the prevalence figure.

One reason for this concern is that the 1978 RPFS, the source of the prevalence estimates for 1978 and the fertility estimates for 1975, has been widely quoted as showing that prevalence was 37 percent in 1978. The 1983 NDS showed a corresponding figure of only 32 percent, implying a decline of five percentage points during an interval of time when an increase would have been expected. The overall prevalence for 1973, taken from the 1973 NDS, was 23 percent. The estimate of 43 percent in 1980 was then based on an extrapolation of the 1973 and 1978 results. Closer comparison of the three surveys, with a restriction to program methods, tells quite a different story. There was actually a monotonic increase in the prevalence of program methods. With a further restriction to modern program methods, this increase was even more conspicuous. For example, in 1973 only one percent of MCRAs were sterilized. In 1978 the percentage was five percent and in 1983 it was 10 percent.

There are reasons to believe that the 1978 RPFS was somewhat misleading. First, as a part of the international program of the World Fertility Survey, its definition of marital status was broader than that used in the NDS sequence, which may account for the low fertility estimates for 1975. Second, RPFS questions on contraception were worded differently from those of the NDS, and may have brought in users of traditional, non-program

methods. The comparability of the full sequence of surveys is a subject of current research at UPPI. It seems likely, however, that when comparability is established, it will become apparent that changes in fertility from 1975 to 1980, and in prevalence from 1978 to 1983, were a monotonic, though slackening, continuation of the earlier trend.

It is important to emphasize that the only component of prevalence that should matter for program monitoring is the prevalence of program methods. Again, it is clear that if attention is restricted to program methods, the surveys show monotonic increases in prevalence.

In summary, the specification of the project's purpose, and certainly the analysis of improvements in contraceptive use, must be sensitive to the effect of age structure on a crude rate; to the fact that the demographic impact of contraceptive use depends much more on the age of the user than upon the method used; and to the distinction between program and non-program methods.

II.1.1.2.2 Specification and Achievement of Target Values. The targeted increase in prevalence, from an estimated 43 percent in 1980 to a goal of 53 percent in 1985, was apparently derived by an extrapolation of earlier trends, as mentioned above. At the time the project purpose was specified, it was believed that overall prevalence of program and non-program methods combined was 23 percent in 1973 and 37 percent in 1978. Exactly as with the specification of the program goal, the starting figure for 1980 was an extrapolation of earlier figures and the 1985 target was a further but more conservative extrapolation. As with the program goal, non-program factors and components of change were completely overlooked. As with the program goal, no reliable mechanism for monitoring progress was instituted. At this point there is only one solid estimate of prevalence within the project period: 26.5 percent for program methods and an additional 5.6 percent for non-program methods in 1983. Across the full 1973 to 1983 interval, the prevalence of program methods rose by about one percent per year. Applying the simple logic of extrapolation that appears to have been used to specify the prevalence target, one can project that the prevalence of program methods will be 30.0 percent by the end of 1986, when PP III ends.

### II.1.1.3 Field Targets

II.1.1.3.1 Choice of Target Variables. Largely because prevalence is difficult to assess without a special survey, record-keeping at all levels has been oriented around the notion of "new acceptors" (NAs). A person is counted as a new acceptor if he or she switches to a markedly more effective method, i.e. shifts upward in the hierarchy of traditional rhythm; modern rhythm (with basal body temperature or mucous checks) or condom; injectable, pill, or IUD (RCM, or reversible clinical methods); bilateral tubal ligation (BTL) or vasectomy (together referred to as VSS, or voluntary surgical sterilization). A person will also be a new acceptor, of course, if he or she is a genuine first-time user of any of these methods, and also if he or she transfers to another clinic or starts a new interval of use after an

interval of non-use. Targets have been established separately for the VSS and RCM groups of methods. These have been set at the national level as 1.8 percent and 8.0 percent respectively, of all MCRAs, for 1985, for example. These same percentages are applied to all subpopulations of MCRAs down to the barangay level. Later the report will comment on the specification of the target values, but the first concern is with the choice of measure.

Counts of new acceptors are a measure of incidence, rather than prevalence: of flows rather than stocks. Fertility, however, is dependent on the volume of exposure to the risk of conception or, conversely, on the volume of continuous protection from conception. There is a formal linkage between prevalence and fertility, but no such link between new acceptors and fertility, unless important assumptions are made about continuation of use.

The several definitions of "new acceptor," which go far beyond the simple "first-time acceptor," are motivated mainly by ease of application in the field. The records of FTOWs and BSPOs do not distinguish between the different categories of NAs. It is important to recognize all these types of NAs and to give field workers credit for inducing the use of a more effective method and the return to use after a period of non-use. If a woman switches to another clinic, then it is important to recognize that the records become the responsibility of the new clinic.

The linkage of NA counts to prevalence, let alone to fertility, however, is very difficult to establish. It is possible for an MCRA to be counted as an NA several times within a single year if the couple switches methods, or over the course of two or three years by interruptions in use and perhaps by intervening pregnancies. It is only the VSS acceptances that have an assured long-term and continuous effect. The reversible methods are promoted mainly for birth spacing rather than for termination of childbearing. Therefore, an interval of RCM use can intentionally range anywhere from several months to several years.

The stated upper age limit of the program is 45. Field observations, however, showed that women were included as NAs beyond age 45 as long as they were pre-menopausal. Women approaching or past age 45 were sometimes counted as new BTL acceptors. Certainly, BTL should be available to such women, but the demographic impact of their acceptance will be negligible.

In summary, the setting of understandable targets at the field is a very positive step. The separation of VSS and RCM targets is also a very positive advance.

II.1.1.3.2 Specification and Achievement of Target Values. As already observed, the link between new acceptors (the field target), prevalence (the project purpose), and the CBR (the program goal) is unclear. There is essentially, if perhaps not in detail, however, a compatibility between the following:

- (a) the POPCOM objective of an NRR of 1.0 by the year 2000;

- (b) the annual increase of two points per year in prevalence during the project period, as specified in the original PP III proposal;
- (c) The "high scenario" targets for new acceptors developed by John Laing, which is used for setting new acceptor targets at the field level.

Laing (see Bibliography) developed three scenarios. His "middle scenario" corresponded roughly to observed rates of acceptance up to 1983 and was essentially regarded by him to be a reasonable and achievable target. The "high scenario" trajectory of acceptance was adopted by POPCOM, however, because it was consistent with a NRR of 1.0 by the year 2000. In other words, Laing developed his middle scenario by a "bottom up" logic, picking up from current acceptance levels and increasing them annually by what he judged to be a reasonable amount, in view of program activity. His high scenario was the one selected by POPCOM, using "top down" logic, that is, based on its end result rather than on evidence that it could be attained.

The high scenario target is a trajectory that increases annually and takes account of turnover on the MCRA population due to marriage, death, menopause, etc. For 1985, the targeted number of new acceptors (VSS and RCM, including improved NFP) was 10 percent of the estimated number of MCRAs. This total is allocated across categories in specified amounts: 18.6 percent to VSS, 81.4 percent to RCM and improved NFP.

Even allowing for multiple counting of new acceptors and turnover in the MCRA population, this is an ambitious target. If attained, and if reasonable assumptions about continuation of RCM and NFP were made, then prevalence could increase by at least the two points per year indicated in the PP.

POPCOM figures suggest that in 1985 the overall performance or accomplishment of the high scenario target was 47 percent. For the first two quarters of 1985, the number of VSS acceptors was 66 percent of the target (the annual target scaled down to six months) and the number of RCM acceptors was 42 percent of the target.

Adoption of the high scenario target (as a target, rather than as an achievement) has some positive and negative implications. First, the positive implications. Field observations showed that a high target has typically induced greater productivity and efficiency, although the lack of good before and after data makes this a difficult assertion to substantiate. Officers and workers at all levels know their targets, take them seriously as a measure of job performance, and take real pride in achieving one or another of their targets. The motivational value of the targets would probably be reduced if they were easier to reach. Since they are occasionally achieved, they are apparently taken more seriously than if they were wholly unattainable.

There are three hazards, however, attached to the use of the high scenario. The first is in the field. There is undoubtedly some tendency to sacrifice quality for quantity. Thus, if an FTOW has a target of 15 new

acceptors each month, there is a motivation for her to recruit "easier" MCRAs--older, high parity women instead of younger, lower parity women--or for her to settle for the use of an easier method.

A second hazard is that poor performance in an area whose population is genuinely less receptive to family planning can be demoralizing for staff and can lead to disciplinary actions that are counterproductive. The central and regional offices of POPCOM must realize that recruitment is genuinely more difficult in some areas than in others, and must take this into account in their interpretation of low performance.

It is conceivable that a procedure could be developed to adjust targets at the local level, taking account of local variations in socio-economic measures. At this time, however, this is not a recommendation.

A third hazard of using the high scenario target is that external agencies may use poor performance, relative to the target, as evidence of ineffectiveness. For example, an NGO can employ a bottom up procedure for setting targets and then cite higher performance relative to this target than POPCOM can cite relative to the high scenario. Comparisons of this sort are more accurate if expressed in the same terms, e.g. as acceptors per worker, rather than as percentage of target accomplished.

## II.1.2 Demographic Data Collection

In countries that lack a complete and reliable system of vital registration, population changes of any kind are difficult to monitor. The Philippines is one of many countries with incomplete registration, despite long-term efforts to improve the situation. (In one health clinic the team visited, provincial birth registration figures were prominently posted, with the implication that the provincial birth rate was at least one-third below the national average. This claim was clearly unjustified.)

Large-scale sample surveys are the only reliable source of estimates of contraceptive prevalence and fertility in the Philippines. The record of successfully conducting and analyzing such surveys has been excellent. Two large surveys were conducted shortly before PP III began: the 1978 RPFS and the 1980 Community Outreach Survey (COS). Two other surveys have been or will be conducted during the course of PP III: the 1983 NDS and the 1986 Contraceptive Prevalence Survey (CPS).

These surveys have been well documented and their findings are readily available (except, of course, for the 1986 CPS, which is still in the final planning stages). The purpose of this evaluation is not to review findings, but to assess the relevance and value of the surveys for PP III and to present issues which affect the implementation of data collections and analysis.

II.1.2.1 The 1983 National Demographic Survey (NDS). The 1983 NDS and both surveys mentioned above were conducted by UPPI as were two earlier NDSs

(1968 and 1973). The 1978 RPFS was analyzed primarily by UPPI staff but its field work was done by NCSO.

The methodology and sample design of the 1983 NDS were more similar to the earlier NDSs than to the RPFS, and there is some concern about the continuity of the full sequence of surveys--especially the 1973-1978-1983 comparison. Fortunately, a synthesis of these surveys is now under way. As a source of information about prevalence and fertility and also about marriage patterns and breastfeeding, the 1983 NDS was of excellent quality. The analyses the team has seen are also of good quality and are sometimes excellent.

UPPI is a valuable resource for POPCOM, as is its companion private foundation, the Demographic Research and Development Foundation (DRDF). Unfortunately, cooperation between UPPI and POPCOM has not been ideal. POPCOM (and USAID) staff tend not to appreciate the complexities of data processing and analysis, and the UPPI staff tend not to appreciate the importance of quick and clear reporting of the main findings, especially as they may affect program operations. This is mentioned in connection with the 1983 NDS, because its analysis well illustrates these tensions.

UPPI produced a "quick report" on the 1983 NDS about six months after the field work was completed. This was the first time a quick report was produced, and it should become a standard of future surveys. Well over two years after the field work, however, a "main report" was still not completed. This long interval suggests that the entire reporting procedure for future large surveys needs to be restructured. The modifications cannot be proposed in detail in this document, but they depend fundamentally on an appreciation by POPCOM and its donor agencies, including USAID, that computer processing of demographic data is genuinely complex and that if it is transferred to less experienced contractors, the delays will be even greater.

An improvement in reporting speed will also require some modifications in the priorities of UPPI staff to ensure that they recognize the distinction between basic and applied research and prioritize their analysis plans in terms of topics and production deadlines in close cooperation with POPCOM. A key role in this process is played by Dr. Mercedes Concepcion, who is technical adviser to POPCOM as well as a member of the staff of UPPI and DRDF.

II.1.2.2 The 1986 Contraceptive Prevalence Survey (CPS). Discussion of this planned survey will continue to focus on issues of priorities, reporting and management. The present plans clearly show that the tensions remarked above are liable to recur.

The team reviewed the proposal for the 1986 CPS and the draft questionnaires, and talked with some UPPI staff and with Dr. Laing. There are several concerns. First, the sample size of 26,000 households and an estimated 18,200 MCRA is unnecessarily large and will produce serious field management and data processing problems. The sample size is approximately twice that of the 1983 NDS. Second, the questionnaire is very long, inviting delays in the field, in data entry and in editing of data. Complete birth and

marriage histories are to be obtained, as well as month-by-month details on use of specific methods, breastfeeding, and amenorrhea since January 1983.

The size of the sample and the length of the questionnaire are motivated by a desire to produce continuation rates for each method within each region. The need for such detail is questionable. Also, the computer software to calculate these continuation rates is not available and the budget does not include funds to produce this software.

Of at least as much concern as the ambitiousness of the survey is the claim by POPCOM that it will take over the analysis at the beginning of 1987, when PP III ends. The team does not support this plan--although there is indeed a question about funding sources beyond PP III. POPCOM has a shortage of research staff, and the staff's first priority should continue to be the new MIS. If POPCOM is frustrated by the delays and priorities of UPPI, it would be advised to negotiate with UPPI (and/or DRDF) rather than to try to carry out this highly specialized work itself.

In any case, the forthcoming CPS will be extremely important as a source of program feedback. The records kept at the BSPO and clinic levels are important for counts of new acceptors, but they do not produce credible prevalence levels. In the long run, the new MIS procedures may be able to meet this need, but there is no viable alternative to a sequence of alternating NDSs and CPSs.

There are conflicting reports about plans for future surveys.

### II.1.3 Research on Operations and Policies

II.1.3.1 The 1984 KAPS Survey of Program Professionals. A survey of the knowledge, attitudes, practices, and skills (KAPS) for family planning professionals was conducted in 1984. A lengthy report was prepared by Mrs. I. Z. Feranil of UPPI. Some findings will be discussed later in this report in connection with service delivery (Section II.2).

Of the components measured by this survey, some of the attitudes have special interest. One of these is a technological or supply orientation to population work. In the Philippines, "family planning" itself is a term that appears to emphasize the technology of contraception (although, of course, the term has its origin in an effort to draw attention away from contraception or birth control). "This KAPS survey also noted the tendency for program professionals to define population as merely family planning work.... Population activities appear to be merely family planning acceptance and are not viewed in the wider context of family welfare." (Feranil, p. 74). This view corresponds closely with observation in the field, although it is contrary to central POPCOM intentions. Also of interest was the finding that only about one-quarter of professionals (excluding persons at the CPO level or above) wanted as few as two children. The mean desired family size for FTOWs and BSPOs is about three children. This is about a full child less than the national average, but it is still about a full child above replacement.

II.1.3.2 Other Research on Operations and Policies. Certain changes in operations are under way or have been planned for the near future. These do not appear to have been preceded by feasibility studies or pilot projects.

Greater involvement by local government has been a keystone of PP III, and in many areas it is proceeding very smoothly. Several mayors and local government officials, however, stated in very strong terms that it would be impossible to absorb totally the costs of outreach--that is, the salaries of all FTOWs. In some areas the density of FTOWs has already been cut in half. Also there are inherent management problems if FTOWs are paid at the local level but have responsibilities that are set at the national or regional level.

Although considerable planning went into the effort, there is apparently no research or reference to research on the possible negative consequences of this change. It might have been desirable to develop a formula for the rate of local absorption of FTOW salaries, based on the resources of the city or municipality. There are indeed variations in the rate of absorption, but they do not seem to follow a prescribed pattern. Other issues are discussed elsewhere in this report (See Section II.2); the point here is that there was a "top down" approach with inadequate assessment of local circumstances.

Another example of a top down policy has been the Cost Recovery Scheme (CRS) for pills and condoms. Again, the issues are discussed elsewhere (See Section II.4.2). There is no evidence that any effort was made to determine the impact a change in cost would have upon demand. In various ways, the scheme is contrary to the general program emphasis on making contraception more readily available.

A third program change which has not included a research component is the new MIS. There was apparently no pilot study to identify possible problems with implementation in the field.

Studies to pre-test these changes would not have been easy to design, but there are numerous independent and well-qualified groups, such as the U.P. College of Public Administration, College of Economics, and other consultants who could have been approached for advice.

## II.2 Service Delivery

### II.2.1 The Outreach System

In the nationwide outreach program developed by POPCOM with USAID's strong involvement in 1976, and implemented with AID support in 1977, the fundamental concept was to provide single-purpose, FTOWs at an approximate ratio of one per 2000 MCRAs in the rural areas. Each FTOW was expected to recruit, train and supervise approximately 20 volunteer BSPOs. The FTOWs and BSPOs are expected to generate demand for family planning service through IEC and motivational activities in their catchment areas. With support from the

FTOW, the BSPO resupplies oral contraceptives and condoms to continuing users and serves as the source of information, motivation and referral of NAs to the clinic for IUD insertions, sterilization, or for RCM. Each BSPO, with FTOW assistance, maintains an ongoing record of MCRA's and current contraceptive users within her respective catchment area, and is expected to make home visits and follow-ups. FTOWs are responsible for collection of data on acceptors from their respective BSPOs, reconciling these data with clinic records and submitting reports.

Traditional birth attendants (TBAs) number some 43,000 throughout the country and attend to over 60 percent of births in rural areas. Most TBAs have received formal training from the RHU or work closely with RHU midwives. Currently, the MOH trains some 500 TBAs annually.

This community-based outreach system is backed up and supported by a nationwide service delivery network of public and private clinics, industrial clinics, static and itinerant sterilization teams, and the commercial sector. These agencies also provide family planning services to the approximately 50 percent of the married couples of reproductive age (MCRA's) located in urban areas and elsewhere, who are not living in areas served by the Outreach program.

The FTOWs are supervised by a national network of regional, provincial, city, and district population officers. The 13 Regional Population Officers are POPCOM employees and manage the regional POPCOM offices (one in each of the 12 geographic regions, plus the National Capital Region). Each regional office has a staff of 27 regular and 10 casual employees. They are responsible for the full range of POPCOM activities in the region, including technical direction of the outreach program, storage and supply of contraceptives, the development and distribution of IEC materials, control of funds and MIS reporting. All personnel below the regional office level are local government (i.e. provincial or city) employees and serve under the administrative direction of the local government.

The outreach program and related training activities are by far the largest component of PP III and POPCOM's activities. They involve over 80 percent of the salaried personnel and a major part of the total costs. Outreach and Human Resources Development (HRD) represented 46 percent of total costs and 63 percent of local currency costs in the PP; the comparable percentages for estimated actual life of project costs are 52 and 65 percent respectively. In the comparison of actual costs with adjusted PP cost estimates, the Outreach/HRD component had the second lowest percentage shortfall. This probably reflects the fact that Outreach costs are primarily salaries, which are relatively inflexible, even in times of budget stringency.

The PP provided that USAID's share of all local costs, including Outreach, would decline from 45 to 20 percent by 1985. Within this changing ratio, local governments were to assume an increasing share of Outreach costs. In some regions the objective was to have all salaries paid by the local government by the end of the project, with POPCOM continuing to fund FTOW travel allowances and other administrative costs.

Table II.2-1 gives the relative shares of total Outreach/HRD costs and Outreach salaries, by year, from 1981 through 1985. In the second part of the table the total local government contribution is attributed to salaries, although, in fact, it includes a share of other costs as well. The table shows that USAID's share of both total costs and salaries had declined to 20 percent or less by 1985, as provided in the PP. This percentage share is maintained in the budget for 1986.

The table also shows that the local government share of total costs has increased from 16.3 percent to 35.9 percent over the five-year period, and the share of salaries has increased from 30.6 to 81.6 percent. (Local government contributions are slightly understated, because one or two regions did not report their contributions in some years.) However, in absolute terms, the

TABLE II.2-1

Share of Outreach Costs--By Year

Year	Total Costs	(Expenditures--P00)					
		Pesos	%	Pesos	%	Pesos	%
1981	56,099	25,413	45.3	9,165	16.3	21,520	38.4
1982	54,691	25,355	46.4	11,423	20.9	17,913	32.7
1983	55,366	15,079	27.2	13,841	25.0	26,446	47.8
1984	46,983	20,133	42.9	14,933	31.8	11,918	25.3
1985	36,697	15,695	42.8	14,263*	38.9	6,739	18.3
<u>Salaries</u>							
1981	29,952	7,308	24.4	9,165	30.6	13,478	45.0
1982	28,214	5,505	19.5	11,423	40.5	11,285	40.0
1983	29,299	3,738	12.8	13,841	47.2	11,720	40.0
1984	24,052	1,903	7.9	14,933	62.1	7,216	30.0
1985	17,481	--	--	14,263*	(81.6)	3,496	20.0

\*Estimate

SOURCE: POPCOM Financial Records

local governments' contributions declined slightly from 1984 to 1985. The apparent increase in their percent share is a result of personnel reductions,

with resultant lower total salary costs, rather than increasing contributions. These reductions in FTOWs and other salaried personnel have apparently not been made as part of a deliberate management plan. Rather, they have been made by the local governments in anticipation of reduced USAID support, with the ensuing pressure for them to assume the full costs of the Outreach salaries. (For example, Angeles City in Region III agreed to assume 100 percent of Outreach salary costs in 1986, but achieved this by reducing the number of FTOWs by 50 percent at the end of 1985.)

Table II.2-2 compares local government commitments for Outreach costs with their actual contributions. The actual amounts have consistently fallen short of commitments and the gap has widened in the last three years, as commitments have increased and actual contributions have remained essentially stable.

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Table II.2-2

Local Government Contributions--Actual vs. Commitment  
(P000)

	<u>1981</u>	<u>1982</u>	<u>1983</u>	<u>1984</u>	<u>1985</u>
Commitment	14,769	18,074	25,961	31,994	37,208
Actual Contribution	9,165	11,423	13,841	14,933	14,263
Actual as % of Commitment	62.1	63.2	53.3	46.7	38.3

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\* Estimate

Note: Actual contributions are under-reported in some years

Source: POPCOM Financial Records

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Table II.2-3 shows the total number of Outreach personnel at the end of 1981 and 1985, and the POPCOM forecast for 1987. The table clearly reflects the progressive decline in the number of Outreach personnel. The decline in District Population Officers (DPOs) and the projected change to a smaller number of technical assistants in 1987 is more a conscious management decision than a response to financial pressures. There appears to be a consensus among program personnel that the DPOs have not been as effective as originally expected and that an alternative form of intermediate management is needed. The forecast total reduction of salaried personnel from 1985 to 1987, however, is 18.1 percent, essentially the same reduction that will occur in total outreach funding in 1987, if the USAID contribution is not replaced by an equivalent amount of GOP funds.

Centrally-funded resources from USAID were a major source of funding for NGOs, but this support was reduced when a large bilateral program was instituted in the Philippines, and in the past 10 years USAID support has focused primarily on the government. Historically, AID/W centrally-funded grants and contracts have been a source of funds to test the application of new technology. The commercial sector has no interest in making efforts to expand its contraceptive sales as long as it has to compete with a free government contraceptive program.

Table II.2-3

Number of Outreach Personnel by Category, By Year

<u>Category of Personnel</u>	<u>1981</u>	<u>1985</u>	<u>1987</u>
<u>Salaried Personnel</u>			
Provincial/City Population Officers	145	157	129
District Population Officers	434	324	-
Technical Assistants	-	-	132
FTOWs	2,820	2,250	1,975
Subtotal -- Salaried Personnel	3,399	2,731	2,236
BSPOs	50,964	51,169	52,000

II.2.2 Findings

In the areas the team visited, coordination at the local and regional levels of the Outreach program was quite good. Effective institutional arrangements, the sense of commitment, and good interpersonal relations between personnel of the regional, provincial, and municipal levels are the main ingredients for good coordination. The attitudes toward and degree of understanding of the population problem among governors and local officials ranged from seemingly complete non-interest to strong support; in the majority of cases there was positive concern. Likewise, the quality of POPCOM leadership at the regional, provincial, municipal and city levels varied. Generally, however, most had the initiative, enthusiasm and drive to bring about interagency cooperation in support of Outreach, maintain the morale of field workers, and attempt to meet program targets. Several POPCOM staff members went to considerable effort to devise innovative community incentives for FTOWs, BSPOs and satisfied acceptors, particularly income-generating projects such as raising pigs, planting fruit trees with commercial

possibilities, handicrafts, etc. In the case of handicrafts, marketing was a problem.

There seemed to be no major problem in coordination between Outreach and clinic personnel in MOH or private clinics. Interpersonal relationships between FTOWs and clinic personnel appeared to be cooperative and congenial.

Starting some type of dialogue with local Catholic Church officials remains a goal of most POPCOM regional offices. A policy of non-provocation has enabled Outreach to push its activities to varying degrees of success even in areas where the Church has a strong community influence. In Region VIII, IEC efforts have had some success in obtaining the open support of the Church: a bishop's picture appears on a family planning calendar endorsing responsible parenthood.

The Outreach workers, both FTOWs and the BSPOs, are indispensable as motivational and service delivery agents. While there is general agreement that an integrated health, family planning and nutrition function would be a theoretical ideal, the current staffing and supervision problems of complex integrated structures such as that of MOH preclude the effectiveness of multi-purpose outreach workers, especially volunteers. Maintaining the motivation of BHWs is a major problem. About 20 percent drop out each year for the following reasons: (a) BHWs receive only a few days of pre-service training and no in-service refresher training, therefore they often do not have a clear idea of their roles; (b) lack of basic supplies further reduces their effectiveness and credibility; and (c) supervision, in terms of professional help and moral support, is irregular.

While PHC has been permanently integrated into the MOH program since 1979, the focus of the health care system still appears to be curative, as evidenced in the workload and priorities of RHU and BHS midwives, which greatly affects their supervisory functions over DHWs. A World Bank report notes that in the 1980 MOH study in Bohol Province, midwives spent all morning in the clinic, and much of their home-visit time is used to follow up clinic cases. Preventive health work focuses first on environmental sanitation. Nutrition and health education were not top priorities. Family planning motivation was given least emphasis, as evidenced by the low number of acceptors and the fact that BHWs mentioned this activity last or not at all when asked to describe their jobs. Also, in its field visits, the team was informed that family planning IEC efforts in one city were more effective when POPCOM personnel went on their own rather than when they linked up with health and nutrition field teams. Apparently when they worked as an integrated group, audiences were more concerned with medicines and health problems and had little interest in family planning information.

The team observed several instances where BSPOs claimed to be multipurpose workers, but there was no way of gauging how effective they were in all these roles, or how well each role was served. If family planning activities are served, it is because FTOWs are there with the sole function of supervising FP efforts.

FTOWs are mostly women in their late 20s to early 40s, all college graduates. BSPOs are older housewives, ranging from the mid-30s through 50s; the younger ones often having had some high school education. In general BSPO volunteers are articulate, enthusiastic, hardworking, and appear to take their work seriously. They seem to work well among themselves, with clinic personnel, and with POPCOM.

The BSPOs are important motivators as well as suppliers of contraceptives. In many cases, the BSPO is a multipurpose health worker--she is also a BIW and/or Nutrition Scholar--in addition to being a housewife. These multipurpose workers appear to have no problem performing their multiple functions since health and nutrition activities become the entry point for family planning motivation. They tend herbs to give to clients in their area; keep weekly records of common emergencies and illnesses; weigh babies and provide nutrition advice; motivate clients for family planning; resupply continuing users; bring clients for VSS; and supposedly keep a listing of MCRAs in their catchment area. According to the FTOWs and the BSPOs, this listing of MCRAs is updated yearly. Additions are made on the basis of birth and premarital counseling records.

Comprehensive data on drop-out rates of BSPOs are unavailable. The Zamboanga City CPO estimates its BSPO attrition rate at three per quarter. The major reason for dropping out is lack of incentives. For instance, some BSPOs expressed the desire for some financial incentive for resupplying pills. FPOP personnel receive P0.50 out of each P7 worth of pills.

Outreach workers are not always given credit in evaluation reports for their motivational efforts. Often Outreach workers have no identity; they are mistaken as clinic midwives or nurses. This may partly explain the finding in the 1983 NDS that only about eight percent of all users receive services from population Outreach workers.

FTOWs want to be identified as local government employees rather than as POPCOM employees. As such they would be paid out of local government funds and be entitled to local government benefits. This arrangement is currently implemented among those local governments that have absorbed all the recurrent costs of Outreach. In some municipalities all FTOWs hired by the program were absorbed by local governments; in others, however, the number of FTOWs was reduced when local governments were required to assume additional Outreach costs.

Variations in FTOW salaries depend on the degree to which their salaries have been absorbed by local government and the length of their service. Local governments do not always adhere to POPCOM salary guidelines, granting better pay to their FTOWs when they can afford it. In the early stage of the Outreach program many FTOWs were primarily teachers or nurses who became FTOWs because of better pay. As the salary scales of teachers and nurses improved, however, FTOWs have dropped out of Outreach to return to their former jobs.

Typically, FTOW salaries are approximately P1,000 per month, depending on length of service. In addition, the FTOW receives a transportation allowance of around P300 and a living allowance of around P350 per month. In some areas, FTOWs do not get any living allowance. In some cases, the transportation allowance is prorated, depending on the number of new acceptors generated by the FTOW.

Incentive schemes for BSPO volunteers vary according to the commitment of the community leadership to family planning. BSPOs may receive only the minimum incentives provided by the national program--term insurance, umbrellas, and T-shirts--or they may receive considerably more: a transportation reimbursement when bringing clients to the clinic; umbrellas, for the first seven VSS acceptors, then P100 worth of groceries for the next five and P50 worth of groceries for every subsequent five; encouragement to participate in income-generating projects; organization into BSPO community associations; awards, etc. The utilization of volunteers varies among different local governments. In some places, BSPOs may even receive honoraria. Incentives of one kind or another clearly contribute tremendously to boosting initiative, drive and commitment among all levels of personnel in the Outreach program, but especially so among unpaid grassroots workers.

An October 1985 study by Feranil, "An Analysis of the Results of the KAPS Survey of Population Program Professionals," provides some data on characteristics, knowledge, attitudes and behavior of field and clinic personnel, which may serve as an indirect gauge for assessing effectiveness.

- a) The majority of outreach and clinic workers are female, young, high school or college trained, currently married, and participants in community activities.
- b) Most FTOWs and BSPOs started their population-related work between 1975 and 1979; clinic workers have been in their current positions since the early 70s.
- c) Both FTOWs and BSPOs see field-related activities and motivations as their most important population-related work; clinic workers stress motivation and service delivery. FTOWs also see the management of BSPOs and IEC activities as primary roles, while BSPOs emphasize control of contraceptive supplies. Thus there appears to be a general congruence between activities expected of these workers and the activities they actually perform and consider important.
- d) About one of every four program professionals interviewed indicated they do not perceive any population problem in the areas where they operate. This is particularly true of BSPOs and FTOWs, clinic as well as non-clinic field personnel. Most perceive the population problem at the national level but could not conceptualize it at the local level. The survey also noted that large proportions of BSPOs, FTOWs and clinic and non-clinic personnel see their population activities as merely family planning acceptance rather than part of the wider context of

family welfare. This tendency to confine family planning to the control aspects was more prevalent among field staff from remote areas than among those at hospitals or clinics in major cities.

- e) Among actual field operations personnel, relatively larger proportions (12 percent among FTOWs and BSPOs and about 10 percent among clinic and non-clinic personnel) do not favor the integration of family planning into a wide variety of social and economic services. The predominant reason given was fear that family planning would not receive full attention as a needed priority relative to other services.
- f) Eighty percent of BSPOs and 76 percent of non-clinic workers are opposed to providing family planning supplies to unmarried adults who may ask for such services. FTOWs and BSPOs objected for moral reasons, and because they felt they had not been trained to serve the needs of this group.
- g) Nearly all field personnel have attended at least one course in population training. Training for field staff appears to have concentrated on family planning technology and service delivery, and some management skills. Except for FTOWs, the field staff appear to have little training in community organization. The BSPOs registered the lowest proportion of training on topics that include the Philippine population problem, implications and development concerns, etc.
- h) Most outreach and clinic workers believe that the National Population Program has a guideline on the desired number of children; the majority think it is three children, although many think it is two or four.
- i) While the pill was the most preferred effective method overall, a majority (about 56 percent) of ever-married program professionals had never used pills themselves. Among the field staff, the proportion of never-users was highest among non-clinic workers and lowest for the BSPOs. Among the current pill users, the BSPOs were the largest proportion of users (about 14 percent).

One in five of the program professionals or their spouses had been ligated; as had about 30 percent of the BSPOs. In contrast, only about two percent of field workers or their spouses were ligated.

Rhythm was the most popular contraceptive among all program professionals. Three out of every five who were asked about rhythm had tried it.

### II.2.3 Clinic Services

II.2.3.1 Government Services. The Ministry of Health (MOH), through its primary health care program, is the major provider of clinic-based family planning services. Its family planning program is implemented through the National Family Planning Office (NFPO), which has a staff of around 45 and is

largely concerned with training MOH personnel at various operational levels, and with organizing community-based outreach activities. Actual delivery of family planning services is done through hospitals, clinics, Rural Health Units (RHU), and Barangay Health Stations (BHS). In January 1983, the MOH implemented a decentralization program through which Regional Health Offices (RHO) were given authority over all hospitals and medical services in their areas, except a few specialized services. Within each region, a Regional Field Assistance Unit coordinates family planning and provides logistical and technical support for family planning activities of MOH staff at the provincial health offices and RHUs. Family planning is integrated into the health delivery system at each level as a major component of maternal and child health. The two lowest levels, the Rural Health Units and the Barangay Health Stations, provide free family planning services similar to those provided by the POPCOM Outreach program.

Each RHU serves some 20,000 to 30,000 persons. It is headed by a municipal health officer, who is assisted by a public health nurse, a sanitary inspector, some four to five midwives, and sometimes a dentist. The family planning services include counseling on available birth control measures, providing contraceptives, and referring clients to a physician for clinical methods.

Each BHS covers a population of about 3,000 to 5,000 and is staffed by a trained midwife. Studies conducted by the MOH in five provinces recommended a staffing ratio of 1 to 2,750. The BHS serves as the base of a team of volunteer Barangay Health Workers (BHW), each of whom is expected to serve 20 households. The MOH aims to set up a BHS in every barangay and to field some 350,000 trained volunteer health workers. According to the MOH, all BHWs are now trained. Various reports indicate that although BHWs are supposed to receive five weeks of training, most of them probably have received less than one week, and that the content and effectiveness of the training is questionable.

In 1985, there were 3,779 government and private family planning clinics and 493 active sterilization centers/venues. In addition, over 10,000 Barangay Nutrition Scholars (BNS) under the National Nutrition Council (NNC) supposedly provide family planning information, motivate eligible couples, dispense non-clinical contraceptives, and make referrals.

In 1975 there were 1,705 RHUs and 3,023 BHSs. By 1983, the numbers increased to 2,018 RHUs and 7,250 BHSs. The increase in the number of BHSs has resulted in a considerable improvement in the ratio of BHS to population: from one to 13,917 in 1975, to one to 7,180 in 1983. The ratio of RHUs to population has worsened slightly, however, from one for every 24,675 persons in 1975 to one RHU per 25,796 in 1983.

A World Bank report states that over 53 percent of the RHUs and BHSs either are in need of considerable repair or are badly dilapidated. Most of them have obsolete or badly maintained equipment and poor furnishings. Considerable investment would be required to upgrade these facilities.

The Ministry of Labor and Employment (MOLE), through its Population and Family Planning Office, enforces labor laws and coordinates family planning services provided by health clinics in over 1,000 firms. MOLE also coordinates over 4,500 labor management committees, whose functions include organizing and promoting family planning services.

II.2.3.2 Private Sector Services. Several private organizations provide family planning services on a fee basis. The two major organizations with clinic services are the Institute of Maternal and Child Health (IMCH) and the Family Planning Organization of the Philippines (FPOP).

IMCH is a service organization engaged in promoting maternal and child health through the provision of family planning services. Its three major programs are family planning service delivery; training health, population, and family planning workers; and IEC.

Through its 185 clinics, IMCH annually contributes about one-quarter of the total number of new family planning acceptors in the country. There were some 300 IMCH clinics in the early 1970s, but decreased funding and non-viability of clinics in a number of areas necessitated some closures. Under a new UNFPA NGO program, 50 new IMCH clinics have been established to provide family planning services on a reimbursement basis for contraceptive services. IMCH also has two comprehensive itinerant teams providing sterilization services in Regions II and IX.

The IEC program of IMCH is primarily the "Telephone FP Information Referral Service," commonly known as the "Instant Sagot sa Family Planning." At present this service is available in Baguio City, Cebu City, Davao City, Iligan City, Laong City, Legazpi City and Metro Manila, catering to the needs of thousands of callers for more information, advice, and counseling on family planning, human sexuality, and other related matters.

FPOP is an organization of volunteer-organized units, known as FPOP chapters, in some 24 provinces. An International Planned Parenthood Federation (IPPF) affiliate, FPOP coordinates and supports family planning training, communication, and service delivery through nine clinics and its local chapters. Additional clinics have been opened under the UNFPA NGO project. FPOP introduced the provision of comprehensive family planning services through itinerant teams that make comprehensive family planning and VSS available and accessible in remote areas.

Other private agencies have contributed substantially to national population efforts. The Institute of Community and Family Health coordinates and promotes community-based family planning activities under various private development programs. The Gabriel Medical Assistance Group (GMAG), the Ronn-Carmel Medical Center, the Iglesia ni Cristo, (INC), and the Mary Johnston Hospital Fertility Care Center have successful VSS service and training programs. VSS services are provided free to clients in return for a subsidy from POPCOM for each VSS performed. The subsidy is P200 for a vasectomy and P300 for female sterilization.

In addition, private hospitals, doctors and health practitioners provide family planning services to individuals on a fee basis. On the commercial end, many pharmacies and other retail outlets sell contraceptives over the counter. No data are available on the magnitude of these services.

II.2.3.3 The Pilot NGO Family Planning Support Project. The Pilot NGO Family Planning Support Project, begun in August 1985 with UNFPA assistance, is designed to improve the capabilities of the national NGO network to provide continuous family planning services through self-reliance and community participation. Its principal objectives are to increase contraceptive prevalence and to expand the participation of NGOs, thereby intensifying service delivery. The project calls for establishing, expanding, and/or strengthening 125 clinics in 1986. Project activities include the establishment of a simple mechanism for disbursing and monitoring use of funds for reimbursements for new and continuing acceptors, training in IEC and motivation, contraceptive methods, and record keeping.

To date, 137 clinics have been identified, but only 97 are currently operating; the rest need staff training and clinic accreditation, including accreditation for the provision of VSS services. Of the 97 clinics, 50 are new IMCH clinics; 40 are under FPOP; six under GMAG; and one under INC.

II.2.3.4 The Population Center Foundation. The government, cognizant of the impact made by the private sector in spearheading population control efforts in the 1960s and early 1970s, has always worked for a cooperative partnership. In 1972 the Government assumed a major role in the establishment of the Population Center Foundation (PCF), the country's major private resource institution in population, to provide management and technical services, and increase the involvement of the private sector in the national program. In its 1985-1990 program, PCF seeks to broaden and intensify this role through programs which include mobilizing the commercial sector, small industrial firms and private service providers; mass media campaigns on family planning benefits and contraceptive methods; research and pilot efforts in adolescent fertility management projects; women-in-development projects; continuing technical assistance in research and development, training, and information; and maintenance of a national population library and documentation center.

## II.2.4 Findings

It is difficult to gauge ease of access to clinic facilities in rural areas, but in some cases rural health units are the only clinics in their respective towns. Spot maps indicate where BHSA are located but provide no way to determine how adequately they are staffed by each BHS midwife. According to a 1984 World Bank PHN Sector Review, a recent study showed that about 60 percent of the rural population lives less than five kilometers from an RHU, and 36 percent within five kilometers of a hospital. The problem is that most RHUs are in small towns and are thus inaccessible to people living in barangays located in mountainous terrain or on remote islands.

A 1981 study of health service use in the Bicol region, which is the third poorest region in the country and has an average urban/rural population distribution, found that outpatients and pregnant women were 25 to 30 minutes away from either public or private facilities on the average, and usually less than seven minutes from a traditional practitioner. Twenty-four percent of sick adults and 27 percent of sick children had access to private clinics or hospitals, compared with 15 percent and 13 percent, respectively, who had access to public clinics or hospitals. This finding probably suggests easier access to and better quality of services in private facilities.

Generally, outreach workers tend to emphasize the more effective contraceptive methods, particularly sterilization. Doctors performing sterilization stated that demand for sterilization is high and that not all demand has been met. Where facilities and trained physicians exist, sterilization tends to be a popular method. It seems, however, that many sterilization acceptors are not ideal candidates because a large proportion of them already have four or more children.

Because the sterilization subsidy has been increased to P300 for tubal ligation and P200 for vasectomies, there is growing enthusiasm among physicians and itinerant teams to provide VSS. For efficient doctors, the subsidy has been a profitable source of income. The subsidy appears to be paid on time. In several instances, doctors share the subsidy with BSPOs by reimbursing transportation costs. Outreach workers seem to prefer to make sterilization referrals to private practitioners and clinics rather than to MOH facilities.

Except in Cebu City, vasectomy remains a minor method. The success of vasectomy in Cebu may be attributed to a large number of organizations for vasectomized men, such as the MACHO Club; the requirement that each of Cebu's 910 BSPOs have a least one vasectomy acceptor; the availability of adequate staff and supplies in vasectomy clinics; the example set by some barangay leaders; and the availability of incentives to both vasectomy client and motivator (P25 and P15, respectively). In mountain barangays, each acceptor receives four gantas of rice.

The problem of inadequate qualified staff in government hospitals and RHUs prevents these facilities from performing more sterilizations. RHU and MOH physicians can perform VSS only if they are surgeons, and this is not always the case.

Contraceptive supplies and IEC materials appear adequate, with the only need being a desire for a greater variety of pill choices.

One study comparing 1977-1981 government efforts (primarily by MOH) with NGO efforts to promote specific methods showed that the government's contribution figured prominently in terms of pills, IUDs, rhythm and condoms, while NGOs were more active in recruiting acceptors of sterilizations and injectables. On a per-clinic average, NGO clinics had more acceptors than their MOH counterparts. Service statistics for 1983 disclosed that NGO clinics averaged 446 more family planning acceptors per clinic than MOH

clinics (971 vs. 526). NGOs provided 7,230 sterilizations, representing 22 percent of total NGO clientele, in contrast to 2,890 sterilizations by government clinics, or one percent of acceptors of all methods generated by government clinics.

### II.3 Information, Education, and Communication

From its inception, the national population program has considered IEC an important component. Various government agencies initiated IEC activities in the early 1970s, including the use of field motivators, the production of mass media materials, and population education. The government's National Media Production Center, through its Population Information Education Office, designed and produced both printed and audio-visual educational materials. The University of the Philippines Institute of Mass Communication and the PCF contributed to the formulation of IEC plans, training, research and prototype design. The National Family Planning Office and the MOH's Office of Health, Education, and Personnel Training have also organized family planning, MCH and nutrition-related IEC programs. Many private agencies also have experience in IEC. POPCOM's IEC Division coordinates these IEC efforts for the national program.

Between 1978 and 1983, POPCOM spent 6 percent of its total budget for IEC and another 6 percent for training activities. For the plan period 1987-1991, the objectives of the IEC program are:

1. Supporting the "high scenario" targets by increasing demand and prevalence for all program methods;
2. Supporting IEC partner agencies in reaching respective target audiences;
3. Implementing multimedia activities supportive of both centralized and multi-agency approaches;
4. Conducting IEC training and IEC research towards a nationally managed IEC program;
5. Building up and improving audio-visual capability at both central and field level operations;
6. Institutionalizing volunteer IEC programs, the child spacing campaign, and the male-specific campaign;
7. Continuing the demand creation campaign and revitalizing Satisfied User Clubs and Satisfied Acceptors Clubs as motivators;
8. Continuing Population Education and Adolescent Fertility Program; and

9. Strengthening and expanding population information and public affairs activities.

The main strategic thrust of the IEC program is interpersonal communication through the Outreach project. Print, radio, film, and visual materials have been produced to back up interpersonal information and motivation techniques. For the period 1980-84, the IEC materials produced included the following:

PRINT	RADIO	FILMS & VISUALS
24 brochures	9 dramas (all with many episodes)	9 TV sports
15 posters	8 radio spots	5 film spots
14 comics (one in 12 volumes)	7 jingles	6 films
10 manuals	1 audio-cassette	3 slide-tape presentations
6 periodicals		1 cine slide
5 poster-calendars		2 TV shows (one with episodes)
4 flipcharts		
3 books		
2 wall comics		
2 charts		
2 leaflets		
1 fact sheet		

The program has also produced billboards and streamers, as well as certificates for those who complete pre-marriage counseling sessions.

Although much of the IEC work is still done in Manila, a considerable number of IEC activities have been regionalized. Each regional population office and some provincial and district offices have one or more full-time IEC staff members. In a typical regional population office, the IEC unit is headed by a Supervising Population Information Officer, one circulation assistant, and two or three audio visual technicians/operators.

The development and production work of the IEC materials is contracted to outside agencies; the main source of production is the National Media Production Center and its regional branches.

Population education (pop ed) has been a regular program of the Ministry of Education, Culture and Sports (MECS) since it was implemented in 1972 with UNFPA assistance. This project sought to integrate population education at the three levels of the formal educational system. In 1980, the second-country program of UNFPA assistance included a project to regionalize population education and to extend pop ed to the non-formal education (NFE) sector.

Apparently, except for printing and distributing IEC materials for pop ed, POPCOM has little involvement in pop ed activities. As one POPCOM regional staff person said, "we leave that to the expertise of MECS."

The first UNFPA-assisted pop ed project trained elementary school teachers to integrate population into four subjects: mathematics, social studies, health, and home economics. Textbooks which integrated population concepts were prepared in these four areas. The intent was to cover the secondary schools as well, but only a tenth were reached during the 1972-1977 period. A fifth subject, science, was added at the secondary level.

In 1980, the UNFPA assistance included a project to institutionalize pop ed in the regions. The target would be secondary level education and, to a limited extent, the NFE sector. Limited funds resulted in the coverage of only some 700 secondary schools, however, only a fifth of the country's 3,354 public high schools.

The regionalization of pop ed has given regions the advantage of designing their own plans, and developing and/or adapting curricula and textbooks to be sensitive to regional needs and conditions. Regions also do their own supervision, monitoring and evaluation of pop ed activities.

Training in pop ed has been given to NFE regional and division supervisors, district coordinators/teachers, and field workers. The numbers trained have far exceeded the planned targets in some regions since budgetary adjustments and POPCOM collaboration have made it possible to train additional personnel.

Since 1981, the Population Education Program, with UNFPA assistance and in collaboration with POPCOM, has produced a total of 515,795 copies of 58 titles of pop ed print materials designed to integrate pop ed into elementary, secondary, and tertiary curricula at public and private schools. These materials include resource books, manuals, and flipcharts for use by both teachers and students.

### II.3.1 Findings

A recent evaluation found no dearth of relevant IEC expertise in the country, but also found that the population program has not been able to attract experienced personnel due to low salaries. (see Sections II.5.1 for additional findings related to manpower and training.)

Radio is reported to be the most effective and popular IEC medium; it reaches a majority of the Philippine population. Radio dramas are most popular. Such programs are expected to augment the face-to-face efforts of Outreach workers. However, the 1981 Community Outreach Surveys report showed little systematic linkage between radio broadcasts and the motivational efforts of FTOWs and BSPOs. If FTOWs were informed of radio broadcast schedules and instructed to notify their BSPOs and MCRA about them, this motivational effort would be strengthened, and the number of listeners to family planning broadcasts might be substantially increased.

The print media also have good coverage, especially in urban areas. Of the variety available, comic books have been found to be in greatest demand.

Films also attract a substantial audience. In certain regions, local puppet shows and stage dramas are popular.

More and more IEC materials are being produced in Filipino, Cebuano, Ilocano and Bikolano. More than half, however, are still printed in English. A large proportion of these materials are prepared at the regional level. Despite the number produced, very few reach field workers, and what IEC material they get may not always be appropriate for their needs (Concepcion, 1985). A UNFPA IEC expert has reported that the 58 titles of pop ed print materials, which were produced and distributed to public and private schools nationwide, are now outdated because school curricula are being revised. The government's regionalization program also means periodic adaption and revision are necessary.

IEC messages tend to focus on the presentation of information rather than on motivational, educational, and outcome-specific approaches.

While there is awareness of the need to develop special IEC motivational approaches to reach different subgroups of the population, the response has been slow and insufficient. Motivational strategies for male-oriented services need continual strengthening. The prevalence of the erroneous notion equating vasectomy with castration suggests that IEC efforts associated with this method have not been effective.

A 1985 UNFPA needs assessment report points out that evaluation of IEC programs and activities has received little attention to date. Evaluating IEC activities at various stages would help identify areas of weakness.

The distribution of IEC materials appears to be uneven. Reports point repeatedly to the failure of materials to reach end users. Perhaps the existing channels and networks of distribution have not been fully utilized. Neither have attempts been made to develop an efficient and cost-effective system of distribution.

There is a general perception that IEC materials and approaches should reflect local conditions, traditions and cultural and social variations. The UNFPA report points out that participation by the target audience in planning and executing IEC activities should be encouraged at the community level, and that formulation of messages should be done in cooperation with relevant community members to assure two-way communication patterns.

The problem of commitment to the program at various levels of government and in the private sector has prompted POPCOM and NEDA to push advocacy programs for educating and changing attitudes among political leaders and other influentials. Efforts are being made to utilize all media to educate and influence attitudes about the interrelationships of population growth and socioeconomic development.

The population program has defined six sectors for targeting pop ed:

o Preschoolers (0-6 years)

- o Youth (7-14)
- o Pre-marriage (15-24)
- o MCRA's (15-44)
- o Community influentials (policy-makers, legislators, local government officials, professionals, etc.)

The primary targets have been MCRA's and community influentials. To attain the high scenario targets, the population program is conducting a massive motivational campaign among MCRA's, focused on responsible parenthood.

The greatest effort in the past five years, however, has been directed toward enlisting the active support of the community influentials, particularly in seeking the support of and financial commitment from local government officials. During this period, the program has held training programs for about 2,500 mayors whose re-election prospects were considered good. In its field visits, the team met a few local officials who had apparently benefited from their exposure to population seminars. (Since this training aims to treat these community influentials almost as if they were extensions of POPCOM regional staff, this issue is touched on in Section II.5, Manpower and Training.)

Targeted IEC activities for the other sectors are less intense. Examples include MOH day care programs, youth seminars on population dynamics and human sexuality, and pre-marital counseling programs. Methods include FP demand-generation projects, (e.g., a campaign to promote FP as a way of life), campaigns to involve private service providers in FP, industry-based FP projects, and income- or demand-generation projects in rural areas. Although initial evaluation indicates that such projects have encountered considerable difficulty getting started, two projects in Basilan Province (Region IX) were in their second year and show potentially positive results.

Recently, POPCOM decided to gear IEC messages toward the institutionalization of family planning as a way of life. In support of this project PCF initiated its Demand Generation Campaign to promote family planning as a way of life and to increase demand for contraceptive products and services. The project involves a thematic and tactical campaign designed around four key population concepts: small family size, delayed marriage, effective use of methods, and population's relation to development. Each campaign is directed at specifically targeted audiences, but the message is the same: responsible parenthood.

Dr. Concepcion reports on a nationwide survey of high school teachers and students recently undertaken to determine some evaluation indicators for use in evaluating the extent to which pop ed has been integrated in the secondary school curricula. Some findings are:

- a) Students fared only moderately (average score of 3.2 out of 5) on the issues of family size, age at marriage, responsible parenthood, use/effectiveness of family planning methods, and population and development. Teachers consistently scored better than the students.
- b) Teachers were most favorable to responsible parenthood, but both groups were least convinced about attitude statements on age at marriage.
- c) Both groups favored a mean age at marriage of 25 years, and three as the desired number of children. Both groups preferred the first birth to occur a year after marriage, and to wait three years before the next child.
- d) Four-fifths of the teachers were using contraception, or planned to use it in the future; three-fourths of the students felt they would practice family planning once married.

As Concepcion points out, students reflect their teachers' knowledge, attitudes, practices, and skills in pcp ed.

## II.4 Logistics

### II.4.1 The Current Logistics System

One of PP III's important accomplishments has been the improvement of the logistics system, especially for contraceptives. Warehouses have been constructed with World Bank funds, an inventory control system has been established, personnel have been trained, and the system is functioning at all levels. An annual inventory of contraceptive stocks is made, and reports are submitted showing beginning and ending stocks and issues during the preceding year. One remaining problem is that these reports are consistently late. The data and analysis are almost a year old by the time the reports are received at USAID.

A total 18-month supply is maintained throughout the system. The stock levels in months of supply are: central office, six; regional office, three; provincial or city office, two; district office, two; FTOW, two; and clinics and BSPOs, three. Requisitions are submitted up through the system when the stock at any of these distribution points falls below 60 percent of the authorized stock level.

It has not been possible to make a systematic assessment of the efficiency of the logistics system. Anecdotal evidence, however, indicated that contraceptives were occasionally out of supply at the lower levels of the system, especially the BSPOs. These reports may well represent simply the exceptions inevitable in a system that reaches down to over 50,000 separate issue points throughout the country. As a whole, the logistics system is operating relatively efficiently.

#### II.4.2 The Proposed Cost Recovery System

Major changes in the contraceptives logistics system will occur if the proposed Cost Recovery Scheme (CRS) is implemented as currently designed. The basic concept of CRS is that contraceptives would be sold at prevailing market prices and the proceeds used to provide incentives for program workers and to purchase resupplies. The GOP has developed CRS with virtually no USAID involvement, even though it proposes to sell contraceptives procured with USAID funds, apparently in an effort to develop new sources of contraceptives. The GOP feels its current dependence on USAID limits its financial independence and the range of orals it can offer. There is also a stated belief that Filipinos generally place a higher value on things that are sold rather than free.

There are several serious potential problems with CRS. In the extreme, it may result in a significant drop in contraceptive prevalence. These problems have been clearly recognized within the Mission and most were articulated in a letter to POPCOM's Executive Director on January 6, 1986. The major issues raised in that letter include:

- o The need to define the economically disadvantaged persons who would continue to receive free contraceptives.
- o The need to develop specific guidelines on the use of funds for incentives for program workers.
- o The need to define eligible uses of withdrawals from the fund that will accumulate.
- o The need to reconcile the present position that contraceptives issued through the MOH will continue to be free.
- o The need to conduct market research to determine what potential clients can and will pay for contraceptives, rather than using an arbitrary price based on the present limited commercial market.
- o The value of pilot testing CRS before it is implemented nationwide.

One significant factor of CRS is not mentioned in the January 6 letter: if CRS is implemented, it may effectively negate the fundamental premise of the whole Outreach program, which was developed on the basis of research findings that contraceptive prevalence was inversely correlated with the distance of potential users from a clinic. No subsequent research has shown that this situation has changed, and the provision of stocks at the BSPO level was specifically designed to overcome this problem. Under CRS, however, the lowest stock point for contraceptives will be the clinics; stocks will no longer be maintained at the BSPO level, apparently because of the potential problems of accountability.

Although the number of RHUs has increased substantially since 1976, their numbers and geographic distribution are not adequate to replace the more than 50,000 widely dispersed stock points provided by the BSPOs. It would appear that this sharp reduction in the availability of contraceptives will inevitably reduce contraceptive prevalence.

## II.5 Manpower and Training

### II.5.1 Manpower

Attrition: The high annual attrition rate of 16-18 percent over the past five years leaves only a few of the original staff on board. It is apparent from several documents that staff attrition and turnover have been serious problems.

Overlap of Responsibilities: Although manpower in the regional and POPCOM offices seemed sufficient to handle the program's activities, there was some concern among regional staff about the overlap of job responsibilities and level of supervision

### II.5.2 Training

Need for Training: A recent evaluation of the program's IEC needs indicates that the present (POPCOM) IEC staff at both the central and regional/provincial levels is "adequately qualified but lack[s] specialized expertise in developing comprehensive plans and cohesive strategies."

Types of Training: The manpower development program has trained personnel in three major areas: (1) service delivery, (2) motivation and counseling, and (3) staff development. Efforts have included providing continuing education to program members, setting requirement standards for training courses, accrediting training institutions, and integrating population/FP concepts into the curriculum of professional schools, including schools of medicine, nursing, midwifery, etc.

In-country and International Training: Under PP III, most upgrading of management and technical skills of central and regional POPCOM personnel and partner agency personnel took place in the Philippines.

In-country training has been directed primarily to providing FTOWs and BSPOs with knowledge and skills in FP technology, motivational techniques and community development. FTOWs received a total of 21 days training on contraceptive technology, communication skills, and community development concepts. The training on contraceptive methods and motivational skills appears more successful than the community development training. Some scheduled BSPO training was not conducted because of inadequate attendance or insufficient funds. Many BSPOs and FTOWs feel they are deficient in specific subjects. Phase I of this evaluation, being conducted by UCPA, will provide greater insights into the skill and competency requirements of field workers.

Eighty-three PIO/P employees attended various international training seminars in the U.S. or ASEAN countries between 1981 and 1985; the major focus of the international training was on developing and managing community-based health programs.

Skills Needed by Staff: BSPOs and even some FTOWs were not aware of communication strategies they could use to influence attitude formation. When confronted with reasons for not accepting any FP method (e.g., "my husband disapproves," or "I don't believe in FP"), these field workers were unable to probe into the underlying convictions behind these reasons. Data from the 1980 CPS indicate that the major reasons for non-use of contraception were: currently pregnant (18 percent), amenorrheic (12 percent), no longer able to bear children (10 percent), want to get pregnant (6 percent), and not sexually active (3 percent). This reservoir of potential acceptors (about 35 percent in need of FP services), means that field outreach workers require motivational skills and techniques that will assist them in their outreach strategies (field workers also require more effective IEC materials; see Section II.3, Information, Education, and Communication).

Many members of the central and regional office staff do not have a good understanding of the MIS. The regional staff has received training in financial management, MIS, and logistics and supplies, but has not fully utilized the skills developed in these training sessions; this is particularly true of the data processing, data management, and evaluation components. In fact, there is a considerable discrepancy between how the system was supposed to work and how it actually worked. There was near unanimity about how the data are collected, but not on how they are used for planning and decision-making. (See the following section, II.6, for additional discussion of the MIS.)

Physician Training: Some MOH physicians are asking to be trained in VSS, yet several physicians previously trained by the MOH have either emigrated or are not making use of their skills.

## II.6 Management Information System

Data gathering and data processing have been in progress since the national family planning program began. Under the process, clinics are expected to assemble monthly client records and report to POPCOM the number of client visits, by method, each month. An evaluation of the system disclosed questionable data quality, duplication of reporting, and confusion concerning the manner in which the system would operate. Beginning in 1980, a redesigned MIS Service Delivery Information System (SDIS) was implemented to provide accurate and timely data about contraceptive prevalence on a time-series basis. The SDIS approach integrates the clinic and outreach programs; it was designed to avoid the duplication of records and to cut the competition between clinics and field workers that can lead to inflated estimates of client numbers. The system is built on the flow of data from the Barangay Service Point (BSP) directly to the central computer facilities. The FTOW is

responsible for collecting monthly data from the BSPO and forwarding them to the central office. The clinic also submits monthly reports to the central office. The basic objective of this integration of information was to generate accurate national data on contraceptive use.

In 1981, in anticipation of major data processing and analysis at the central level, several MIS staff members were trained in systems analysis, computer programming, disk operating systems, and computer operations. Because of high staff turnover and the lack of computer hardware, however, this training has not realized its full potential.

The redesigned 1981 SDIS sought to achieve a complete and accurate accounting of new acceptors and continuing users, but the system soon broke down due to low reporting rates, unreliable data validation, a highly centralized data processing system, and varying information requirements and reporting frequencies at regional offices. In response to these problems, it was decided to regionalize the data processing activities and focus primarily on the achievement of high scenario targets. Regional offices would collect clinic and outreach statistics and prepare quarterly reports to indicate the year's target number of MCRAs, the number of acceptors by method for the quarter, and prevalence rates.

The current MIS includes components of the most recent SDIS, namely the decentralized reporting mechanism and the compilation of BSPO and FTOW reports. These data are reconciled with clinic reports, aggregated, and sent to the regional office for processing. The focus on the clinic as the unit of analysis is probably the best direction the MIS has taken in its long struggle to become a viable, effective and efficient data management system. The rationale for such an approach is obvious in that the clinic, as the focal point of activity, is responsible for service delivery as well as the continual monitoring of services. With this system in place, clinic personnel must manage and update client records on a regular schedule. The outreach field workers must work closely to reconcile client resupplies. Furthermore, FTOWs must work closely with the BSPOs in making certain that the clients served by these supply point officers are continually provided with contraceptive methods.

Unfortunately, the MIS is not being used to measure program progress effectively. Much of the data collected at the local level are not tabulated and returned to the clinics for evaluating and restructuring activities. Even when results are returned to the clinics, there is often a delay of several months.

#### II.6.1 Findings

The purpose of the MIS is to facilitate management of the entire system. When critical components of the system are not in place, aggregated results at the regional and national level become questionable and do not permit accurate assessment, program planning and priority setting.

Although there has been a steady improvement between 1981-85, nationally, fewer than 65 percent of the reports are being filed (as of 1985). For the first three quarters of 1985, MIS indicates that overall reporting is improving (from 61.8 percent in the second quarter to 63 percent in the third), but the percentage of units reporting is still inadequate to provide the representative information necessary for program managers. The quality of data from regional coordinators varied considerably. No region indicated the percent of clinics reporting; it is implied that reports are 100 percent complete by each quarter. The wealth of information collected by the BSPO from clinics and in the field is not utilized, including most of the information collected in Form FP-2, which includes the type of client, intention to have additional children, age of wife, number of living children, date last pregnancy ended, educational attainment, place of service, and person who gave service. If this information is sent to the regional office but not made available for local clinic use, the question arises as to its appropriateness in the MIS.

Cross-tabulations of relevant program statistics would also be useful to clinic personnel. Although it is important to know the percent distribution by method of contraception, a cross-tab of method accepted by age group, or by number of living children, would provide specific information more appropriate to motivational activities, target audiences, or redirection of IEC campaigns.

The regional coordinators and staff indicate that they were trained in microcomputer applications in anticipation of receiving hardware and software. Development of a form that could collect client information for recording clinic services and for direct data entry is required before setting up the computer system. In addition to forms, the data entry program must be able to translate individual clinic records into aggregated data sets. In order for clinics to be efficient and to utilize the MIS intended, there must be specific time limits for reporting results.

## II.7 Overall Project Performance

### II.7.1 Financial Performance

The original project authorization provided a total of \$122.33 million for the USAID-supported portion of PP III. Of this amount, \$56.75 million was AID funding and the equivalent of \$65.58 million was the GOP counterpart. Actual project costs will fall far short of this total. As of December 31, 1985, one year before the end of the scheduled six-year project, USAID obligations had totalled \$34.43 million (\$19.34 million grant and \$15.09 million loan). The loan obligations reflect a de-obligation of \$2.8 million in September 1985. Of the total net obligations of \$34.4 million, an estimated \$7.2 million will remain unused at the end of the project, assuming the proposed \$2.225 million grant for future contraceptive requirements and 1986 local costs is utilized.

There will be a comparable shortfall in GOP funding. GOP costs are expected to total the equivalent of \$27.1 million by the PACD. Thus, total AID and GOP funding for PP III (including contraceptive forward funding) will be \$56.9 million, 53.5 percent less than the original estimate. Seventy percent of this shortfall (or \$45.5 million) came as a result of an overestimation of costs in the PP, which arose in turn from two incorrect financial assumptions:

- o Devaluation of the peso. The PP was prepared on the assumption that the rate of exchange would remain constant at P7.5 = \$1.00. In reality, the value of the peso has declined steadily throughout the project, and is now about 40 percent of the initial value, relative to the U.S. dollar.
- o Contraceptive prices. The PP assumed that contraceptive prices would rise at an annual rate of 12 percent for condoms and seven percent for orals. In practice, the annual inflation rate has been four percent for condoms and negative for orals. (The price per cycle for orals in 1985 is half the 1985 price forecast in the PP, in U.S. dollars.)

Neither of these developments could have been foreseen at the time the PP was prepared.

Table II.7-1 provides the financial data to support the assertion that 70 percent of the spending shortfall was due to overestimation of costs. It compares AID and GOP forecasts of actual life of project costs, by project element, with costs as projected in the original PP, and with an adjusted PP projection. The adjusted PP projection keeps all elements of the original PP constant except for exchange rates and contraceptive prices. To adjust for these changes, local costs were recalculated using the actual average exchange rate by year, and contraceptive costs were based on the PP forecast requirements at actual prices through 1985.

Table II.7-2 shows that forecast total actual project costs will fall \$65.4 million short of the \$122 million in the PP, but only \$19.9 million short of the adjusted PP estimates. Thus \$45.5 million of the apparent shortfall can be attributed to financial overestimation.

There were several other reasons for the remaining shortfall in project obligations. First, the project did not perform as well as expected in contraceptive prevalence and contraceptive effectiveness. As a result, the anticipated requirements for orals, condoms, and sterilization subsidies were not needed. The PP had forecast that \$12.855 million would be required for orals and contraceptives, adjusted to reflect actual procurement prices. In fact, actual procurement requirements through 1986 will be only \$8.4 million, 35 percent less than forecast. The sterilization subsidies are about 16 percent less than forecast, even after adjusting for devaluation of the peso.

The second major reason for lower fund requirements was the budgetary pressure experienced by the Government, particularly in the wake of the

economic recession in the later years of the program. This pattern is reflected in Table II.7-2, which shows a sharp acceleration during 1981 and 1985 in the degree to which the GOP level of funding diverges from forecast requirements. (In the table, the total difference is less than the differences by year would produce, because the total estimated actual costs include \$5.8 million of costs to be incurred in 1986, which were not included in the original PP forecasts. Through 1985, estimated actual expenditures were 33 percent less than the adjusted PP forecast.)

### II.7.2 Project Outputs

In the Logical Framework, the seven broad system services listed in Section I.6.2, above, are translated into 14 more specific outputs. The forecast outputs and the current status of each are as follows:

TABLE II.7-2

Percent Difference, Local Currency Cost  
Estimated Actual Costs Vs. Project Paper Estimate Adjusted for Devaluation  
(\$000)

<u>Project Activity</u>	<u>1981</u>	<u>1982</u>	<u>1983</u>	<u>1984</u>	<u>1985</u>	<u>TOTAL</u>
Outreach/Human Resources Development	- 14	- 27	- 35	- 53	- 65	- 27
Clinic Support	- 34	- 38	- 99	- 50	- 59	- 33
Information, Education & Communication	- 24	- 58	- 58	- 95	- 93	- 67
Logistics	- 35	- 43	- 43	- 66	- 62	- 40
DMA/Evaluation and Operation & Policy Research	- 38	- 82	- 49	- 58	- 63	- 55
Management Information System	- 39	- 8	- 20	33	- 74	- 20
Special Projects	- 67	- 100	- 568	+ 61	+ 68	+ 36
<b>TOTAL</b>	<b>- 22</b>	<b>- 36</b>	<b>- 32</b>	<b>- 54</b>	<b>- 63</b>	<b>- 30</b>

**NOTE:** The forecast requirements are adjusted to eliminate the effect of the devaluation of the peso.

**Source:** Project Paper and AID Estimates.

1.a. Increase management capability at central regional, provincial, and city levels.

Status: It is not possible to quantify this output, but available evidence indicates that management capability at all levels, while in need of continued improvement, has improved during the life of the project.

Following a self-imposed freeze on new hires and a position-by-position analysis of staffing requirements, 91 positions were eliminated from POPCOM's central office. As a result of this analysis, proposals have now been submitted to utilize these positions in the POPCOM regional offices.

b. Train and deploy 3,000 FTOWs, 466 DPOs, 165 PPOs/CPOs, 45,000 BSPOs, to cover approximately 50 percent of the estimated 6.5 million MCRA's mainly concentrated in the rural area.

Status: As of the end of 1985, there were 2,250 FTOWs, 324 DPOs, 157 PPOs/CPOs, and 51,169 BSPOs covering approximately 49 percent of an estimated 7.2 million MCRA's, mainly in the rural areas.

2.a. Establish and operate 12 Regional Comprehensive Family Planning Centers with itinerant family planning capability and Provincial Mobile Family Planning Clinics to provide comprehensive, clinical back-up support.

Status: The regional centers have not been established, but 41 comprehensive itinerant family planning teams are operating.

b. Sterilization services available in 840 sterilization centers, laboratory services obtainable in 12 regions, 484,000 VSS cases subsidized, transportation assistance provided to clients as required, medical assistance accessible for complications.

Status: There are 876 registered sterilization centers and other sterilization venues operating, of which 493 are active. Laboratory services are available in all 12 regions. Roughly 375,000 VSS cases have been subsidized. Transportation and medical complication assistance have been provided.

c. Coordinated private sector program on family planning.

Status: NGO activities are important, but they are not well coordinated with GOP activities.

3. Intensified central and regional IEC campaign addressed to pre-MCRAs (pre-schoolers, students, out-of-school youth, pre-marital couples), MCRAs, special groups, e.g. opinion leaders and influentials (GOP/IBRD/USAID).

Status: Intensified IEC campaigns have been addressed to most of the special groups listed.

4. Maintain appropriate supply levels and adequate storage facilities at all operational outlets.

Status: Storage facilities are available and appropriate supply levels have generally been maintained. There is an effectively functioning logistics system.

- 5.a Family planning and fertility surveys to be conducted in 1982, 1983, and 1985, and information disseminated to appropriate people for information and action.

Status: The 1982 survey was cancelled and the 1985 survey was postponed to 1986. Results of the 1983 NDS have been disseminated, but the final report has not been issued.

- b. Joint POPCOM/USAID evaluations and monitoring conducted.

Status: An evaluation of PP II was conducted in 1981. The scheduled evaluation of PP III in 1982 was not conducted, and the evaluation scheduled for early 1985 was not begun until early 1986 (the current Phase I and II evaluations).

- 6.a. Operational and policy research projects are completed and findings disseminated and utilized.

Status: Limited research has been conducted in connection with new operations and policies.

- b. Approved alternative plan to Outreach tested for cost effectiveness for implementation of population/family planning services after 1985.

Status: No alternative plan has been tested.

- c. Assess and improve local government participation in alternative plans for cost effective Outreach network under PP III and after 1985.

Status: There has been a substantial effort to increase local government participation in Outreach, especially in financial terms.

d. Implement community incentive schemes; methodology started in 1981-1982.

Status: Some income-generating, projects are underway, but they appear to have been developed and sustained at the local level, with little central support.

7. MIS data are produced, analyzed and distributed in an accurate and timely manner for use by appropriate persons at all levels. (GOP/IBRD/USAID)

Status: Although substantial effort has been expended on MIS, an accurate and timely MIS still does not exist.

In summary, project outputs have fallen short of the original targets in the majority of cases. The extent of the shortfall, however, is not sufficient to explain the major failure to achieve the project purpose of 53 percent contraceptive prevalence and 83.5 percent contraceptive effectiveness, or the expected crude birth rate goal of 28 per thousand. This failure is the subject of much of the preceding analysis in this chapter, but several points can be made specifically within the context of the Logical Framework.

The first point is that several critical Logical Framework assumptions have proven not to be valid. Specifically:

- o Filipino couples--or at least a sufficient number of couples--have not increasingly sought family planning services as they have become available.
- o There has not been a continuing decline in desired family size.
- o The effect of the age structure and marriage on the birth rate has not remained favorable. The average age at marriage has declined over the project period.
- o The purpose and goal assumptions that social and cultural conditions allow promotion of more effective methods have, at least to a degree, been diluted. Church opposition to more effective methods has apparently increased and overt top level political support for the program has declined.

The second point is that many of the outputs are only intermediate outputs in terms of achieving the purpose. In the final analysis, it is not the number of trained and deployed FTOWs and BSPOs that is important. It is their success in motivating couples to practice effective family planning.

## II.8 Behavioral Science Framework

The absence of a behavioral science/health education, diagnostic, planning and evaluation framework is a basic problem inherent in the

implementation of programs like PP III. Programs are usually developed after needs assessment analyses. Objectives are often measured only in terms of outcomes, and little consideration is given to the educational and behavioral linkages expected to occur between inputs and outcomes.

It is true that IEC activities stimulate knowledge and motivation, which may increase the number of new acceptors over time. However, several socio-psychological attitudes intervene between activities and an individual's desire to accept family planning. (See Appendix D)

## II.9 Demand Generation

Thus far PP III has focused on contraceptive supply. The original justification for the outreach program was to provide access to reversible methods, particularly condoms and pills, in remote areas. The program was built on the premise of a large pre-existing need for contraception; an explicit assumption of PP III was that this need would expand during the course of the program. That is, it was projected that desired family size would fall steadily over the course of PP III at the same rate it had fallen between 1973 and 1978.

It is now clear that this assumption was not justified. The mean desired family size in the 1983 NDS has remained at four children. A more recent summary of program staff (Feranil, et al., 1985) indicates that even the program's field workers generally want three or four children.

According to the 1983 NDS, the TFR in 1980 was 5.0. If it suddenly fell to 4.0, conforming to the mean desired family size, it would represent a decline of 20 percent. Under the most liberal allocation of this decline across all age groups, the CBR would also decline by 20 percent, from 36 to 29, and the CRNI would fall from approximately 2.8 percent to 2.1 percent. Virtually the same amount of decline would occur if all births after age 35 were suddenly eliminated.

This amount of change would be welcome. It corresponds roughly to the rate planners hoped the program would reach by the present time. Even with a mean desired family size of four, however, it would mean that demand was being fully met with the CRNI still in excess of 2 percent annually.

It appears that desired family size is indeed high in the Philippines, and there is no reason to cast doubt on the 1983 NDS estimate, nor to believe that dramatic change is underway. The culture has strong pro-family values, which are reinforced by Catholicism and by Islam. In some rural areas there are few opportunities to invest in children through education, and even young children can perform necessary household tasks. In most low-fertility countries, at least a quarter of all women will have no children or only one; in the Philippines a negligible number of married women end up with fewer than two children, because it is considered important to have at least one son and one daughter.

Various officials placed an overwhelming emphasis on service delivery. Several officials are familiar with the macro level implications of high growth for national, regional, or even local development. Some mayors talked disparagingly of the procreation of the poor. Generally, however, the alleged solution is to improve access to methods, to overcome rumors, to provide incentives and better training for outreach workers, etc.

But there is little apparent general appreciation of the relationship between family size and family welfare at the micro level. The most serious challenge to the program is to work within the strong pro-family emphasis of Philippine culture--which is certainly positive.

Certain related developments in the program during the past few years, which appear to have been generated within POPCOM and PCF, are encouraging. The Responsible Parenthood Campaign is an excellent example of demand generation. It presents family planning as a concept, not as a set of techniques, and emphasizes family planning as a part of family building. It also attempts to build the essential bridges with the Catholic Church.

The continuing alliance of population with health and nutrition is also related to demand generation. It shows the links between welfare and fertility regulation and may thereby lower the desire for a large family. However, some reviewers and agencies may be overly optimistic in believing that an integrated program will be more effective than the current program. Integration will mean less visibility at the local level, lower commitment, and reduced funding--at a time when the program needs more of these resources.

#### II.10 Additional Observations: POPCOM

There is a need to examine one additional function of POPCOM beyond its relationship to PP III: POPCOM's regulatory role in reviewing research proposals. POPCOM now reviews any proposal involving "population," regardless of size, funding source, or executing agency. Such a review is required whether the work involves Filipinos or foreigners, whether or not it includes foreign exchange, or whether or not it involves family planning. POPCOM usually--but not always--approves such projects.

This role is not functioning optimally, either for POPCOM or for the parties being regulated. Many individuals outside POPCOM mentioned this issue.

#### II.11 Additional Observations: USAID

During PP II and the early years of PP III, the USAID Mission had a large population staff and played an interventionist role in the activities of POPCOM and the Philippine population program. As recently as early 1983 the Mission had three direct-hire expatriate population officers, four contract expatriate population advisors, who were housed in USAID but worked primarily with POPCOM, and four Filipino professionals. In the next two years, overall Mission staff was reduced and contracts expired. By the fall of 1985 the

Population staff was down to three professional Filipinos: a population officer, a logistics officer, and a financial analyst. There has been no Population Officer since the middle of 1985, although another one is expected in April 1986. This staff is simply not adequate to manage a project the size of PP III or to do the continuing project development work that the AID Mission should be doing in population in the Philippines.

Partly because of major cuts in staffing in all areas of the Mission including population, there has been a gradual downplaying of the USAID role. Beyond this factor, there has been a strengthening of Filipino expertise and experience. At present there appears to be healthy cooperation and communication between USAID and most Philippine agencies with which it deals, but there is evidence of communication problems between USAID and POPCOM. There are several reasons for this.

The first is an apparent desire on POPCOM's part to be more independent in conducting its population program. This desire is almost certainly partly in reaction to the highly interventionist USAID operation of the past, and the pendulum may have swung too far as a result. However, the desire for a greater independence is a healthy and natural tendency as the Government's population program and the POPCOM staff have matured over the years.

The second reason, however, appears to be excessive reduction in USAID staff. The staff has been reduced to the point where it necessarily has focused almost exclusively on formal project administration, which all too often has the negative connotation of rule enforcement. The informal dialogue and contact that are critical ingredients in any successful USAID effort have fallen by the wayside, and some problems that might have been forestalled have been turned into formal exchanges and counter-exchanges. Filling the vacant local professional position and the restored direct-hire population position should help materially to correct this and to restore more open communication between POPCOM and USAID.

### III.12 Some Organizational Issues

This report will close with some comments that lie outside the strict scope of work, and which go beyond the role of USAID.

The administration of the population program needs certain structural changes. There are two issues which should be considered carefully by the Board and officers of POPCOM and by NEDA. This evaluation does not propose detailed mechanisms for dealing with these issues, or specific alternative administrative structures, because the initiative for any changes clearly lies with the agencies involved.

The first issue concerns the combination of POPCOM's "coordinating" and "implementing" functions. POPCOM's charter clearly states that POPCOM is to be a coordinating agency. The Chairman, Executive Director, and other officers within POPCOM emphasized that it is solely a coordinating agency. According to them, POPCOM coordinates the regional offices, local government

involvement, activities of MOH clinics, the NGOs, research activities, and so on.

Everyone outside POPCOM with whom this issue was raised clearly regards POPCOM as the primary implementing agency of the population program--whether or not they are familiar with the POPCOM charter. Even a top official of NEDA referred to POPCOM in these terms. POPCOM's involvement in target setting, service delivery, logistics, financial arrangements, etc., attests to this role.

POPCOM is indeed the implementor of the Outreach program, in much the same way that the Ministry of Health implements Primary Health Care. It is only a matter of semantics to argue this point.

In addition, POPCOM certainly has coordinating activities. It serves as a clearinghouse for the funding of research, as described in section III.9, and for some of the activities and funding of the NGOs. It approved the Special Project 10 (SP 10) contracts within PP III, although it does not administer any budget other than its own.

The point is not that POPCOM is violating its charter. To outsiders, the question is immaterial. The concern, rather, is that it is dysfunctional to have the two types of activities--implementation and coordination--in the hands of the same agency. Some examples will be given of the conflict between these two kinds of functions.

The implementing activities of POPCOM and the NGOs are complementary in many ways. They have separate targets, staffs, recordkeeping, and so on. But there is no question that the government-sponsored outreach effort results in some acceptances recorded at NGO clinics, and similarly, some of the efforts by NGO motivators result in acceptances attributed to FTOWs and recorded at MOH clinics. It is not appropriate, therefore, for POPCOM to have authority over any part of the NGO budgets. Such authority places it in competition with the NGOs, or at the least appearing to compete with them.

The expiration of PP III at the end of 1986, with no follow-on proposal currently pending, may well mean a hiatus in the government funding of population activities. Responsibility for a new proposal is in the hands of government agencies--specifically NEDA and POPCOM. Under the present structure, however, it is difficult for NGOs to be funded directly by donor agencies. It is dysfunctional for the overall program that the government's inaction have this kind of impact on non-government organizations. It would be desirable to have a mechanism for direct funding of the NGOs, including the Population Center Foundation as well as those involved in delivery, such as the Family Planning Organization of the Philippines and the Institute of Maternal and Child Health.

POPCOM apparently intends to take on the analysis of survey data, which has been done for the past 20 years by UPPI. Survey analysis is definitely not a coordinating activity. It is something which should continue to be contracted out, whether or not it is specifically contracted to UPPI.

POPCOM recently rejected a proposal for hospital research on a specific type of IUD on the grounds that it is an inappropriate type of IUD for the Philippines. The funds for this research would not have competed with other research. It is undesirable to make a judgment of this kind before the research is carried out. This is simply one example of a decision that affects other organizations and which POPCOM was not in fact qualified to make. Section III.9 presents some specific suggestions for separating research activities from POPCOM.

A second structural issue within the overall program concerns accountability. It is not clear that POPCOM is accountable to any other agency or institution within the Philippine government. If there is any such agency, it would presumably be NEDA. However, NEDA's role seems mainly to concern issues of foreign exchange. There is no evidence that the Philippine government had itself conducted periodic reviews of the population program; the several recent reviews were mandated by donor agencies. There is no clearly defined external locus of decision-making, policy-setting, and monitoring of the program.

### III. CONCLUSIONS AND RECOMMENDATIONS

Based on the findings in Chapter II, many recommendations may be drawn. Most of these are organized in the same framework as Chapter II, but those that are more general are included in the additional sections.

#### III.1 Demographic Impact and Research

1. The goal and purpose of the population program should be stated in terms of variables that are relatively insensitive to non-program factors. The goal should be stated in terms of the TFR or (less desirably) the NRR. The purpose should be measured only in terms of the prevalence of program methods.
2. Target values of the goal and purpose should be expressed in terms of changes rather than levels. The levels at the start of a project are never known until several years afterward.
3. Targets should be set more on the basis of previous changes than on a theoretical goal, although the desired change should be an acceleration of previous change. Targets that are not based on previous performance are likely to result in failure.
4. Field targets should continue to distinguish between voluntary surgical sterilization and reversible clinical methods. No credit should be given for rhythm users unless they are using improved NFP; other types of rhythm are not used effectively. If possible, more credit should be given for younger, lower parity women than for older, high parity women.
5. A set of indicators of program impact should be defined that are more specifically related to socio-economic development. Development of more immediately visible indicators should increase the likelihood of local government financial support. These indicators would be readily available in each local jurisdiction and monitored on a regular basis. Examples include the rate of unemployment, expenditures on education, levels of food production, coverage of rural electrification, etc. These indicators should be identified, quantified and agreed upon in cooperation with local planning and development agencies.
6. Research is needed that will better link the targeted changes of the field targets (new acceptors), the purpose (prevalence of contraceptives use), and the goal (reduced fertility rate).
7. There is a serious need for frequent measurements of prevalence, preferably with a mechanism that is independent of the program (that is, independent of the MIS). Regular measurements of fertility should also be continued. Therefore, the alternating sequence of NDSs and CPSs should be continued.

8. The reporting from such surveys, especially of contraceptive and program-related information, should be as rapid as possible. Preliminary reports on the main variables should be issued within six months after the completion of field work. Adequate staffing and computing equipment for this purpose should be made available.

9. There should be more field testing of operations and policy changes before such changes are instituted.

10. POPCOM should continue to contract out its research projects, including analysis as well as data collection. Its staff should limit its activities in this area to establishing research priorities and monitoring research that has been contracted.

### III.2 Service Delivery

1. The government's goal of integrating outreach workers will require a clear definition of role functions; clinics and BHSs adequately staffed to provide supervision; good training and supervision of outreach workers; sufficient logistic support for integrated services; and continuing incentives to sustain motivation. Even if functional integration were achieved through better supervision and training, however, problems of organization and management would still need to be addressed, e.g., lines of authority, ultimate responsibility for outcomes, and responsibility for financial support.

2. The program must address the question of sustaining the motivation and morale of program volunteers through continuous incentives. Although workers may have been attracted to the job for reasons of community prestige and social service, motivational experience shows that voluntary service without adequate compensation is not sustainable in the long run. In addition to the incentives currently available to BSPOs, community level income-generating projects might be encouraged and given better support by local governments and by POPCOM.

3. A scheme should be devised whereby FTOWs and BSPOs could be paid for each contraceptive user brought to the program. Payments should be only for more effective methods and pro-rated on a method-specific basis. Eventually, however, the government ministries, both at the local and national levels, must address themselves to the question of more effective, adequately trained, paid field workers, perhaps in lesser numbers than the current goal of poorly trained, poorly supervised volunteers.

4. Program personnel should actively promote and encourage the long-range goal of POPCOM, namely an average number of two children per family. This will require constant reinforcement of the Outreach workers.

5. BSP survey techniques should develop a system to ensure complete enumeration of MCRA in geographical areas. Training should include a session on MCRA enumeration, using a systematic approach of household enumeration. A

map of the geographical target should be prepared and updated by the BSPO and FTOW. Spot checks for accuracy and completeness should be done on a regular basis.

6. Traditional birth attendants (TBAs) should be co-opted into the family planning service delivery effort to assist, cooperate and refer clients to FTOWs and BSPOs.

7. There is need to provide greater assistance and support to the private sector--both PVOs and the commercial sector. It is unrealistic to expect the government to provide all the management and drive to implement the national program, especially when service statistics show that PVOs contribute a significant number of acceptors to the family planning effort.

The PCF is the logical organization to coordinate, organize, support, and serve as a broker for private sector funding. It has, to some extent, attempted to do this by bringing new organizations into the population effort, and providing them with technical assistance through centrally funded sources. This broker function, however, is limited. It could be expanded and further articulated so that PCF could truly complement POPCOM as a channel for local and foreign assistance to major private sector programs.

8. USAID should explore other alternatives for funding certain NGOs. One avenue might be through USAID's PVO Co-Financing Program. Not-for-profit organizations recognized by the Philippine Government could be registered with USAID so that they would be eligible to submit proposals for funding. There are USAID staffing constraints under this program, however, so if this avenue were available to NGOs, only a limited number of proposals might actually be considered.

### III.3 Information, Education, and Communication

1. POPCOM IEC staff would benefit from technical assistance for IEC planning and strategy development. POPCOM should synthesize and evaluate all earlier IEC studies and projects to ascertain what is known and to devise more effective and efficient IEC strategies. Relevant studies and projects undertaken by the U.P. Institute of Mass Communication could be more adequately utilized in IEC planning activities.

2. IEC activities should be synchronized with family planning services provided by itinerant teams and with FTOW and BSPO motivational efforts. Thus, as the COS survey suggests, FTOWs should be systematically informed of radio broadcast schedules and instructed to inform their BSPOs and MCRAAs about them, so that motivational efforts are strengthened and the number of listeners to family planning broadcasts are substantially increased.

3. IEC support to Outreach and clinic workers could be greatly improved if enough materials were produced and made widely available through a regularized, systematic, and cost-efficient distribution system. Comic books and leaflets are most useful to FTOWs and BSPOs. As the COS survey

recommends, efforts should be made to ensure that each BSPO receives printed IEC materials and keeps at least one copy of each for her own reference and for the reference of MCRAs in her catchment area.

4. Since interpersonal communication remains by far the most effective means of providing information and generating motivation, FTOWs, BSPOs and clinic staff should periodically get refresher courses to update their information and sharpen their skills. Such training would allow them to receive adequate supervision and guidance in their motivational work. The importance of home visits by FTOWs and BSPOs should be emphasized, and both should be encouraged to increase their home visiting functions. Priority should be given to visiting MCRAs who live relatively far from the clinic or BSP as they are less likely to be reached by other field personnel.

5. IEC activities should be intensified and undertaken on a wider scale to motivate special groups for family planning. While some IEC projects targeting males are under way, these can certainly be expanded and intensified. More attention should be given to motivating husbands, since they are more likely than their wives to want large families and to oppose family planning practice. Likewise, Muslims require special IEC approaches because of their relatively high resistance to family planning practice.

6. Emphasis should be placed on formulating and transmitting IEC messages that are motivational and outcome-specific in design and delivery. In addition, there is a need to organize special campaigns and train staff to counteract rumors about the side-effects of various contraceptive methods, especially the notion that vasectomy and castration are the same thing, or that vasectomy leads to impotence.

7. The IEC programs of POPCOM, NEDA and the PCF should be encouraged because of the importance of drawing political leaders, program administrators, media personnel, and other influentials to support population efforts. POPCOM, NEDA, and PCF should intensify their activities in the formulation of strategies to sensitize these groups through continuous dialogues, seminars, workshops, and dissemination of information on the implications population growth has for economic development and family welfare.

8. Given that IEC materials design and development are increasingly being done in the regions, IEC messages should reflect local cultural needs and sensitivities and should be in the local dialect.

9. The IEC program should capitalize on the use of community influentials as role models for the program. For instance, in Leyte the picture of a bishop on a family planning calendar endorsing responsible parenthood is a powerful IEC strategy. The acceptance of vasectomy by some community officials and influentials should be widely publicized through IEC messages.

The Catholic Church has a significant influence on an individual's decision to accept a method of family planning. The present approach of advocating responsible parenthood should be continued as an IEC strategy.

However, the more effective FP methods should be stressed on the individual level. These IEC approaches should address action specific behaviors related to the theme of responsible parenthood. For example, once the concept is widely disseminated, IEC should focus on activities designed to produce specific results, e.g., talk with your husband about FP, visit an FP clinic, etc.

10. There should be stronger linkages and interaction between POPCOM and the pop ed program. Considering how crucial pop ed can be in formulating the population attitudes and values of children and youth, and the magnitude of pop ed activities nationwide, POPCOM needs to take a more active interest and involvement in this program.

11. Parents must be persuaded that high investment in a small number of children can be more rewarding than low investment in a large number of children. This will be much easier to accomplish, of course, in an economic environment where resources for investment exist in the first place. But it can be done even when resources are low, as has been shown in other Southeast Asian countries with strong pro-family values.

12. Demand generation should be regarded as more than simply another type of IEC. Unless desired family size resumes its earlier decline, the demand for family planning will be saturated while growth remains high. A strong and vocal commitment from the national leadership is one of the most important mechanisms for a future decline in desired family size. Strong support from this level can have an effect on attitudes and priorities at all levels of the government bureaucracy. It can have a direct impact on the preferences of households, as well as an indirect impact through economic, educational, and health institutions.

13. POPCOM should try to persuade the leadership of the critical role of population growth in national and regional development. USAID can help, but the Philippine agencies that are most involved in development activities must take the lead.

#### III.4 Logistics

The issue of withdrawing stocks from the BSPO level should be resolved before AID agrees to the sale of AID-supplied contraceptives. The best way to resolve it might be the pilot test proposed in AID's January 6, 1986 letter to POPCOM concerning the CRS.

#### III.5 Manpower and Training

1. POPCOM should carefully review the duties and responsibilities of regional personnel, making certain there is no overlap. Where duplication of responsibilities is identified, staff in regional offices should be reduced or shifted to the field.

2. Careful screening of all physicians should be a regular process before admission. Some MOH physicians are asking to be trained in VSS, yet several MOH-trained physicians have either emigrated abroad or are not making use of their skills.

3. Itinerant teams should be used in areas where there are no trained physicians, in conjunction with MOH trained BTL physicians working in municipal hospitals. Because of higher priority surgery schedules in hospitals, many VSS procedures are postponed. A mechanism is needed to use the itinerant team as a backup for VSS procedures in case of conflicting surgery schedules. Furthermore, higher priority must be given to attending to VSS clients. Physicians responsible for the VSS should arrange with the itinerant team or another trained physician in the hospital to substitute in case of an emergency.

4. POPCOM central and regional staff should be allowed flexible time to undertake short-term training programs specific to their area. Fellowship opportunities should be provided to staff to enroll in relevant courses that require an academic paper, research report, or research proposal.

5. Outreach field workers must be equipped with both technical and essential communication skills to counter attitudinal barriers to FP acceptance. Training programs should be updated to include skill-building sessions in subjects identified by recent surveys. Training programs should include role playing situations in which communication skills can be improved.

6. TOWs and BSPOs should receive additional training in recordkeeping and reporting. Timely MIS feedback to the outreach team should result in continued interest and motivation.

### III.6 Management Information System

1. Each item of information collected on the numerous reporting forms should be critically reviewed. A rationale should be developed defining why the item is important and how it will be used in program planning, decision making, and priority setting. Once this list has been prepared, variables to be correlated and cross-tabulated should be identified, and an outcome, action-oriented statement developed to describe how these bivariate relationships will be used to implement motivational activities and IEC campaigns. A cross-tabulation of distance from clinic and method of contraception, for example, would allow a clinic to emphasize motivating and recruiting clients in the more remote areas where larger percentages of the population lives.

2. Clinics should reconcile their active client file on a monthly basis in cooperation with the TOW who brings updates from the BSPO. Major attention should be given to NCM, particularly to contraceptive acceptors, to ensure that clinic records are in accordance with BSPO records. These validated records would be sent quarterly to the regional office for data verification and monitoring of contraceptive prevalence and use effectiveness.

3. In order to make an accurate assessment of the number of continuing users, a random sample (e.g., 10 percent) of RCM users could be identified, visited, assessed and recorded by the FLOW/BSPO on a quarterly basis. These data would be specific to the respective clinic and reported to the regional office.

4. Regional offices must acknowledge that incomplete data from clinics and inadequate data validation do not allow for an effective and efficient MIS. Furthermore, local areas must begin to appreciate the MIS and identify how it benefits them in order to gain their cooperation and compliance.

5. Before implementing a computer data processing system in all regional offices, staff responsible for data entry and processing should be trained at the central office. A software package including both a data-base management program (e.g. dBASE III) and a statistical program (e.g. SPSS-PC+, Systat, or Stat Pak) should be ordered for each regional office. A computerized system should greatly improve the timeliness and completeness of data reporting, processing, interpretation and evaluative action.

6. An external data processing/data management consultant should be contracted to work with the regional offices to collect and aggregate all clinic information for the national program. Data from each clinic in the region would be submitted to the regional office on a monthly basis where it would be entered, processed and evaluated. Quarterly statistics should be aggregated by clinic and univariate frequencies provided.

7. USAID should continue funding the MIS, with particular emphasis on key staff training and skill development. Regional office staff in charge of the data base management should all be trained using a standardized curriculum agreed upon by the external consultant and POPCOM. The GOP should fund the printing and distribution of the data collection forms. Major efforts must be directed toward improving of the data collection system to ensure that it is responsive to management needs.

### III.7 Additional Recommendations to POPCOM

1. POPCOM's review of population-related research should be perfunctory or omitted entirely if the proposed research does not involve service delivery. Virtually all funding agencies have their own review processes, and most research organizations have regulations regarding the treatment of human subjects, audit controls, etc. It would be sufficient for POPCOM simply to maintain a registry of projects, only investigating further those which bear on POPCOM's coordinating function.

2. If the research review function must be maintained, it should be conducted in a regular and timely manner by qualified independent advisors. The advisors or reviewers should be researchers in the appropriate fields, who

have no conflict of interest with the projects reviewed. A standing committee with standardized review forms could be utilized, reducing demands placed on POPCOM.

3. Even if neither of these suggestions is accepted, POPCOM should not evaluate outside proposals primarily in terms of their probable contribution to the high scenario. POPCOM can use this criterion with its own funds, of course, but other research organizations should be allowed to do scientific research even if it has no bearing on the high scenario.

4. POPCOM should re-evaluate its growing reluctance to incorporate collaborators from other countries. It is true that the Philippines has developed its technical and scientific expertise beyond the point where foreign advisors, as such, are needed. But collaboration among investigators, regardless of nationality, is another matter and should be continued. It is would be better if judgments about collaboration were made solely on the basis of technical requirements.

5. The organizational structural issues related to the four recommendations above should be taken seriously. NEDA should commission a Philippine organization, such as the U.P. College of Public Administration, to conduct a review of the functions of POPCOM and to recommend an improved structure to perform these functions.

### III.8 Additional Recommendations to USAID

1. It is important that USAID continue to be reactive rather than directive and that it avoid the appearance of intrusiveness. There are certain regulations regarding contracts, procurements, etc. that are beyond the control of the local Mission Officers. Apart from following these regulations, the main concern should be to facilitate, to present options, and to offer advice.

2. It is extremely important that the position of Population Officer be filled again, as scheduled. The volume of population funding and the importance to all of USAID's development projects of a decline in the growth rate require strong staffing of the population office. Obviously, the staffing should be calibrated with any future projects. Although at this time there is no successor to PP III, a Population Officer could stimulate the development of new projects as well as monitor ongoing ones.

3. USAID should look beyond supply issues--the availability and attractiveness of contraceptive technology--and pay more attention to demand generation at the household level. USAID, more than any other major actor in the population field, has fostered the overwhelming emphasis on supply of contraception in the present program.

4. In funding future population projects, USAID should strongly emphasize the inclusion of components for evaluation, monitoring, research,

and MIS. There is a tendency to downplay the importance of these activities in an action program. It is essential that the NDSs and CPSs be continued.

5. USAID should ensure that its support to NGOs continue, even if there is a hiatus after 1986 in the funding of the main Outreach program. The evaluation team supports USAID's continued funding of contraceptive supplies, which has been extended to 1989.

6. USAID should take a more active role in facilitating the exposure of Philippine population professionals to programs that have proved successful in other countries, especially in Asia, (e.g., through study visits to those countries or technical assistance from them).

7. USAID staff, including the PHN Officer, should become more familiar with field operations. More familiarity with circumstances at the barangay level is needed if USAID is to continue to be useful in program development.

8. It is critical to identify the components of an educational program and to write specific educational objectives for each activity. (See Appendix D, Behavioral Science/Health Education Framework.)

9. Future proposals should identify specific, measurable and quantifiable objectives. USAID should work closely with the cooperating agency to identify specific impact and outcome measures and to ensure that these are realistic and time-specific. An evaluation component should be prepared for each input, with specific attention given to identifying educational and behavioral outcomes. Evaluations should be conducted on an annual basis and should include a report on the status of the project and an assessment of each input activity and its resultant impact.

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**APPENDIX A**  
**SCOPE OF WORK**

Appendix A

SCOPES OF WORK

I. Scope of Work for Phase I Evaluation--University of the Philippines

A. Core Scope of Work

1. Assess the progress in the process of institutionalization especially for outreach--with findings and recommendations for future USAID assistance. Subjects for investigation:

- a. Role of Local Governments (provinces, cities and municipalities)
- b. Financial feasibility (national and local)
- c. Administrative feasibility (national and local)
- d. Adequacy of training
- e. Adequacy of supervision

B. Additional Questions to be Addressed

1. To what extent has attrition of outreach personnel been a problem, and what are the causes?
2. What actions were taken in response to the recommendations from the PP II evaluation?
3. What form will outreach take in the local governments which cannot afford to fully absorb its cost?
4. What form of assistance is needed by local governments that are already absorbing salaries and part of recurrent costs?
5. What is local government perception of outreach personnel functions?
6. Determine the adequacy and responsiveness of current training provided to outreach personnel.
7. Is the commodity procurement/distribution procedure responsive to the needs of the program?
8. What is the extent of availability and adequacy of IEC materials?

II. Scope of Work for Phase II Evaluation--The Current Evaluation

1. Assess the project input level timeliness and utilization experience and provide findings and recommendations with regard to adequacy or excess of funding; scope (focus too narrow or too broad?) of project involvement; limitations of input approval, financing and monitoring requirements.

2. Assess the project output level achievements and provide findings and recommendations regarding: (a) continued importance of outputs; b) priorities for balance of PP III; c) priorities for future AID assistance.

3. Assess the project purpose and goal level achievements. To what extent has modest project progress at the purpose and goal level been due to: less than full utilization of inputs; difficulty in translating inputs into outputs; lack of linkages between outputs and purpose; factors external to the project? What can be done--within the context of a development project--to design a future assistance framework which will avoid these factors and increase the likelihood of purpose and goal achievement?

B. Additional Questions to be Addressed

1. What is AID's comparative advantage to GOP vis-a-vis GOP and other donors as sources of financing? How can we capitalize on this in future plans?

2. Did PP III provide adequate support to the private sector? Should a major private sector initiative be encouraged? How would such a package be coordinated to insure complementary [sic] and consistency with GOP policies/activities?

3. Were project financed research findings integrated into program activities? Were program managers integrated into research designs as potential consumers of findings?

4. How can project linkages with universities, private sector organizations, and other RP ministries be strengthened to gain maximum advantage from all available sources of support? Are "partner agencies" and "participating agencies" contributing to their full potential?

5. To what extent were PP III resources in excess of program needs and absorptive capacity so that resource transfer considerations overtook rational planning and became a principal objective rather than a means to an end? Have we managed for movement of resources or achievement of purpose? How can we remedy this in a future project?

6. What is the current status of MIS, and how is it being used to measure program progress?

7. How important is the sterilization subsidy and should cost reimbursement to service providers be considered for reversible clinical methods?

8. In light of the 1983 National Demographic Survey results, what issues are likely to be raised by AID/Washington in approving additional bilateral population assistance to the Philippines? How can we best respond to those issues?

**APPENDIX B**  
**DESCRIPTION OF TEAM MEMBERS**

Appendix B

DESCRIPTION OF TEAM MEMBERS

Thomas W. Pullum, Ph.D., (Team Leader) is Professor of Sociology, University of Washington, Seattle, and Director, Center for Studies in Demography and Ecology, University of Washington. He holds a Ph.D. in Sociology (1971). Earlier relevant experience includes Research Associate for World Fertility Survey (1976-77 and 1983-84) and Assistant Professor, Department of Population Studies at Harvard (1972-74). Dr. Pullum was Visiting Research Associate at the Population Institute, University of the Philippines (1971-72) and has maintained continuing contact with the Philippines since that time. Dr. Pullum co-authored the Impact Assessment of PP II in 1981.

Elizabeth Q. Bulatao is a Filipina who has worked recently in the United States including: 1981-83, Programme Officer for International Women's Health Coalition, and 1977-80 as a research intern at East-West Population Institute in Hawaii working primarily on Philippines data. In 1976-77 she was Program Assistant for FPIA in the Philippines. 1974-75, Fellow, Project Development Division, Population Center Foundation in Manila, and 1971-1974 Social Services Specialist for NEDA. She holds an MA degree in Sociology from Loyola University, Chicago.

Donald E. Morisky, Sc.D. holds Sc.D. and M.S. degrees in public health from Johns Hopkins (1981 and 1977) and an M.S.Ph from Hawaii in family planning studies, demography and health services administration (1971). He is Assistant Professor of Behavioral Sciences and Health Behavior at UCLA. He spent six years in the Philippines including 1973-75 as a postgraduate fellow of the Carolina Population Center assigned to the Institute of Community and Family Health, and 1968-71 as a Peace Corps Volunteer. Additional family planning-related work has included coordinating a grant for a Hawaii family planning needs assessment project, and acting as Co-Principal Investigator for traditional birth attendants and family planning projects in the Philippines through Asia Foundation and Rockefeller Foundation.

William R. Thomas 3d is a staff member of the International Science and Technology Institute, Inc. (ISTI) Washington D.C. He has a BBA from the University of Georgia (1950) and did graduate studies at the University of Maryland (1950-51) and National War College (1963-64). With ISTI, he completed short-term assignments as chief-of-party for the evaluation of USAID projects in Sri Lanka and Egypt, and project development for USAID projects in Pakistan (1982-84). He has also been involved in senior capacities in various development projects in Syria, Greece, Burma, and Indonesia under the auspices of IBRD, ADB & SEATEC (1977-80). From 1968-76 he worked in Thailand, Pakistan, and Washington in various assignments with AID.

**APPENDIX C**

**PERSONS INTERVIEWED, LOCATIONS VISITED**

Appendix C

SCHEDULE OF MEETINGS IN MANILA  
PP III EVALUATION TEAM

January 6, 1986      Mr. William H. Johnson, Chief,  
                         Office of Population, Health and Nutrition,  
                         USAID/Manila

                         Mrs. Zynia L. Rionda, Program Specialist, USAID/Manila

                         Mr. Stirling Scruggs, United Nations Fund for  
                         Population Activities (UNFPA)

January 7, 1986      Mr. Ric E. Rhoda, Deputy Program Officer and  
                         Evaluation Officer, USAID/Manila

                         Mr. Frederick W. Schieck, Director, and  
                         Mr. John S. Blackton, Deputy Director, USAID/Manila

                         Mr. Vicente Salazar, Jr. Acting Director for External  
                         Assistance, and  
                         Mr. Eduardo Callanta, Assistant Director of Social  
                         Services, National Economic & Development Authority  
                         (NEDA)

                         Dr. Alex Herrin, U.P. School of Economics

January 8, 1986      Atty. Eugenia G. Jamias, Executive Director,  
                         Commission on Population (POPCOM)

                         Atty. Senon Posadas, Executive Director, Family  
                         Planning Organization of the Philippines (FPOP), and  
                         staff

                         Dr. Perla Sanchez, Executive Director, Institute of  
                         Maternal and Child Health (IMCH)

January 9, 1986      Dr. Zelda Zablan, Director, UPPI and staff

                         Minister Jesus C. Azurin, Ministry of Health (MOH)

                         Dr. Conrado Lorenzo, President and Executive Director,  
                         and Ms. Aida Sayson, Officer-in-Charge, Programs  
                         Division, Population Center Foundation (PCF), and staff

                         Minister Sylvia Montes, Ministry of Social Services  
                         and Development (MSSD)

January 10, 1986      Mr. Gaudioso Sosmena, Jr., Director, Bureau of Local Government, Ministry of Local Government

                         Mr. Kenji Ikari, Japan International Cooperating Agency (JICA)

January 20, 1986      Ms. Fleur de lys Torres, Director, Social Services Staff, NEDA

January 22, 1986      Dr. Flora Bayan, Project Director of Primary Health Care, and Dr. Emma Robles, Acting Director of MCH/Family Planning Services, Ministry of Health (MOH)

Additional meetings were held with several of the above individuals and with the following staff of POPCOM:

Dr. Ester Sy-Quinsiam, Deputy Executive Director

Ms. Florina Dumlao, Planning Division Chief

Mr. Tomas Osias, Population Project Officer, Planning Division

Ms. Luisa Nartatez, Planning Officer I, Planning Division

Mr. Ephraim Despabiladeras, IEC Division Chief.

Ms. Bethel Villarta, Population Manpower Development Division Chief

Mr. Anthony Arenas, Logistics Division Chief

Mr. Lamberto P. Balagtas, Administrative Division Chief

FIELD TRIP  
PP III EVALUATION TEAM  
(Pullum, Bulato, Morisky)  
JANUARY 13 - 18, 1986

January 14-15, 1986

Region IX: Zamboanga City & Basilan (Isabela & Lamitan)

January 14, 1986

Zamboanga City Hall

Mr. Manuel A. Dalipe	- City Mayor
Mr. Rustico Varela	- City Administrator
Mr. Jaime Vaquez	- City Treasurer
Mrs. Virginia Gara	- City Budget Officer
Mr. Francisco Barredo	- City Population Officer
Mr. Generoso Celerio	- District Population Officer
Ms. Cecilia Reambonanza	- District Population Officer
Mr. Wilfredo Petilos	- District Population Officer
Ms. Cristina Arevalo	- District Population Officer

POPCOM Regional Population Office Staff

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Ms. Encarnita M. de la Paz	- Service Delivery Coordinator
Ms. Floreza Z. Ligayo	- Training Specialist
Ms. Cecilia Alda I. Magbanua	- Supervising Information Officer
Mr. Francisco S. Aquino	- Administrative Officer
Mr. Enrique Pioquinto	- COA Auditor
Mr. Librado T. Catapang	- Budget Officer
Ms. Belinda T. Tangco	- Regional Accountant
Mr. Enrique Asuncion	- Logistics Officer
Ms. Estrella Annastacio	- BSPO (Campo Sutterville)
Ms. Josefina Bue	- FTOW (Campo Islam)
Ms. Nelinda Saipuddin	- FTOW (Malivanan)
Mr. Felix V. Rosario	- Director, Neighbors Pop. & Dev. Services

	Ms. Isabel Rosario	- Clinic Manager & Coordinator
	Ms. Nurmina Tandoc	- Clinic Nurse
<b>Health Office Family Planning Clinic</b>	Dr. Purita Fernandez	- City Health Officer,
	Ms. Natividad Ledesma	- Supervising City Nurse
	Ms. Erlinda Sta. Teresa	- FP Nurse
	Ms. Soledad Tiongco	- FP Clinic Attendant
<b>January 15, 1986</b>		
<b>Basilan Province (Isabela)</b>	Mrs. Macute	- Acting Provincial Treasurer
	Mr. Eduardo Bairdo	- MSSD Provincial Social Welfare Officer
	Ms. Catalina Pastrana	- FTOW
<b>Isabela Rural Health Unit</b>	Ms. Bienvenida Lahaman	- Public Health Nurse
	Mrs. Leonora Democrito	- Public Health Midwife
<b>Integrated Prov. Health Office/ Isabela District Hospital</b>	Dr. Jaime Junio	- PHO
	Dr. Agnes Yu	- Asst. PHO
	Mrs. Evelina Arceo	- Supervising Public Health Nurse
	Mrs. Olympia Olana	- Public Health Nurse & M.C.H. and FP Coordinator
<b>Lamitan</b>	Mr. Wilfredo Furigay	- Municipal Mayor
	Mr. Romeo Rivero	- Budget Officer/ Acting Population Officer
	Ms. Putlih Casalin	- FTOW
	Ms. Araceli Claridad	- FTOW
	Ms. Florecita Garin	- FTOW
<b>Others:</b>	Ms. Josefina Bautista	- NFA Prov. Manager (Basilan)
	Mrs. Furigay	- Lamitan
<b>January 16, 1986</b>	<u>Region VIII: Cebu City, Lapu Lapu City &amp; Mandaue City</u>	
<b>City Population Office: Cebu City</b>	Dr. Felicitas Manaloto	- Acting CPO
	Mr. Jesus Gutierrez	- DPO
	Ms. Carlota Redona	- DPO
	Dr. Veronica Alivio	- Vasectomy Clinic Physician
	Dr. Andres Saberon	- Vasectomy Clinic Physician
	Ms. Norma Velasquez	- Vasectomy Clinic Nurse

Dr. Frediswinda del Mar	- IMCHP FP Physician (Sugbuanon Rural Bank FP)
Mrs. Emergencia Lumakong	- IMCH FP Midwife (Sugbuanon Rural Bank FP)
Mrs. Ester Subingsubing	- IMCH FP Nurse, OIC- Instant Sagot (IMCH Hotline)

City Population Office: Mandaue City

Mayor Demetrio M. Cortes	
Ms. Aleta E. Cabilao	- CPO
Ms. Dulce E. Sester	- FTOW
Ms. Merve S. Acain	- FTOW
Ms. Marietta Ll. Latonio	- FTOW
Ms. Liza L. Briones	- FTOW
Ms. Annabella P. Ceniza	- FTOW
Ms. Teresita B. Enriquez	- FTOW
Ms. Gloria C. Adolfo	- Clerk
Ms. Loreta I. Perez	- Clerk

Regional Population Office 7

Mr. Felix C. Sevidal	- PPC
Ms. Sandra V. Manuel	- Acting PPO/Research & Evaluation Coordinator
Ms. Annabelle V. Abano	- Clinic Services Coordinator
Mr. Cesario Castro	- Senior Population Research Assistant
Mr. Miguel Carillo	- Training Coordinator
Mr. Olimpio Andan	- IEC Coordinator

City Population Office: Lapu-Lapu City

Mayor Maximo V. Patalinghug	- City Mayor
Mr. Benjamin Canete	- CPO
Ms. Fe Aton Baguio	- FTOW
Ms. Carmelita Dungog	- FTOW
Ms. Cristina Quirol	- FTOW
Mr. Salem Paquibot	- FTOW
Ms. Francisca Senerpida	- FTOW
Ms. Elsa Calvez	- Clerk

January 17 - 18

Region VIII: Tacloban City, Leyte Province  
(Alang-alang municipality), Ormoc City

**Regional Population Office Senior Staff**

Mr. Leo R. Rama	- Population Programs Coordinator
Ms. Reynalda L. Perez	- Population Project Officer
Ms. Lucy V. Sundiang	- Administrative Officer
Mr. Jose L. Jocano	- Service Delivery Coordinator
Ms. Jesusa I. Villarante	- Training Specialist
Mr. Indalecio M. Abogado	- IEC Coordinator
Ms. Dolores G. Mondragon	- Research Coordinator & MIS Unit Head
Mr. Edilberto T. Torralba	- Supply Officer
Mr. Benedicto V. Perez	- Budget Officer
Ms. Susan B. Tejada	- Regional Accountant

**Field Support Team (FSTs)**

Ms. Clemencia C. Tabao  
Mrs. Ma. Teresita L. Dapon  
Ms. Evangeline B. Mendoza  
Mr. Jeffrey G. Gallito  
Ms. Ma. Jane M. Baranda  
Ms. Sylvia O. Banquerigo

**Tacloban City**

Mayor Obdulia R. Cinco	- City Mayor
Ms. Lourdes Racho	- City Population Officer
Ms. Betty Garrido	- Provincial Population Officer, Leyte

**Alang-Alang Municipality**

Mayor Andres Yu	- Mayor
Dr. Edilberto Trinidad	- RHU Physician
Ms. Joyce Mosca	- RHU Nurse
Ms. Haydee Restor	- RHU Nurse
Ms. Delia Aparillo	- RHU Midwife
Ms. Olivia de Veyra	- RHU Midwife
Ms. Remedios Barantes	- PPO/FTOW
Ms. Anita Adarne	- FTOW

**Jaro, Leyte**

Mayor Juan Arbes	- Mayor
Ms. Lolita Arigo	- FTOW
Ms. Rosauro Diola	- FTOW

**Ormoc City  
Population Office**

**Acting Mayor Jose Aviles  
Mr. Edwin L. Davis  
Ms. Clodetha A. Davis  
Ms. Ma. Dina T. Arradaza  
Ms. Amelia E. Agija  
Ms. Chonita B. Arcuvino  
Ms. Ma. Lily C. Capala  
Ms. Delia D. Corbo  
Mr. William Roy C. Dadios  
Ms. Juliet B. Escalon  
Ms. Vivian Z. Martizano  
Ms. Emilia J. Tingson  
Ms. Elena Q. Tolentino  
Ms. Conchita L. Yrastorza**

- CPO  
- DPO  
- DPO  
- FTOW - POW  
- FTOW - POW

**Ormoc General  
Hospital**

**Dr. T. Marte  
Dr. S. Abano**

- Hospital Director  
- Family Planning  
Physician

FIELD TRIP  
(Thomas)  
JANUARY 17, 1986

P L A C E

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	Ms. Luz Salonga	- FTOW, Mexico City, Pampanga
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	Mr. Ruben S. Rojas	- Assistant Population Officer, Pampanga
	Ms. Marie A.J. Ventura	- Provincial Population Officer, Pampanga
	Ms. Carmencita Tolentino	- Chapter Program Officer Family Planning Organization of the Philippines, (FPOP), San Fernando, Pampanga
	Mrs. Criselda Bonifacio	- Barangay Supply Point, Pampanga
	Mrs. Gloria Icano	- Midwife, Macabehe Rural Health Unit, Pampanga

**APPENDIX D**  
**BEHAVIORAL SCIENCE/HEALTH EDUCATION FRAMEWORK**

## Appendix D

### BEHAVIORAL SCIENCE/HEALTH EDUCATION FRAMEWORK

The absence of a behavioral science/health education, diagnostic, planning, and evaluation framework is a basic problem in many programs. Programs are usually developed after needs assessment analyses. Objectives are often measured only in terms of outcomes, however, and little consideration is given to the educational and behavioral linkages that are expected to occur between inputs and outcomes.

Consider the hierarchy of objectives figures in which IEC activity inputs are directly related to knowledge and motivation outputs and acceptors (Figure D-1). This model reflects the thinking of the early family planning programs in which knowledge would affect attitudes, and attitudes would be positively related to the practice of family planning. It is true that IEC activities stimulate knowledge and motivation, which may increase the number new acceptors over time. However, several socio-psychological attitudes intervene between activities and an individual's desire to accept family planning.

A useful framework for examining the many factors (both structural and cognitive) is presented below (Figure D-1). The framework is known as PRECEDE, an acronym for predisposing, reinforcing and enabling causes in educational diagnosis and evaluation. Given that acceptance of family planning is the behavior to be affected, one first identifies the various predisposing factors that are positively or negatively related to the behavior. These predisposing factors include an individual's attitudes, knowledge, beliefs, and values. One would carefully examine the relation of these variables to the outcome behavior. Perhaps an individual possesses all positive attitudes, beliefs and values related to FP acceptance, but supplies are not readily available, or the distance to the FP clinic is too great. Then one would examine the various enabling factors that both positively and negatively affect the behavior. A third factor is the reinforcing mechanism so important in decision making and the maintenance of FP practice. Reinforcement can be negative (husband objects) or positive (constant motivation and support from the BSPO). Again, a thorough analysis of the positive and negative influences of reinforcement is necessary. The critical activity in this whole diagnostic process is to identify the components of an educational program (e.g., IEC, mother's classes, day care, adolescent sexuality, etc.), which would be represented from each of the predisposing, enabling and reinforcing factors. Specific educational objectives should be written for each activity. For example, one activity in a BSPO training program would be to provide communication skills and reinforcement techniques to BSPOs, which they can use to appeal to and influence the existing motives of MCRA's currently in need of FP services. This activity would be quantified as a training objective which defines who will do how much of what by when. (For example, 50 BSPOs will be trained during a three-day period to acquire communication skills required to motivate and reinforce positive attitudes and

beliefs regarding FP acceptance.) A series of educational objectives would be identified for each activity in the training program.

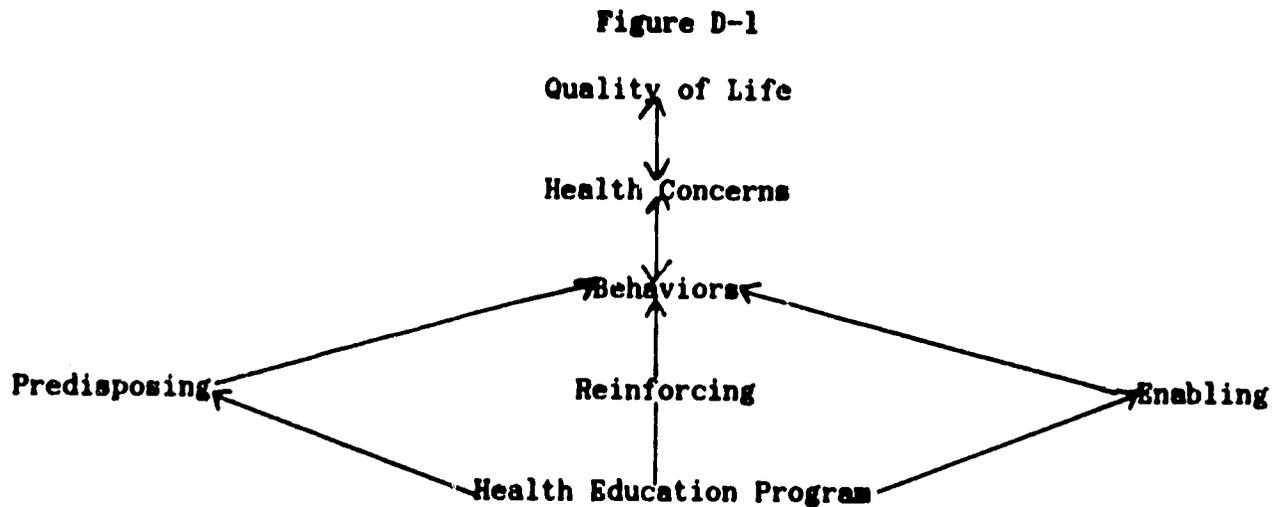


Figure D-1: The PRECEDE Framework (predisposing, reinforcing, and enabling causes in educational diagnosis and evaluation).

These steps are mainly concerned with diagnosis and planning. It is essential that educational and behavioral objectives be stated quantitatively, for the evaluation is based on these objectives. The evaluation process consists of taking an object of interest and comparing it with a standard of acceptability. The evaluation can be done at any stage in the educational program.

An evaluation systems usually has four components: structure, process, impact, and outcome. The structure is concerned with the organization, its staffing pattern, span of control, roles and responsibilities. Process is assessed by enumerating the type and kind of activities implemented during the program. Impact is concerned with immediate program effects of changes in knowledge, attitudes, beliefs, values, and behaviors (e.g., contraceptive practice). Outcomes measures are directed toward the short- and long-term effects of the impact measures: contraceptive use effectiveness, prevalence rates, numbers of births averted, changes in the fertility levels, and cost benefit/cost effectiveness.

This series of diagnostic activities must take place prior to the implementation of the educational program. The framework allows one to diagnose the behaviors related to the health outcome, and then identify specific factors that either facilitate or prevent the behavior from taking place. Based on the outcome of the education diagnostic process, an educational program can be planned and implemented. Working in the opposite direction of the framework allows one to evaluate structure, process, impact, and outcome variables at each stage of the program.

Recommendations

(1) Greater specificity must be directed to identifying and understanding the causes that either facilitate or prevent the desired behavior from taking place. Educational and behavioral objectives should be stated in quantifiable terms. These statements of objectives are identified for each process and impact variable which appears in the program.

(2) Future proposals should identify specific, measurable and quantifiable objectives. USAID should work closely with the cooperating agency to identify specific impact and outcome measures, and to ensure that these are realistic and time-specific. An evaluation component should be prepared for each input, with specific attention given to identifying educational and behavioral outcomes. Evaluations should be conducted on an annual basis, and should include a report on the status of the project and an assessment of each input activity and its resultant impact.