

PD-ABF-69
81902

Prepared for

USAID/Manila
under PIO/T 492-0396-3-20078
and Office of Population
Bureau for Research and Development
Agency for International Development
Washington, D.C.
under Contract No. DPE-3024-Z-00-8078-00
Project No. 936-3024

MIDTERM EVALUATION OF THE
FAMILY PLANNING ASSISTANCE
PROJECT (492-0396): PHILIPPINES

by

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Fieldwork
September-October, 1992

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Report No. 92-166-146
Published April 9, 1993

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Acknowledgments

The evaluation team wishes to express its sincere appreciation to all of the staff of USAID/Manila for making the team feel at home and for the professional exchanges that made the exercise such a pleasant, yet challenging, one. The team is equally grateful for similar professional exchanges with its Philippine hosts in the public and private sectors all the way from the secretary of health to the volunteer village health workers at *barangays*. Team members also wish to note that they thoroughly enjoyed and profited from the many discussions with members of the devolution team.

Glossary

A.I.D.	Agency for International Development
AVSC	Association for Voluntary Surgical Contraception
BHW	<i>barangay</i> health worker
BSPO	<i>barangay</i> supply point officer
CBD	community-based distribution
CPR	contraceptive prevalence rate
CSM	contraceptive social marketing
DOH	Department of Health
EDF	Economic Development Fund
EPZ	Export Processing Zones
FHSIS	family health statistical information system
FPAP	Family Planning Assistance Project
FPMD	Family Planning Management Development (project)
FPOP	Family Planning Organization of the Philippines
FPS	Family Planning Services (section of the DOH)
FTOW	full-time outreach worker
ICS	interpersonal communication skills
IECM	information, education, communication and motivation
IMCCSDI	Integrated Maternal and Child Care Service and Development, Inc.
IMCH	Institute of Maternal and Child Health
IUD	intrauterine device
JHPIEGO	Johns Hopkins Program for International Education in Reproductive Health
JSI	John Snow, Incorporated
KAP	knowledge, attitudes and practices
LGU	local government unit
MCH	maternal and child health
MCRA	married couples of reproductive age
MIS	management information systems
NEDA	National Economic and Development Authority
NFP	natural family planning
NGO	non-governmental organization
OR	operations research
PSI	Population Services International
PCPD	Philippine Center for Population and Development
PCS	Population Communication Services (project)
PFPP	Philippine Family Planning Program
PNGOC	Philippine NGO Council
POPCOM	Population Commission of the Philippines
PVO	private voluntary organization
SOMARC	Social Marketing for Change
TFR	total fertility rate
TS	Technical Secretariat
UNFPA	United Nations Population Fund
USAID	Agency for International Development (overseas mission)
VSC	voluntary surgical contraception

Executive Summary

History and Management Issues

The Family Planning Assistance Project (FPAP — project 492-0396) is a five-year (May 10, 1990 to December 31, 1994), \$40 million grant from the U.S. Agency for International Development (USAID) mission to the Philippine government, with the stated purpose of increasing the availability and utilization of family planning services through support of the Department of Health's (DOH) Philippine Family Planning Program (PFPP). The grant is complemented by \$22.4 million provided by the Philippine government. The project's prime goal is to assist the government to reduce the total fertility rate (TFR).

This report is an evaluation of the project at its midpoint. Fieldwork took place during the fall of 1992, at time when the climate for family planning in the Philippines was more favorable than at any point in recent years. The new administration had publicly committed itself to family planning and to fertility reduction. Top government officials, including the secretary of the National Economic and Development Authority (the equivalent of a ministry of planning) and the secretary of health, had made statements recognizing the importance of family planning and pledging support for critical aspects of the program. Funds had been increased for social services, especially health and family planning, and the secretary of health had pledged to streamline program operations.

At the time of the evaluation, however, the PFPP itself was found to be seriously flawed, the legacy of nearly 10 years of disarray and lack of consistent support. During the 1970s and early 1980s, the Philippines had had one of Asia's most successful family planning programs. For the remainder of the 1980s, however, serious difficulties arose, due largely to a combination of a dropoff in high-level political support, economic stagnation, growing political discontent, and increasingly strong opposition from the Catholic Church. Between 1987-1989, the program's very existence, strategies and thrusts were questioned. During this period, there were two major casualties. The Population Commission of the Philippines (POPCOM), which had spearheaded the program during its successful early years, was stripped of its responsibilities for family planning and left only with development of population policy. The DOH, which took over the provision of services, totally ignored the non-governmental organization (NGO) sector, which had up until then provided more than 35 percent of services as well as a large share of information, education, communication, and motivation (IECM) activities and training. Without POPCOM and a strong NGO sector, the program was unable to provide enough services to meet demand. At the time of the evaluation, the contraceptive prevalence rate (modern methods) in the Philippines was only 22 percent, well behind its neighbors in Thailand, in Indonesia, and even in Bangladesh.

Efforts to find administrative solutions through the creation of a Technical Secretariat (TS) in the DOH have not lived up to their promise. Rather, the result has been that the family planning program is now speaking with two voices, representing DOH's Family Planning Services and the TS. This lack of clear direction from DOH will become even more critical with the recent decision to decentralize many government activities. The new Local Government Code, devolving political, financial, and administrative authority from the central government to local governments, has raised many questions with regard to funding, supervision, and monitoring. It is not only a challenge, however. Devolution also offers significant promise since enthusiasm and commitment for a renewed family planning program appear to exist at the local level: Local investments in this program would increase sustainability and complement both their health and overall development efforts.

This report contains a wide range of recommendations pointed toward restructuring and strengthening of DOH management, reactivation of the NGO sector, and energizing service delivery, training, and IECM. At the same time, no changes are recommended in the design of the FPAP. Rather, the project was found to have made an important contribution toward moving the DOH to reorganize and to make a renewed commitment toward family planning. Moreover, the FPAP is sufficiently flexible to accommodate the challenge and opportunities that devolution presents.

Service Delivery

The PFPP contains ambitious plans for increasing contraceptive use, although a weak DOH management information system (MIS) results in considerable uncertainty with regard to present numbers of users and acceptors. It is believed that numbers of acceptors have risen since 1986, but this encouraging record is marred by high drop-out rates and clinics' failures to meet targets. Pills are the preferred program method but the virtual absence of Depo-Provera, a progestin-only oral contraceptive, and Norplant limit the choice of effective methods available to women. Other areas needing attention are quality of services and coordination of the program both with maternal and child health (MCH) and primary health care activities and with the training, logistics, and IECM aspects of family planning.

From providing 35 percent of services, NGOs had fallen in 1990 to managing only about 17 percent of the family planning clinics in the Philippines. The major constraint to their operating at full capacity stems from a 1990 TS decision that all NGOs had to be reaccredited. The result is that three years later, the status of many of the largest and best-established NGOs remains in limbo. Other curbs on their effectiveness include lack of training, delays in funding, poor logistics support, and failure of the TS to include NGOs in policy decisions regarding family planning.

Of two private sector efforts that are also under way, a work-based project, which targets large businesses with predominantly female employees, was found to merit expansion. A social marketing project, which features condoms (believed to represent about 13 percent of contraceptive use), was judged to be too new to evaluate.

Training

The PFPP's five-year Plan calls for training nearly 50,000 clinical family planning personnel. This massive undertaking is progressing acceptably on the DOH side but not at all for the NGOs, although more than 60 percent of the training was to be directed to this sector. Other areas of concern relate to the lack of a coherent strategy or database and poor coordination among public and private providers. Much remains to be done in completing guidelines for the 14 different courses to be offered, and it was found that many clinical standards were overly restrictive and in need of modification. In addition, scheduling of some courses needs reexamination and a system needs to be established to ensure that equipment, supplies, and materials are available at training sites. Most important, a needs assessment of training requirements should be undertaken on a priority basis.

IECM and Advocacy

IECM has been identified by the DOH as a key element in energizing the PFPP, and USAID and UNFPA are sharing the responsibility for supporting activities. A major deficiency in the overall effort is the lack of a targeting strategy; in particular, strong dividends in terms of new users might be expected if non-contracepting women at health risk were targeted. A large percentage of women

in that category were found to want to plan their families. Although interpersonal communication is arguably the most important element of IECM in the Philippines, little progress has been made either in incorporating outreach workers into plans for IECM or in training clinical staff, particularly midwives, to provide personal counseling on family planning. Population advocacy is the other main aspect of IECM. Although POPCOM has carried out a number of successful advocacy efforts at the regional level, these will need to be extended to lower administrative levels if they are to influence local government unit (LGU) officials to support strong family planning programs. Other opportunities for advocacy exist in the areas of mass media coverage of population issues and the lobbying of various organizations, particularly by women's groups.

Monitoring, Evaluation, Research, and Logistics Management

The dearth of good service delivery data is a serious problem, because without good reliable reports of users, new acceptors, coverage, and quality, it is impossible to measure program accomplishments or deficits. The DOH MIS, to have been instituted in 1990, remains largely a plan. The reports that are generated are of questionable accuracy, and many locations still depend on hand-tallying. Moreover, the NGOs are using a different system with no effort made by the TS to incorporate NGO figures in the DOH totals. A major block to progress in this area is a continuing debate as to the national indicators that should be adopted. With devolution, the need for these standards and indicators will become even more acute.

The PFPP has done no operations research, although evaluations have suggested that studies of this nature might have helped identify solutions to the problems of high drop-out rates and low modern method use.

In the area of logistics, delivery systems have improved under the project, although supplies are still uncertain for NGOs and provision of supplies is not always coordinated with service delivery needs.

Complete Listing of Recommendations

Recommendations for the Department of Health¹

The following recommendations are designed to address four major issues facing the Philippine family planning program: (1) managing the restructuring of the program's administration, (2) taking advantage of opportunities afforded by the devolution challenge, (3) freeing the program's IECM component of existing restrictions, and (4) revitalizing the NGO network and resources.

Five Priority Actions

1. **Management and Organization** — The management of the DOH should be restructured so that the family planning program speaks with one voice to the regional offices, LGUs, NGOs, legislators, donors, and the community at large. This would require that the family planning program in the DOH be a unified command headed by a regular DOH employee.

¹These recommendations were contained in a letter dated October 27, 1992 to the secretary of health, sent him on his request after hearing the findings of the evaluation and devolution teams. The secretary requested a list of actions which he should take immediately to expand and accelerate the program. The list provided contains five major actions plus eleven additional activities that also need attention in the near future. See Appendix C for the text of the letter.

2. **LGU Support** — The 5 to 10 LGUs most likely to accelerate their family planning programs should be selected, based on commitment of their leadership to promoting and supporting family planning. Negotiations should take place with each of the selected LGUs for their future commitment in terms of the staff, space, budget, transportation, advocacy support, and MIS data. In turn, a comprehensive package of training should be offered them, including family planning skills, clinical, as well as MIS, fiscal and resource management skills, computer for data base management, contraceptive supplies, and IECM materials. Finally, the DOH should offer to provide a clinical package of equipment essential for IUD insertion to all *barangay* health stations with trained midwives. Under DOH leadership, support for this initiative could be provided immediately by USAID and perhaps other donors as well.
3. **Standards and Accreditation** — The new accreditation requirements should be waived for all NGOs that were accredited during the POPCOM years. The accreditation process should be completed for all remaining NGOs within the next six months. Training of NCJ staff should begin immediately, employing the existing training modules now being used for the current training of DOH staff in family planning. USAID should be requested to modify the new Economic Development Fund (EDF) training cooperative agreement to enable NGO training to get under way rapidly.
4. **Communication and Logistics** — The IECM program should be activated on television and radio. The latter should focus on informing women of the new family planning program with recently trained staff, improved, gentler oral contraceptives, and the new long-lasting IUD. The CARE network should be used to distribute existing IECM materials, which would be developed and printed under the PCS project.
5. **Human Resource Development** — DOH regional staff should be strengthened through training and technical support for their increased responsibility in family planning. The number of regional staff (including MIS [management information system] and IECM specialists) involved in family planning monitoring at the LGU level should be increased.

Eleven key actions to be carried out simultaneously with the previous list or shortly thereafter:

1. Policy discussion should be initiated with the secretaries of finance and budget and other appropriate offices to establish a budget line item for family planning.
2. The DOH should resume its mandated role of setting policy and establishing guidelines rather than delegating these authorities to the TS and the technical policy committees. This will be key to a successful devolution of DOH resources to the LGU level. Technical assistance can be provided in this area.
3. Policy discussions should continue between the National Economic and Development Authority and POPCOM regarding a collaborative role to strengthen the devolution process.
4. National strategies for training and supervision should be completed.
5. National strategies for IECM should be promulgated.
6. The accreditation process for training and service institutions and individuals should be simplified.

7. Existing clinical manuals and guidelines should be reviewed to identify and eliminate all unnecessary medical barriers that inhibit quality family planning services. Technical assistance could be provided to assist in this area.
8. A program should be initiated to identify, recruit, train, and supply private sector medical institutions and individuals for family planning provision throughout the country.
9. *Barangay* health stations with trained midwives that have not yet received the equipment and supplies needed to support IUD insertions should be provided with these supplies as soon as possible.
10. Technical policy committees should be dissolved. Instead, committee members and other experts can be called upon as needed as paid technical experts to support DOH standards and guidelines work.
11. The work of Technical Policy Committee on Advocacy should be transferred to POPCOM in line with the latter's current responsibilities.

Recommendations for USAID/Manila

Overall Strategy for USAID

Although a new project is contemplated for 1994, no recommendations have been made for revising any section of the FPAP to meet the programmatic needs of the next two years of implementation under FPAP. As a well-designed project, and one that included in its original plan many of the recommendations contained in this report, the FPAP continues to provide an ideal context within which program reforms can take place.

Management (Chapter 1)

1. The FPAP project should remain as designed. No changes are recommended for any of its sections.
2. USAID should support the DOH in its ongoing effort to restructure the PFPP and to get a line-item budget for family planning.
3. USAID should encourage some restaffing of POPCOM leadership so that it acts in complementarity with the DOH.
4. USAID should assist with the selection of up to 10 LGUs in which an integrated family planning and population program would be undertaken. The program would have as a major goal the identification of that organizational and management structure which is most appropriate given the changing roles of all organizations.
5. USAID should support the DOH in disbanding all technical policy committees and assist the DOH in securing technical expertise when needed.
6. USAID should support the transfer of responsibilities of the Technical Committee on Advocacy from the DOH to POPCOM.

7. The monitoring structure of the PFPP should be defined and a choice needs to be made as to whether there should be a unified DOH-NGO or separate monitoring structure.
8. Technical assistance should be given at the national level in the development of a supervision strategy including guidelines. All the supervisory approaches that are developed will need companion plans of execution.
9. The criteria for selection of the project monitoring teams should include requirements for at least one member who has been trained and has experience in clinical family planning and one member experienced in the management of training and supervision.
10. USAID should support requests from the DOH for technical assistance for the management training of regional staff and midwives.

Service Delivery (Chapter 2)

DOH Service Delivery

1. USAID should encourage the government to establish quality assurance teams at the national level.
2. USAID should encourage the DOH to review all clinic service delivery procedures to determine how best the delivery of family planning services and information can be improved and integrated into clinic operations.
3. USAID should urge the PFPP to expand the range of available contraceptives by adding a progestin-only oral contraceptive; expanding the number of service sites offering Norplant; and approving, registering, and offering Depo-Provera at service sites and through the social marketing program.
4. USAID should encourage the DOH to develop a trainee deployment strategy — one that assigns trained personnel according to client demand for family planning and for specific contraceptive methods.
5. USAID should encourage the DOH to coordinate all service delivery, IECM, and training activities by establishing quarterly meetings among relevant staff at both national and regional levels.

NGO Service Delivery

for the NGOs

1. NGOs should attempt to make their strengths known on a wider scale, in particular their innovative strategies to reach the young and unmarried, the men in the workplace, and women at high health risk; their experience in advocacy; their management and financial capabilities; and their abilities in training and research. The most capable and institutionally

strong NGOs should develop family planning training and service delivery technical assistance and support packages and market them to LGUs.

for USAID

1. USAID should encourage the DOH to waive accreditation requirements for all the NGOs that were accredited during the POPCOM years.
2. USAID should also urge the DOH to complete the accreditation process for all other NGOs within the next six months. This can be accomplished by simplifying and liberalizing the accreditation criteria and by streamlining the accreditation process.
3. USAID should attempt to facilitate and expedite the flow of funds to NGOs, either from LGUs, government organizations, or private agencies.
4. USAID should urge the DOH to make a greater effort to coordinate NGO affairs. The coordination should be limited to encouraging cooperation between NGOs and government and among NGOs, and not in any way to limit or impede NGO initiative and creativity.
5. USAID should work to ensure that NGOs are privy to data and information on demography and family planning services so that NGOs can contribute to the maximum in reaching of national goals.
6. USAID should help ensure that area-based planning exercises more adequately reflect the interests and ability of specific NGOs and avoid duplication of effort.

Work-Based Family Planning

1. The work-based family planning project can and should be expanded. USAID, with PCS, should review the program in depth and make recommendations as to how it can be streamlined and modified and then extended rapidly to other industries. Ways to expand the program could involve enrolling exceptionally promising plants (large industries with older, married populations and a committed management) beyond the regions listed in the Philippine Center for Population and Development (PCPD) grant. They could also involve recruiting parastatals, police academies, utilities, and other non-commercial organizations.
2. USAID should encourage the PCPD to streamline its IECM operations, making more effective use of print materials and referrals to clinic staff.
3. USAID should urge that IECM programs be tailored to the particular demographic characteristics of the workforce (i.e., young, unmarried women; older married men; etc.).
4. USAID should also urge that supervision and monitoring programs be redesigned to reduce cost and improve efficiency.
5. USAID should encourage PCPD to undertake rapid assessments of its most successful companies in order to replicate the pattern elsewhere.

6. USAID should recommend that IUDs and tubal ligations be included in the industry-based program, even if insertions or surgery must be performed off-site.
7. USAID should encourage program sustainability through the introduction of social marketing programs in the workplace.

Social Marketing

1. USAID should review carefully the social marketing activities of SOMARC and assess their potential for increasing sales of condoms and pills through expanded promotional activities.
2. The SOMARC program should be carefully monitored for impact.

Training (Chapter 3)

Training Strategy

1. USAID should encourage the DOH to develop a national training strategy.
2. A national training database, including information on number of trainers, personnel trained, number of training courses, etc., should be established to help in the management and planning of training programs.
3. USAID should encourage the DOH to carry out a training needs assessment of all private practitioners and service.
4. An annual training coordination meeting should be held to review training progress, problems, and issues. Both private and government agencies should participate.
5. USAID should urge the PFPP to give maximum attention and support to the NGO training component to avoid any further delays and to assist the program in meeting its targets.

Training Standards

6. USAID should encourage the establishment of uniform training standards that reflect the reality of training in the Philippines without compromising the quality of care.
7. USAID should recommend to the DOH the removal of all unnecessary medical barriers to family planning.

Training Courses

8. USAID should urge DOH that training course content material include more information on the benefits of family planning and the health risks of pregnancy, with more of a public health client-oriented approach.
9. USAID should suggest that the pros and cons of training midwives in the full basic comprehensive family planning course directly after graduation be explored.

10. USAID should strongly encourage competency-based training wherever possible.
11. USAID should urge the DOH to make some adjustment to the practicum segment of clinical training so that the time could be used more efficiently.
12. USAID should continue to encourage focusing the surgical contraception course on the minilaparotomy procedure.
13. The "no touch" technique for IUD insertion should be included in all relevant courses.

Equipment, Supplies and Materials

14. USAID should participate in an inventory of all equipment supplies and materials that are currently available for trained personnel and training sites. A similar assessment of NGO facilities should be undertaken. Based on these inventories, two options should be considered: one, equip those clinics that are considered to be in priority areas; two, if sufficient funds are unavailable to supply non-priority clinics, defer training for their staff.
15. Training courses should be enhanced with audio-visual and other graphic aids. A high priority should be given to the acquisition of more pelvic models for IUD practice.
16. USAID should urge the DOH to employ the training modules currently in use by DOH staff in the NGO training as well.

Follow-up, Monitoring, and Supervision

17. USAID should strongly encourage the development of a plan for the supervision of newly trained family planning workers including training modules modified to include this supervision.
18. As soon as possible, a training course should be developed and implemented for the project monitoring teams at all levels of the system: national, regional, provincial, municipal and district. This same course should be offered to the NGOs.
19. A course should also be developed for the local health boards.

IECM and Advocacy (Chapter 4)

Overall Strategy

1. USAID should have PCS assist with the development of an IECM marketing strategy that targets groups that are the most likely candidates for new acceptors.
2. USAID should also direct PCS to work with the public and private sectors to reach men and unmarried men and women with population and family planning messages.

3. USAID should direct PCS to assist with the development of an operational plan reflecting the strategy proposed above. This would include a plan for each channel of communication — mass media, support media, and interpersonal communication.
4. Under this strategy, USAID should urge the DOH to give mass media immediacy and prominence. Radio and television campaigns should begin as soon as possible — particularly campaigns that inform the populace about the new, improved, and revitalized family planning program.
5. Under the strategy, USAID should also support the resuscitation of the interpersonal education component of the family planning program, modified where appropriate (based on OR findings).
6. USAID should assist with the restructuring of the IECM and advocacy components of the PFPP so that all activities — from research, planning, and development to implementation and evaluation — are given a well-defined institutional home.

Interpersonal Communication

7. USAID should help with the establishment of realistic performance indicators against which IECM personnel can measure their work.
8. USAID should encourage the completion of the new ICS training module currently being developed by the TS, ensuring that the FPS, currently using a different module, provides its inputs.
9. USAID should recommend to the DOH that the basic comprehensive and ICS training courses be held sequentially. Such an arrangement would be more cost-efficient and logical than the current one.
10. USAID should support the functional integration of family planning and other MCH services at the clinic level, thus affording additional opportunities for family planning information to be presented.
11. USAID should urge the DOH to recast the IECM program message from promoting all methods neutrally to placing the emphasis on effective family planning methods in all IECM efforts.

Advocacy

12. USAID should support increased advocacy activities that would include education of elected LGU officials and their staff through training, conferences, and workshops; mass media coverage of population issues; lobbying of local officials by women's groups and other citizen organizations; and lobbying other organizations — such as radio and television networks and stations — to promote responsible sexuality and parenthood. A special effort should be made to include private sector health providers.
13. USAID should urge the DOH to undertake a careful review of all IECM materials currently in use and determine those that are appropriate for further use, given the likely shift in

IECM strategy. For new materials, the focus should be on cost effectiveness; reduction in purchases of high-cost, relatively unproductive mass distribution items such as posters; and an increase in narrowly targeted materials such as leaflets for a particular audience.

Monitoring, Evaluation, Research, and Logistics Management (Chapter 5)

MIS

1. USAID should urge the DOH to complete its national indicators review in the near future.
2. USAID should urge that these indicators be included in the FHSIS.
3. USAID should recommend that the FHSIS be improved according to those modifications recommended in the FPMD assessment.
4. USAID should play a prominent role in the resolution of the MIS issue, working to attain consensus that a modified FHSIS serve as the one MIS system in the Philippines. NGO data should be included in the FHSIS as rapidly as possible.
5. USAID should ensure that the MIS not be built into logistics management until *both* logistics and MIS are fully functional.

Research

1. USAID should urge the government and other donors to develop a priority list of 10 OR studies to be carried out before implementation of the new USAID family planning project.
2. USAID should encourage the DOH, Philippines universities, and donors to develop a national research agenda.

Logistics

1. A study should be carried out to determine the appropriateness of the DOH equipment list for clinics, particularly equipment needed for IUD insertions (i.e., tables, lamps, IUD kits, etc.).
2. A similar study of basic equipment requirements for NGO clinics should also be undertaken.
3. USAID should hire a consultant to participate in a one-time inventory of all equipment supplies and materials for every training site for personnel (both DOH and NGO) to identify and prioritize needs. If sufficient funds are unavailable to supply non-priority clinics, training for their staffs should be deferred.
4. Procurement based on the aforementioned lists and inventory should be acted upon a priority basis.

Recommendations for A.I.D./ Washington

1. The Bureaus for Asia and for Research and Development (R&D) should provide financial and technical support to USAID/Manila as it seeks creative ways to utilize the ongoing FPAP project as a vehicle for additional funds for family planning. The importance of these funds is particularly critical, given the unprecedented opportunities for family planning and population programs in the Philippines. For the short term, these funds should be made available through some suitable innovative funding mechanism.
2. The Bureaus for Asia and for R&D should look favorably upon increased funding for the new FPAP to take advantage of the opportunities presented by the enthusiasm and support for the devolution process.

1. Project History and Management Issues

1.1 Project Background

The Family Planning Assistance Project (FPAP — project 492-0396) is a five-year (May 10, 1990 to December 31, 1994), \$40 million grant from the U.S. Agency for International Development (USAID) mission to the Philippine government, with the stated purpose of increasing the availability and utilization of family planning services through support of the Department of Health's (DOH) Philippine Family Planning Program (PFPP). The grant is complemented by \$22.4 million provided by the government of the Philippines. The project's prime goal is to assist the government to reduce the total fertility rate (TFR).

The PFPP, supported through this project, has the following general objectives: 1) to increase the number of married couples of reproductive age (MCRA) practicing family planning and responsible parenthood in order to improve maternal and child health (MCH) and reduce fertility; 2) to promote the values of responsible parenthood (e.g., responsible sexuality, delayed marriage, lowered health risks of certain categories of pregnancies, increased child spacing and small family norms); and 3) to strengthen support services of the program specifically in management, logistics, information, education, communication and motivation (IECM), research, and training.

The FPAP is designed to help further PFPP's objectives through supporting its various activities, primarily family planning service delivery, but also IECM, training, logistics, monitoring and evaluation, and research. The program is directed to both the public and the private sectors.

FPAP was about half-way through its implementation in late summer of 1992 and was thus scheduled for the required midterm evaluation. This report is the result of that evaluation. Specifically, the evaluation covers the period of August 1990 to October 1992, starting with the date that the government of the Philippines met all the conditions precedent to the disbursement of funds under the FPAP.

The major issues to be addressed are set forth in a scope of work (see Appendix A — also, see Appendix B for a listing of the documents referred to during the evaluation). In addition, two overriding questions came to the fore during the evaluation process: Was the FPAP as designed adequate to provide assistance under the previous and the current administrations for a vigorous, broad-based family planning program? Were the administrative arrangements of the PFPP sufficiently efficient to lead to the revitalization of the family planning program and its expansion under the new more supportive administration of President Ramos? The major focus of the evaluation is on the future, specifically on two issues: What specific interventions can the current FPAP support to energize the family planning program? What shape should any *new* USAID project take to improve that support?

1.2 Background on Philippine Family Planning Program

1.2.1 The Early Years — 1970s and early 1980s

The Philippine family planning effort was recognized in the 1970s and early 1980s as one of the most ambitious, innovative and successful in Asia. During these years, the Population Commission of the Philippines (POPCOM) became increasingly powerful, gradually taking up tasks originally carried out by the DOH and assuming the dominant role for development of population policy while the DOH continued to provide services and training, although at a declining rate. POPCOM carried out its role through an active network of non-governmental organizations (NGO) and the OUTREACH program, which was initiated in 1973 to accommodate persons living at considerable distances (over three miles) from the nearest health unit. Under this program, which was initially funded by USAID but gradually taken over in large part by the local government units (LGU) — governorates, municipalities, and *barangays* — POPCOM selected and trained outreach workers.

During this period, the NGO sector played a major role in delivery of family planning in the Philippines, providing more than 35 percent of services as well as a large share of IECM and training. During the first half of the 1970s (1969-1975) when the program was just getting under way, NGOs pioneered and championed the spread of family planning awareness and services in areas that the government facilities could not cover. In the second half of the 1970s and the first half of the 1980s (1976-1986), NGOs remained a key element in the program, particularly in its efforts to spread family planning information and services throughout the country.

From a service delivery standpoint, the POPCOM years had two major flaws: Drop-out rates were high and prevalence for modern contraceptive methods was low.

1.2.2 Program Decline — Mid-1980s to Late 1980s

During the 1980s, the population program went through a difficult period. Its desultory performance has been attributed largely to a decline in high-level political support, economic stagnation, growing political discontent, and increasingly strong opposition from the Catholic Church. Between 1987-1989, during what is described as the "era of policy debate," the program's existence, strategies, and thrusts were all questioned.

The major programmatic consequence was a decline in POPCOM's leadership as questions arose as to its mandate and role. As a result of the more assertive Church opposition and fearful politicians, the once powerful POPCOM was reduced to a less than effective planning and implementing agency for family planning. In the late 1980s, the family planning component of the program was transferred to the DOH, leaving POPCOM with responsibility only for population policy development.

Shortly after the transfer of family planning activities to the DOH, USAID provided bridge funding to support NGOs and the private sector in a limited way. Funding was also provided by the United Nations Population Fund (UNFPA), part of which was reserved for the production of new training and clinic management manuals which were written and tested by the Family Planning Services (FPS) section of DOH. In addition, the training of trainers, supervisors, and eventually DOH providers themselves was also undertaken with success by FPS, relying both on new materials and on materials previously developed by POPCOM.

1.2.3 Revitalization of DOH Program — 1980s to the Beginning of the Ramos Administration

Re-Establishment of Family Planning as a Maternal and Child Health Program

A turning point came during the early years of the Aquino government (1986-1992), when several courageous individuals within the government, most notably the secretary of health and his chief of staff, convinced the president to re-establish the public sector family planning program as an MCH measure.

During this period, FPS moved forward in the area of service delivery. Even without a program strategy, it has trained large numbers of DOH staff and taken steps to increase delivery of services. This was a practical and realistic approach to a difficult situation.

At the same time, serious problems remained in the ability of the family planning program to provide services. FPS turned out to be a weak substitute for POPCOM, handicapped by a lack of adequate staff and funds to support the massive logistical support requirements of the program. In particular, the NGO program was almost totally ignored by FPS. NGOs received virtually no logistical support, training, or operating funds. In addition, FPS did not provide an adequate substitute for POPCOM in the area of providing technical policy guidance or standards.

Establishment of the Technical Secretariat (TS)

To address the gaps with regard to the NGOs and standards, the DOH, in response to considerable pressure from the donor community, established a Technical Secretariat of the PFPP, with eight technical policy committees and one steering committee. The major rationale for the formation of the secretariat was FPS' neglect of the once powerful NGOs which were nevertheless programmed to deliver more than 35 percent of services as well as a large share of IECM and training. The secretariat was charged with recommending technical policy, developing program guidelines, coordinating public and private (largely NGO) efforts, and assuring compliance with all national program standards. The chief function of the committees is to develop guidelines and standards for various aspects of the program, to be presented to the TS for review and eventual dissemination. The TS also used the committees to review proposals from NGOs and to draft strategies.

This arrangement has not worked as well as had been expected, either with respect to the committees or to the TS itself. The TS has no budget to pay staff, fund committee work, or coordinate family planning activities. Committee members have thus had to contribute their time without pay. Perhaps understandably, the performance of these volunteer groups has been spotty. Some have worked exceptionally hard and completed guidelines and policy standards, but others have never met. Particularly noteworthy is the Technical Policy Committee on Advocacy, which did some excellent exploration on options for ways in which family planning might be promoted among various NGOs and government organizations (see Section 4.4.3).

The TS staff has consisted entirely of contract personnel paid by donors and vested with no authority over regular DOH staff members, either at headquarters or in the field. This has placed the director of the TS in a weak position, for he is just one of the chiefs working on population. The others — the heads of POPCOM and of FPS — are both government employees, and thus have considerably more authority than does the director of TS, despite the leading role he has been assigned in the areas of policy, coordination, and compliance with all national program standards. As a consequence,

the DOH leadership has often failed to promulgate the standards that the committees prepared, leading to confusion and delays in many aspects of the family planning program — particularly in the important area of accreditation of NGOs (see Section 2.3.3).

Even with the best will in the world, such an administrative arrangement would result in major programmatic inefficiencies. In the current environment of the Philippine population community, however, there is little good will in the sensitive area of family planning. The DOH itself does not speak with one voice. Nor do the DOH and POPCOM agree on key issues. Likewise, the leadership at the TS and POPCOM maintain an icy relationship, with, for example, each side refusing to send representatives to planning meetings called by the other.

In brief, the management structure has not served as a useful vehicle to mount a revitalized national family planning program. Rather, it is more of a handicap to the four most important implementation actors — the NGOs, the DOH staff, POPCOM, and the private sector. Although designed for the best of reasons and with donor encouragements, the implementing/administrative arrangements of the PFPP, particularly the TS, would seem to be seriously flawed.

Despite the creation of the TS, the neglect of the NGOs has continued. For many reasons, almost two years have passed under the secretariat's mantle with only a few NGOs having been accredited and no NGO staff having received training. Since NGOs are expected to provide approximately 35 percent of prevalence, this neglect is having serious repercussions on the effectiveness of the PFPP. In addition, the IECM efforts of the PFPP have been handicapped by inter-committee second-guessing of the technical experts on the technical committees, thereby leaving another major DOH component in limbo. Likewise, again as a result of indecision on the part of TS and its committees, management information systems (MIS), monitoring and evaluation, and operations research (OR) remain largely at the discussion stage, as does private sector involvement. The only area in which there has been real progress has been to make the contraceptive logistics system into the beginnings of a solid working system.

1.2.4 Recent Developments

Encouraging Signs

Recent events have given rise to a certain optimism. The new Ramos administration has publicly committed itself not only to family planning but to fertility reduction. In a statement to the August 1992 International Conference on Family Planning held in Bali, which was reportedly cleared by the president, the secretary of the National Economic and Development Authority (NEDA — the equivalent of a ministry of planning) committed the government to more direct attention to fertility reduction within its overall framework of health. Indeed, the secretary projected a reduction in the country's population growth from the current 2.35 percent to 2 percent by the year 2000 or earlier. His statement further noted that the government considers family planning "an integral component of its human development efforts, insofar as it promotes maternal and child health, and overall population and sustainable development concerns." From a practical standpoint, he promised government commitment to an IECM campaigns, provision of all legal methods of family planning, and encouragement to participation of the private sector, especially NGOs.

The new secretary of health has also publicly and privately restated his commitment to family planning, placing a renewed emphasis on the private sector, in particular, NGOs. Given the past performance of the Philippine NGO sector, the importance (in terms of service delivery) of private

health practitioners, and the vigor of the commercial economy, this emphasis holds promise for the family planning program. The secretary has also reiterated his commitment to the concept of responsible parenthood — important for the long-awaited inclusion of men in the family planning program; his commitment to community involvement; and his identification of the midwife as a central player in the delivery of high-quality information and services.

From an administrative standpoint, the president's Five Point Program for National Development, which focuses on streamlining the bureaucracy, and the secretary of health's commitment to management clarity, simplification, and streamlining of program operations, both augur well for a more efficient and successful program. As part of the streamlining process, a restructuring of the family planning program within the DOH is under way, under the leadership of the new secretary of health.

The new Local Government Code, devolving political, financial, and administrative authority from the central government to local governments, also offers significant promise. Enthusiasm and commitment for a renewed family planning program appear to exist at the local level, with local governments apparently willing to invest in this program to complement both their health and overall development efforts.² Whereas family planning services will become the responsibility of the LGUs, administration, IECM/advocacy, training, standards, private sector (NGO and commercial) involvement, and logistics are likely to remain centralized. Policy discussions have begun between NEDA and POPCOM regarding a collaborative role to strengthen the devolution process.

The devolution process will make it more important than ever that the DOH speak with one voice to its regional staff, to the LGUs, to other government organizations, to NGOs, to the private sector, to legislators at various levels, and to international donors. Under the new secretary of health, the restructuring of the management of the family planning program that is under way should enable the DOH to project a consistent message.

Finally, the Philippine government has demonstrated its renewed commitment to family planning by increasing the flow of public resources allocated to social services, especially health and family planning, while striving to improve the quality of such services. The active support of the Philippine legislature in encouraging and facilitating this commitment has been crucial.

Financial and Administrative Issues

With regard to funding of the PFPP, although the government has increased the resources for family planning and has continued the national budget line item for POPCOM, there is no line item in the DOH budget for family planning. This represents a major constraint to implementation of the program.

With regard to the administrative structuring of the newly devolved system, much remains to be worked out. The present DOH system relies on the 14 regional and 75 provincial family planning coordinators who now operate in a hierarchical way, with service providers at the municipal and *barangay* levels being monitored by a four-person team at the provincial level which in turn is

²This reflects the view of a companion team to the team that prepared this report, the "devolution team," which worked in tandem with this evaluation team to prepare a report on devolution. Although the devolution team concerned itself primarily with issues of decentralization, management, and finance, and the evaluation team focused on issues of service delivery, the work of each team was inextricably linked to that of the other.

monitored by a four-person team at the regional level which is in turn is monitored by a central DOH/FPS monitoring team. At all levels, the coordinators are responsible for coordinating not only family planning but six other public health programs as well. Further compounding the management difficulties is the coordinators' lack of mobility and the frequent mismanagement of the available vehicles. Thirdly, no supervisory guidelines or supervisory plan have been developed. The supervision that is provided is carried out on an *ad hoc* basis. All these factors result in the system's being under considerable strain. Moreover, the job of follow-up supervision can only become more difficult with the large numbers of health personnel in training or slated for training. No monitoring team exists for the NGO family planning activities and little attention has been directed to whether their service delivery activities should be included under the DOH system or whether they should be monitored separately. In short, under the present system, little monitoring, technical support, supervision, and evaluation are provided for field activities.

Plans for monitoring under a decentralized system remain fluid. Most likely, even with devolution, the current chain of command will remain intact — national level overseeing regional level, overseeing provincial level, overseeing district levels. The DOH staff, however, will have lost much of its former control and mandate and will instead need to market itself and its programs to the LGUs.

One proposed model would involve creating project monitoring teams, including a physician, nurse, and midwife, at the regional level. The proposal has two serious flaws. First, the teams would be too small to give the health programs the attention they would need. Second, it is not clear that plans call for team members to have the necessary combined experience in clinical matters, training, IECM, supervision, monitoring, and management. In addition, team members will need skills of negotiation and marketing, to convince LGUs of the importance of funding training, and they will need to provide technical assistance to the LGUs to provide quality services. The DOH has requested USAID to provide technical assistance for the management training of regional staff and midwives.

On the other hand, with devolution, LGUs may opt for an entrepreneurial system of program management and enter into contracts with NGOs for the provision of family planning training and services. Thus, NGOs will also need assistance in developing family planning training, service provision, and technical assistance proposals. They, too, will need training in how to market their products and services.

Another broad issue is that no concerted effort has been made to identify, recruit, train, or supply private health professionals to strengthen the PFPP. This is a critical omission, for the private sector accounts for a considerable percentage (over 50 percent) of health activity in the country. Such private sector health associations as the Philippine Medical Association and the Philippine Association of Nurses and Nurse/Midwives, etc. could be useful avenues through which to approach the private health sector.

1.3 General Issues

1.3.1 Overall Progress to Date

In the field of population, the Philippines has failed to match the achievements of its neighbors in Thailand and Indonesia let alone the programs in other Asian countries such as Korea and Taiwan. By 1991, the program in the Philippines could not even claim the success of the program in Bangladesh, a country with much lower economic and social indicators, e.g., female literacy.

Specifically, between 1965-69 and 1988, the TFR in the Philippines had declined only 1.42 (from 5.72 to 4.3).³ This compares with a decline of 4 in Thailand and 2.17 in Indonesia (between 1967 and 1987). The slower decline in the TFR in the Philippines reflects the slower improvement in the contraceptive prevalence rate (CPR). The annualized increase in contraceptive prevalence for the Philippines was only 6.16 between 1968 and 1986 whereas that for Indonesia was 9.33 and for Thailand 7.79 for approximately the same period.

Since the Philippines is the only Catholic country in Asia, many observers have cited religion as the key factor in its less successful family planning program. An impact evaluation carried out by the Agency for International Development (A.I.D.),⁴ which studied the years 1968-1988, looked carefully at the religion issue and found it to be a minor factor in individual couple's decisions on whether or not to use a modern contraceptive. As suggested above, however, it has been a significant issue with respect to the support that politicians, particularly those at the central level, would risk for family planning.

1.3.2 Assessment of the FPAP

USAID design and staffing for the FPAP have been outstanding in every respect, capable of supporting population programs both under the more cautious Aquino administration and under the more expansive Ramos administration. The project was an important catalyst in moving the DOH to reorganize and to make a renewed commitment to family planning. Moreover, the existing design needs no revisions. Until a new project is in place in 1994, the FPAP will be fully able to meet the programmatic needs of the next two years of implementation.

The sound approach of this creative, flexible project is complemented by an outstanding staff of a public health physician and a population adviser, plus private sector, IECM, and logistics experts.

1.4 Strategy for the Future

If the DOH is to be capable of conveying a consistent message to all its constituencies, restructuring of the management of the family planning program within DOH must be completed. The relationships between DOH and POPCOM must also be dramatically improved if the ambitious integrated program desired by government is to succeed.

Two other important management issues, less broad in scope than those cited above but with implications for the long-term success of the program, also need attention in the near future: 1) upgrading the DOH regional staff for its new responsibilities (evaluation, monitoring, and technical supervision) under devolution; and 2) providing short-term intensive management training in supervisory skills for midwives to ensure quality services and accurate data collection from their village health workers and family planning volunteers.

³World Bank, *New Directions in the Philippine Family Planning Program*, 1991.

⁴Schmeding, Robert et al. *Evaluation of A.I.D. Family Planning Programs: Philippine Case Study*. A.I.D. Technical Report No. 4, October 1992.

Without these two levels of management training (regional officers and midwives), there is grave danger that the program will perpetuate two of the major flaws of the POPCOM years — high drop-out rates for contraceptive users and low prevalence for modern contraceptive methods.

Recommendations

for the DOH⁵

1. **Management and Organization** — The management of the DOH should be restructured so that the family planning program speaks with one voice to the regional offices, LGUs, NGOs, legislators, donors, and the community at large. This would require that the family planning program in the DOH be a unified command headed by a regular DOH employee.
2. **LGU Support** — The 5 to 10 LGUs most likely to accelerate their family planning programs should be selected, based on commitment of their leadership to promoting and supporting family planning. Negotiations should take place with each of the selected LGUs for their future commitment in terms of the staff, space, budget, transportation, advocacy support, and MIS data. In turn, a comprehensive package of training should be offered them, including family planning skills, clinical, as well as MIS, fiscal and resource management skills, computer for data base management, contraceptive supplies, and IECM materials. Finally, the DOH should offer to provide a clinical package of equipment essential for IUD insertion to all *barangay* health stations with trained midwives. Under DOH leadership, support for this initiative could be provided immediately by USAID and perhaps other donors as well.
3. **Human Resource Development** — DOH regional staff should be strengthened through training and technical support for their increased responsibility in family planning. The number of regional staff (including MIS and IECM specialists) involved in family planning monitoring at the LGU level should be increased (also listed in Chapter 3).
4. Policy discussion should be initiated with the secretaries of finance and budget and other appropriate offices to establish a budget line item for family planning (1).
5. The DOH should resume its mandated role of setting policy and establishing guidelines rather than delegating these authorities to the TS and the Technical policy committees. This will be key to a successful devolution of DOH resources to the LGU level. Technical assistance can be provided in this area.
6. Policy discussions should continue between NEDA and POPCOM regarding a collaborative role to strengthen the devolution process.

⁵These recommendations were contained in a letter dated October 27, 1992 to the secretary of health, sent him after he was debriefed by the evaluation and devolution teams (see Appendix C for full text of letter). The secretary requested a list of actions which he should take immediately to expand and accelerate the program. The list provided contains five major actions plus eleven additional activities that also need attention in the near future (see Section 6.1.2 for a full listing). In the following text, the first three recommendations were in the top priority list of five and the remaining seven were in the second listing.

7. National strategies for training and supervision should be completed (also listed in Chapter 3).
8. A program should be initiated to identify, recruit, train, and supply private sector medical institutions and individuals for family planning provision throughout the country (also listed in Chapters 3 and 4).
9. Technical policy committees should be dissolved. Instead, committee members and other experts can be called upon as needed as paid technical experts to support DOH standards and guidelines work.
10. The work of the Technical Policy Committee on Advocacy should be transferred to POPCOM in line with the latter's current responsibilities.

for USAID

1. **The FPAP project should remain as designed. No changes are recommended for any of its sections.⁶**
2. **USAID should support the DOH in its ongoing effort to restructure the PFPP and to get a line-item budget for family planning.**
3. **USAID should encourage some restaffing of POPCOM leadership so that it acts in complementarity with the DOH. One arrangement that might resolve current tensions would be the appointment of the secretary of health as the chairman of the POPCOM Board of Directors. Such an arrangement would also bring the DOH regional staff working on family planning and the POPCOM regional staff under a single command at the point of greatest field implementation. It would have the additional benefit of bringing physical resources belonging to POPCOM (primarily vehicles and warehouses) to bear in program implementation. Although all of the foregoing speaks to improved effectiveness and cost efficiency, the final decision concerning a joint command for the DOH and POPCOM must be balanced against the risk of providing a single target at which opponents of family planning could aim all of their fire.**
4. **USAID should assist with the selection of up to 10 LGUs in which an integrated family planning and population program would be undertaken. The program would have as a major goal the identification of that organizational and management structure which is most appropriate given the changing roles of all organizations.**
5. **USAID should support the DOH in disbanding all technical policy committees and assist the DOH in securing technical expertise when needed.**
6. **USAID should support the transfer of responsibilities of the Technical Committee on Advocacy from the DOH to POPCOM.**

⁶The boldface sections of the recommendations to USAID appear in the complete listing of recommendations provided at the end of the executive summary.

7. **The monitoring structure of the PFPP should be defined and a choice needs to be made as to whether there should be a unified DOH-NGO or a separate monitoring structure.** Since large NGOs integrate maternal and child health in all activities in their service delivery structure, there seems to be good reason for a unified monitoring structure.
8. **Technical assistance should be given at the national level in the development of a supervision strategy including guidelines.** All the supervisory approaches that are developed will need companion plans of execution (see also Recommendation 17 in Chapter 3).
9. **The criteria for selection of the project monitoring teams should include requirements for at least one member who has been trained and has experience in clinical family planning and one member experienced in the management of training and supervision.**
10. **USAID should support requests from the DOH for technical assistance for the management training of regional staff and midwives.**

2. Service Delivery

2.1 Project Objectives

As noted in Section 1.1, the overall objectives of the PFPP are as follows:

- 1) To increase the number of married couples of reproductive age (MCRA) practicing family planning and responsible parenthood from 3 million in 1990 to 4.37 million in 1994 in order to contribute to the improvement of MCH and reduction of fertility. The main activities to achieve this objective are
 - expanding program coverage during the plan period (1990 to 1994); and
 - improving the quality of service to encourage and maintain family planning practice.
- 2) To promote the values of responsible parenthood. These include responsible sexuality and delayed marriage, awareness of health risks of certain categories of pregnancies, and motivation toward child spacing and small family size. The overall goal is to counteract the trend towards prevention of births after conception has taken place.
- 3) To strengthen support services of the program, specifically management, logistics, IECM, research and training.

2.2 DOH Service Delivery

2.2.1 Program Coverage

Overview

Over the past five years (1987 to 1991), the DOH family planning program is believed to have made considerable gains with respect to program coverage. Nonetheless, as noted in Section 1.3, the Philippines has lagged behind other Asian countries in the key areas of the CPR and TFR. According to the Philippine 1988 Contraceptive Prevalence Survey, the CPR is now in the vicinity of 36 percent, but of this, only 22 percentage points are modern methods. This is below the nearly 40 percent Bangladesh, of which about 32 percentage points are modern methods (1991 Contraceptive Prevalence Survey), and well below the 67.5 percent in Thailand, of which 65.5 percentage points were modern methods (1987 Thailand Demographic and Health Survey). Moreover, the performance of the program between 1988 and mid-1992 has been marred by considerable numbers of acceptor drop-outs and clinics' failures to meet CPR targets.

Due to the inadequacies of the service delivery MIS (see Section 5.1.2), it is virtually impossible to ascertain numbers of current users or new acceptors. The figure of 3 million MCRA's practicing contraception in 1990 is a rough estimate, probably containing about half (1.6 million) from the public sector and the rest from NGOs and other private/commercial sector efforts.

Number of Current Users by Method

Although precise numbers of users may not be available, there is no doubt that oral contraceptives are the preferred method in the DOH program. Together with the intrauterine device (IUD), these two temporary program methods probably account for about two-thirds of all users of the government program. The other program methods are voluntary surgical contraception (VSC) and the condom (accounting for another quarter of the users). In addition, about 7 percent of the total use natural family planning (NFP) and "other" methods (e.g., withdrawal).

Table 1

Current DOH Users by Method 1991

Pill	912,311	57 percent
IUD	142,032	9 percent
Condom	201,489	13 percent
VSC	222,597	14 percent
NFP	24,046	2 percent
Others	86,420	5 percent

Source: DOH

Overall Assessment of Progress: Prospects for the Future

Three factors indicate that the rate of new acceptors may begin to accelerate — the steady growth in users in the past few years; the expectation that the government will take a more direct and practical approach (e.g., filling the contraceptive pipeline) to family reproduction, which focuses as much on the ways to encourage families to limit their fertility as to instruct them on the health reasons for so doing; and the existence of considerable unmet need in the country (see Section 4.2).

2.2.2 Service Delivery Issues

Availability of Quality Clinical Services

Under the five-year plan, the DOH plans to increase the total number of service delivery outlets offering family planning from 4,622 to a total of 6,830 by 1994. Whether this ambitious 50 percent increase can be achieved is difficult to assess, particularly given that there are discrepancies in the various reports on the number of existing facilities. One source, for instance, suggests that there are as few as 2,200 DOH service delivery points at present.

In addition, no formal mechanism has been established for quality assurance. Even prior to devolution, the system was overtaxed, with only one supervisor at the provincial level available to oversee all the components of primary health care, including family planning. Under devolution, the supervisory system is anticipated to be even less rigorous, and the guarantee even less that staff will

have time to oversee the quality aspects of family planning services. (See Section 1.2.4.) This could have negative consequences on the long-term sustainability of the program.

Limited Choice of Methods

Compared with most programs worldwide, the PFPP offers a fairly limited choice of methods. Neither the injectable, Depo-Provera, nor the progestin-only oral contraceptive is available and the implant, Norplant, is available in only a limited number of sites. Depo-Provera had been available earlier but was taken off the market in the Philippines before it was approved by the U.S. Food and Drug Administration for contraceptive use. (The Philippines follows U.S. standards for drug approvals.) Depo-Provera could be distributed both through the regular program and within the social marketing effort (see Section 2.4 below). The progestin-only oral contraceptive is widely available in other programs and offers an excellent method for breastfeeding women, both to protect them from unwanted pregnancy and to encourage a longer duration of breastfeeding. All programs need such a pill. The use of Norplant is growing worldwide, offering long-term protection for women. Although its present cost makes it very difficult for most governments to purchase Norplant without donor support, the next generation of Norplant is expected to be much less expensive.

With regard to NFP, the new secretary of health has advised the Catholic Church that he plans to elevate the level of service delivery and IECM support provided through the PFPP to NFP to the same level accorded to other contraceptive methods. As part of this effort, all Catholic NGOs agreed as of September 30, 1992 to align their operations with the policies and guidelines of the PFPP. A national NFP program framework is being prepared as a basis for project proposal preparation.

Functional Integration of Family Planning

In theory, family planning is an integral part of the government's MCH and primary health care services. In practice, it is not. Many service outlets, for example, have designated only certain days for certain services. Clients are rarely referred to clinic services beyond those for which they have come. Because family planning services may not be available every day, many opportunities for providing services are lost.

Coordination of Resources

Little effort appears to have been made to ensure that services are uniformly available throughout the country or that use of existing services is well coordinated. In particular, no trainee deployment strategy has been developed that would assign trained personnel according to client demand. For example, in one area, a well-staffed and well-equipped rural health unit with five members of the staff trained in family planning had very few clients. By contrast, the nearest *barangay* health station was poorly equipped and staffed by only one midwife and two volunteers, but it had more than 20 women waiting to have their babies immunized. It is understood that it will take time for the trained personnel to be assigned to most *barangay* health stations. In the meantime, however, with better coordination, one of the trained staff from the nearby rural health unit could be made available to offer family planning services. Likewise, better coordination should alleviate the potentially difficult situation in which midwives trained to insert IUDs will not have the supplies and equipment to provide such services (see Section 5.3.2 for further discussion).

As will be shown below, most of the major elements of the family planning program, such as logistics and training, are reasonably well under way, subject to the recommendations made elsewhere in this

report. What remains is the strengthened coordination of these efforts. Training personnel and sending them to a work station with no commodities is a waste of time. Conversely, providing IECM materials to trained personnel and supporting their services by creating demand through IECM greatly enhances the effectiveness of training.

Recommendations

for the DOH

1. Existing clinical manuals and guidelines should be reviewed to identify and eliminate all unnecessary medical barriers that inhibit the family planning program. Technical assistance could be provided to assist in this area (7).⁷

for USAID

DOH Service Delivery

1. USAID should encourage the government to establish quality assurance teams at the national level. These teams should be mobile and should, on a systematic basis, visit all service and training sites. This national effort should be complemented by equivalent efforts at the regional and LGU levels.
2. USAID should encourage the DOH to review all clinic service delivery procedures to determine how best the delivery of family planning services and information can be improved and integrated into clinic operations. Once this has been accomplished, service policies and guidelines could include specific instructions to clinic managers and providers on when, where, and how family planning services should be delivered; and how they should be functionally integrated with other services.
3. USAID should urge the PFPP to expand the range of available contraceptives by adding a progestin-only oral contraceptive; expanding the number of service sites offering Norplant; and approving, registering, and offering Depo-Provera at service sites and through the social marketing program. At the same time, a closer examination of the nature of NFP as a program method is imperative in view of its uniqueness and the implications it would have on the total IECM and service delivery strategy of the PFPP.
4. USAID should encourage DOH to develop a trainee deployment strategy — one that assigns trained personnel according to client demand for family planning and for specific contraceptive methods. For example, in those areas in which the rural health units and *barangay* health stations are in close proximity, consideration should be given to rotation of trained staff so that a full range of services is available at both the rural health station and the *barangay* health station.

⁷This recommendation came from second-level listing in the letter to the secretary of health.

5. **USAID should encourage the DOH to coordinate all service delivery, IECM, and training activities by establishing quarterly meetings among relevant staff at both national and regional levels.**

2.3 NGOs

2.3.1 Historical Overview

In the Philippines, the NGOs are widely recognized for their long-standing and substantial contributions to program outputs, in particular their innovative approaches to service delivery and their administrative flexibility. They have used creative strategies to reach the young and unmarried, men in the workplace, and women with a high health risk. NGOs also have experience in advocacy — concerning both the promotion of progressive population policies in the legislature and the promotion of family planning programs to local politicians and civic leaders. Some NGOs have strong management and financial capabilities. Others have the ability to train and to undertake research.

Even during the late 1980s, when the NGOs received almost no government encouragement or support (see Section 1.2.2), most continued to operate, exercising a number of efficiency measures to stay afloat. The fight for survival was a harsh one, however, and the NGO contribution to the national family planning program declined. When substantial levels of donor resources again became available to support family planning programs during the 1990-1992 period (see Section 1.2.3), funds were largely concentrated in revitalizing the DOH program. NGOs received only a small share of fund allocations.

2.3.2 Current Status

In 1990, NGO service outlets probably represented about 17 percent of the total number of family planning clinics in the Philippines. The PFPP's five-year plan envisages the establishment of 330 new NGO clinics. Of the new clinics, 23 are to be new NFP clinics.

The largest NGOs, all national in scope, are the Institute of Maternal and Child Health (IMCH), the Family Planning Organization of the Philippines (FPOP), and the Integrated Maternal and Child Care Services and Development, Inc. (IMCCSDI). All three provide training, services, and IECM within the context of MCH services.

2.3.3 Constraints

NGOs continue to operate under the constraints that began during the late 1980s, and, for the most part, they have been unable to operate at full capacity for the last two years. Problems are many, including the following:

- 1) **lack of support for service delivery**
 - delays in the release of operating funds,
 - delay in training for NGO clinical staff, and
 - weaknesses in the provision of support services, e.g., logistics support from DOH.

2) **lack of administrative oversight and support**

- failure to accredit NGOs,
- delays by DOH in conveying information, policies, guidelines, and plans clearly to NGOs and in applying these uniformly,
- minimal technical support and monitoring provided by TS,
- weak DOH central coordination of NGO activities since POPCOM no longer provides this support, and
- inaction at DOH central level on NGO initiatives for expansion and sustainability.

The most serious problem relates to accreditation of NGOs. After many of the NGOs had been operating and accredited to operate in the Philippines for upwards of two decades, the government decided to redefine these standards in 1990 with the result that all NGOs must become reaccredited. The process has been very confused, with the result that many of the NGOs are currently not officially accredited to operate. The change in policy came with the decision that the TS Training Policy Committee should develop accreditation procedures as part of larger task of developing national accreditation and standards for training. In June of 1992, however, the task of accreditation was turned over to a newly established Accreditation Board, chaired by the head of TS, whose mandate was to ensure that appropriate policies, strategies, and guidelines for the PFPP were in place and to encourage compliance by, and oversee accreditation for, all participating agencies. Unfortunately, this board has not been able to resolve the accreditation problem. The present situation for accreditation remains confused, with various documents containing different standards currently in existence.⁸ No list exists of accredited institutions and the status of many of the largest and best established NGOs is in limbo. The IMCH has still not been accredited and FPOP and the University of the Philippines General Hospital are both on probation. NGOs do not receive any formal notice when they are accredited. Rather, the word is passed to them informally.

With regard to funding, sufficient funds for NGOs have not been forthcoming, and this has also inhibited their ability to carry out activities. A number of funding sources exist, including LGUs, government organizations, and private agencies, which might be further explored. For example,

- **LGUs.** NGOs, through their representatives on the new Local Health Boards, could incorporate their proposals in the LGU proposals. The LGUs could deal directly with funding agencies, and NGO operations could be administered by LGUs and monitored by the DOH's District Monitoring Teams. For population and environment as well as women in development activities, funds could be obtained from LGUs with grants provided for these purposes.
- **Donor Agencies.** NGOs that are national in scope could choose to deal directly with funding agencies, rather than through the DOH. Their operations would be semi-

⁸The FPS uses a document entitled *Guidelines for the Implementation of Training*. The TS also has guidelines on training, policies, and principles. Additionally, the TS has two forms that are supposed to be completed as part of the accreditation application process. One is a training institution inventory form and the other is a self-assessment/survey form for family planning service outlets.

autonomous, with monitoring this time performed by the DOH's regional monitoring team.

- **DOH or POPCOM.** NGOs could get funds from DOH or POPCOM (or also LGUs, as described above) depending on the nature of their activity. For outreach activities, funds could be obtained from POPCOM. For family planning service delivery, funds could come from DOH.

With regard to information on policies, plans, etc., the DOH has not always made sure to convey important information to NGOs. For example, NGOs are not always privy to data that have been generated on demography or on family planning services. Likewise, when planning geographic areas for concentration in service provision, the TS has not always taken into account the abilities and interests of specific NGOs. It also has not always taken care to avoid the duplication of effort often found when public and private agencies are assigned to the same populations.

With regard to the monitoring and technical support from TS, only one project officer at TS is assigned to monitoring NGO operations. This individual does not travel to the field; rather, he reads reports submitted by NGOs and discusses problems with them during consultations.

With regard to NGO initiatives for expansion and sustainability, these are being thwarted by inaction at the DOH central level. One large national NGO reports that six proposals for expansion were submitted in 1991 and three in 1992 to DOH but none has been acted upon to date. As a result of this, plus the low level of funding and other operational difficulties, only a few NGOs have been able to gear their efforts towards fiscal sustainability.

In short, although many NGO problems can be attributed to overregulation (e.g., reaccreditation) and bureaucratic procedures, a continuing decline in donor support and a delay on the part of NGOs themselves in adopting measures to assure sustainability have further eroded their impact and importance.

2.3.4 Declining Contribution to Family Planning Services

The consequences of the lack of support to NGOs over the past several years are particularly evident from figures relating to clinic operations, which indicate that the NGOs have begun to trail government clinics in terms of attracting new clients. Not only did the percentage of total users served by NGOs drop between 1990 and 1991, from 23 percent of acceptors in 1990 to 17 percent in 1991 (or just exactly the same as their 1990 share of clinics); the number of new acceptors attracted to individual NGO clinics also dropped considerably. Prior to 1990, NGO clinics served two or three times as many new acceptors per clinic as DOH clinics. In 1990, DOH and NGO clinics were both showing an average of 23 acceptors per clinic per month, however, and in 1991, the average for the NGOs declined to 19 while the same figure increased for DOH clinics to 27.

2.3.5 Funding for Family Planning Service Delivery Activities: The Philippines NGO Council (PNGOC)

Under the FPAP, the PNGOC is the main conduit of funds to the larger NGOs for family planning service delivery. The Council, however, does not fund research or training activities. A John Snow, Inc. (JSI) observer regularly sits on the Project Review Committee for service delivery activities.

Technical assistance for NGO activities is provided through JSI on matters such as fiscal management, advocacy, planning, organizational assessment, and management training.

After the PNGOC has agreed upon a proposal for funding, it is required to forward the proposal to the TS for review. This is not a technical review and, at one point, TS officials agreed informally that proposals would need to be forwarded to the DOH "for information only." The requirement for review, however, currently remains in place, despite the NGOs' view that it is unnecessary.

Indeed, this review has served to slow the approval process considerably. Between July and September 1991, of some 45 NGO proposals received and favorably reviewed by the PNGOC Project Review Committee, only 11 had received TS approval.

2.3.6 Service Delivery Policy Issues

As part of the broader PFPP, the NGOs are expected to follow the policies set down by the program and the secretary of health. The most important of these is emphasizing the health benefits side of family planning and ensuring that MCH services and family planning services are well integrated. The larger NGOs understand this approach well, and their future expansion plans reflect commitment to this concept. It is not known whether the smaller NGOs reflect these viewpoints.

2.3.7 Decentralization

With the implementation of the 1991 Local Government Code, the NGOs are expected to lead the way in the revitalization efforts of the family planning service delivery network at local levels. This will require greater funding support to NGOs and decisions on what mechanisms should be used and what DOH's role would be. Aware of the newly devolved structure of government, most NGOs have registered for accreditation in the locality in which they operate.

Recommendations

for the DOH

1. **Standards and Accreditation** — The new accreditation requirements should be waived for all NGOs that were accredited during the POPCOM years. The accreditation process should be completed for all remaining NGOs within the next six months. Training of NGO staff should begin immediately, employing the existing training modules now being used for the current training of DOH staff in family planning. USAID should be requested to modify the new Economic Development Fund (EDF) training cooperative agreement to enable NGO training to get under way rapidly (also listed in Chapter 3).⁹
2. The accreditation process for training and service institutions and individuals should be simplified.¹⁰

⁹This was one of the five key recommendations contained in the letter to the secretary of health.

¹⁰This was one of the second-echelon recommendations contained in the letter to the secretary of health.

for the NGOs

1. **NGOs should attempt to make their strengths known on a wider scale, in particular their innovative strategies to reach the young and unmarried, the men in the workplace, and women at high health risk; their experience in advocacy; their management and financial capabilities; and their abilities in training and research. The most capable and institutionally strong NGOs should develop family planning training and service delivery technical assistance and support packages and market them to LGUs.**

for USAID

1. **USAID should encourage the DOH to waive accreditation requirements for all the NGOs that were accredited during the POPCOM years.**
2. **USAID should also urge the DOH to complete the accreditation process for all other NGOs within the next six months. This can be accomplished by simplifying and liberalizing the accreditation criteria and by streamlining the accreditation process.**
3. **USAID should attempt to facilitate and expedite the flow of funds to NGOs, either from LGUs, government organizations, or private agencies.**
4. **USAID should urge the DOH to make a greater effort to coordinate NGO affairs. The coordination should be limited to encouraging cooperation between NGOs and government and among NGOs, and not in any way to limit or impede NGO initiative and creativity. This would permit better promulgation of the policies and guidelines that are relevant for NGOs.**
5. **USAID should work to ensure that NGOs are privy to data and information on demography and family planning services so that NGOs can contribute to the maximum in reaching of national goals.**
6. **USAID should help ensure that area-based planning exercises more adequately reflect the interests and ability of specific NGOs and avoid duplication of effort. Fostering the complementarity of NGO and DOH program operations will be increasingly important in the current devolved situation.**

2.4 Work-Based Family Planning

2.4.1 Background

One of the Philippine's most impressive family planning programs is the In-Plant Family Planning/MCH grant administered by Philippine Center for Population and Development, Inc. (PCPD), a Philippine NGO. The small but important three-year project, funded at about \$1.6 million, had drawn down about half its funds at the time of the evaluation (almost \$800,000 or 49 percent). The Population Communication Services (PCS) project provides some informal technical assistance to project activities.

The project goal is to bring family planning/MCH information and training for family planning services to 120 work sites. The sites that have become involved in the project employ a combined labor force of 157,000, 50 percent of whom are married. The project is confined to the National Capital Region plus Regions III, IV, X and XI, areas close to Manila in which the FPAP is not otherwise active in in-plant programs. Any company that enters the three-year program must make a cash contribution toward recurrent costs of 25 percent for year I, 50 percent for Year II, and 75 percent for Year III. This contribution helps to ensure program sustainability over the longer run. An anticipated extension of this project will allow companies that were recruited after the beginning of the three-year period of the project life to make a three-year commitment. Contraceptives are provided free by the DOH.

The primary consideration for inclusion in the program is that the company employ a relatively large workforce. Although there is no requirement for size of workforce, 500 has been a suggested minimum. In addition, companies that employ a predominantly female labor force are targeted.

Currently, the in-workplace approach consists of using company volunteers, guided on a weekly basis by PCPD staff, who informally try to convince their fellow workers to adopt family planning. The effort is based entirely on person-to-person persuasion or informal meetings during the workday. Few or no materials are provided. Referrals to clinics for long-lasting methods (VSC and IUDs) are difficult, as worker absences are charged to vacation time.

2.4.2 Performance

At the time of the evaluation, only 55 of the 120 companies targeted in the project had been activated. The main reason is that many of the company candidates had been forced, due to power shortages, to reduce their labor forces below the 500 figure informally agreed upon in the project. The program continues to sign up new participants, however. During this evaluation, the two food processing giants — Dole and Del Monte — were recruited for the program.

In those firms in which the program is under way, efforts to attract new contraceptive users have been highly successful. Some showed significant rates of growth in new acceptors. For example, at San Technology contraceptive prevalence increased from an already high 50 per cent to 83 percent. Likewise, FILCON almost doubled its prevalence (17 percent to almost 32 percent prevalence) after joining the project. Only one firm had drop-outs from the program, and they constituted an insignificant number.

Following the national pattern, the contraceptive method mix shows pills as the number one choice, followed closely by NFP and VSC. In spite of having good jobs, and in many cases the financial resources to purchase pills, most users elect to use the free contraceptives provided by DOH through the clinic at their worksite.

2.4.3 Areas of Concern

Simplifying and Streamlining Current Approach

The IECM effort in this program needs review and modification. Interventions are either too formal, consisting of long, after-hours classes for employees, or unrealistic, involving volunteer employees talking about family planning during a workday with only two ten-minute breaks and a half-hour

lunch. Given the high literacy rate in the Philippines, it may be simpler and more cost effective to rely more on promotional leaflets that suggest visiting the clinic nurse for more information.

Moreover, the IECM approach has not been tailored to the different labor force characteristics of each industry. No attempt has been made to vary the message, which has been designed for married women, to accommodate the young unmarried males and females who predominate in many of the workforces. PCPD has made some effort to reach unmarried women in special sessions (after-hours, longer, monthly lectures), in which the focus has been more on marital relationships and sexuality. Unfortunately, the IECM programs have found no good way to target men.

Third, the supervision and monitoring requirements may be unnecessarily stringent. The weekly visit schedule for PCPD staff may be too onerous, given staff's other workloads and the cost of the visits.

Fourth, sometimes barriers exist that make it difficult for employees to leave the workplace for clinical methods, particularly IUDs and tubal ligation, without penalty.

Many industries in the country have clinics. If the current program approach could be simplified, and a cost effective way found to provide information, contraceptives, and training of clinic staff, the growth of the program could be markedly accelerated. Alternatively, social marketing of contraceptives at the worksite might increase the likelihood of sustainability of the work-based project.

Expanding Scope

Limiting the geographic scope of the project is ruling out a number of promising opportunities. The Philippines industrial workforce is now estimated at almost 10 million employees, most of them fertile age men and women. Moreover, it is growing rapidly. In particular, the number of companies operating in the country's four Export Processing Zones (EPZ) has been increasing in line with increases in exchange earnings (these grew 31 percent for the first seven months of 1992). The project already operates in the EPZ in Region IV and could certainly make a contribution to family planning for employees if it were to expand to reach workers in the other three zones. Other opportunities also exist outside the project area, including a number of large industries with older, married populations and a committed management. In addition, the project currently rules out a number of non-commercial operations with large workforces such as police academies, universities, and utilities.

Recommendations

1. **The work-based family planning project can and should be expanded. USAID, with PCS, should review the program in depth and make recommendations as to how it can be streamlined and modified and then extended rapidly to other industries. Possible ways to expand the program include using the number of married couples rather than 500 workers as a basis for plant selection. Other ways to expand the program could involve enrolling exceptionally promising plants (large industries with older, married populations and a committed management) beyond the regions listed in the PCPD grant (and getting a waiver from USAID to do so, if necessary). They could also involve recruiting parastatals, police academies, utilities, and other non-commercial organizations.**

2. **USAID should encourage the PCPD to streamline its IECM operations, making more effective use of print materials and referrals to clinic staff.**
3. **USAID should urge that IECM programs be tailored to the particular demographic characteristics of the workforce (i.e., young, unmarried women; older married men; etc.).**
4. **USAID should also urge that supervision and monitoring programs be redesigned to reduce cost and improve efficiency. This could involve adopting a more cost effective schedule of monthly rather than weekly PCPD visits and focusing these visits primarily on IECM and future planning for the young workers.**
5. **USAID should encourage PCPD to undertake rapid assessments of its most successful companies in order to replicate the pattern elsewhere.**
6. **USAID should recommend that IUDs and tubal ligations be included in the industry-based program, even if insertions or surgery must be performed off-site.**
7. **USAID should encourage program sustainability through the introduction of social marketing programs in the workplace.**

2.5 Social Marketing

2.5.1 Background

The PFPP public and NGO sector efforts to provide family planning are supplemented by vigorous private sector sales of contraceptives. The 1988 National Demographic Survey data show that approximately 30 percent of contraceptive users obtained their last supply from the private sector. In 1989, approximately 1.6 to 2 million pill cycles and 2 million condoms were sold through 6,000 pharmacies and 364 supermarkets. Usage rates for both methods indicate that commercial sales account for 27 percent of the oral contraceptive market and 16 percent of the condom market, according to the 1988 National Demographic Survey.

2.5.2 Kabalikat/SOMARC Partnership

Accomplishments

Under the FPAP, the Social Marketing for Change (SOMARC) project and DOH are supporting a contraceptive social marketing (CSM) campaign, with project management by the NGO Kabalikat and with distribution by Philusa, a pharmaceutical company that earlier distributed a commercial brand of condom called "Sensation." The Kabalikat/SOMARC partnership began with a condom-based AIDS prevention effort, featuring a different condom, also called "Sensation," and is to be expanded to include oral contraceptives. SOMARC estimates that by the end of the first year of operation, sales of Sensation should reach 800,000, an increase of 30 percent over sales levels (600,000) of its purely commercial predecessor.

The effort has taken more than two years to get under way, with product launch for condoms having taken place only in late summer of 1992. Considerable work went into the IECM aspects of this

launch, however, including developing a unifying theme and creating promotional materials for different purposes. The launch campaign itself features the airing of five radio jingles on condom use that target urban married men who are between the ages of 25 and 45 years of age and who belong to the C and D economic classes, urban unmarried adult males ranging in age from 20 to 30, urban male teenagers aged 15 to 19, and male overseas workers (about to leave for their foreign assignments).

SOMARC has a baseline to determine the degree to which attitudes have shifted and plans to monitor sales to determine the degree to which sales have increased over recent commercial Sensation sales. Although the advertising campaign appeared attractive and well presented, an evaluation must await a more objective assessment of impact, based on client attitudes and purchases.

Areas of Concern

A major area of concern is whether the Sensation condom reaches C and D populations. The price is 8.90 pesos (P8.90) for three, which appears to be well within social marketing guidelines, representing a theoretical outlay of only approximately P27 monthly, or only 0.6 percent of the poverty-level income (P4750).¹¹ Since, however, this is the same price as that of the formerly purely commercial brand, and since commercial contraceptive products are often priced for higher income groups of the population, the ultimate consumer profile will have to be determined. The issues of price and market are important, because experience in other countries has shown that men are reluctant to obtain condoms from public clinics where they are distributed free, largely because of the predominantly female clientele and health staff at these clinics and the lack of privacy there.

Price and accessibility are further complicated by the entry of DKT, an affiliate of Population Services International (PSI), on the market. In 1991, DKT introduced a second CSM condom, "Trust," with no USAID support. DKT claims that it reached 1 million customers after just one year of sales and estimates that customers will double over a second year of operation. Trust is sold at P4 per pack of 3, a low price that should be affordable to the C and D populations. DKT claims that its investment in advertising is the same or lower than that of the SOMARC program. Although Trust is currently subsidized, DKT plans to introduce another fully commercial condom and other pharmaceutical products in the near future, the proceeds from which, according to PSI, will subsidize Trust and make the program self-sustaining.

Recommendations

1. **USAID should review carefully the social marketing activities of SOMARC and assess their potential for increasing sales of condoms and pills through expanded promotional activities.** For example, under devolution, a new community-based distribution (CBD) system could be devised in which contraceptives are sold house-to-house (on the assumption that their sale price was at least worth the opportunity cost of travelling to and waiting at the clinic) with part of the proceeds going as stipends to volunteer personnel. The feasibility of this or other IECM/CBD schemes should be investigated.
2. **The SOMARC program should be carefully monitored for impact.**

¹¹Half the Philippine population has an income below P4750 per month, defined as poverty-level income (as reported in World Bank, *New Directions in the Philippines Family Planning Program*, 1991). Expenditure of approximately P27 per month is based on the assumption that contraceptive protection would be provided through the purchase of 9 condoms monthly.

3. Training

3.1 Overall Plans

3.1.1 Objectives

The first major goal of the PFPP is to expand program coverage and the third, obviously a key to achieving the first goal of rebuilding and revitalizing the network of service outlets (see Section 2.1), is to strengthen training. To achieve this objective, the PFPP's five-year plan calls for training of 48,919 family planning workers. Of these, before devolution, 32,792 were expected to be from NGOs, or nearly double the number who were to be trained from the DOH. It is estimated that these trained NGO staff will provide 35 percent of the family planning coverage nationwide.

Plans call for training of doctors, nurses, and midwives, both DOH and NGO, in the following skill categories:

- 21,659 health personnel trained in integrated basic family planning skills;
- 7,255 in specialized skills;
- 1,622 in voluntary surgical contraception; and
- 18,383 in interpersonal communication skills (ICS) and VSC counseling.

A local private voluntary organization (PVO), the Economic Development Foundation (EDF), was selected to assist PFPP as the lead agency in the implementation of both the government and non-government's extensive training activities. The FPS defined DOH's training needs, based on regional training plans, and entered into an agreement with EDF to support the implementation of training within the FPS service network. The agreement with EDF to support training in the NGO sector was not signed until August 1992, however.

3.1.2 Need for Training

Training nearly 50,000 persons over a five-year period represents a massive undertaking. It was deemed necessary, however, since training came to a virtual standstill during the difficult 1986-1989 period. During this period, systems that had been set up to train trainers and monitor post-training performance virtually disappeared. Providers previously trained in family planning were further hampered by irregular or no supplies of commodities.

As a result, according to a 1990 assessment, many services were staffed with personnel who had had no training in family planning. The following suggests the lack of training among existing personnel:

- of 4,897 *barangay* health stations surveyed, only 1.9 percent had both trained personnel and adequate supplies of contraceptives;
- of 1,312 rural health stations surveyed, only 0.5 percent had adequate trained personnel and supplies;

- of 192 DOH hospitals surveyed, none had both trained staff and adequate supplies for family planning services;
- only 82 percent of public health nurses and 62.3 percent of midwives had training in basic family planning; and
- only 10.3 percent of rural health station physicians had training in basic family planning and IUD insertion and only 3.1 percent of hospital physicians had the required training in basic family planning, IUD, and VSC courses.

Another study, this one conducted by UNFPA in 1988, revealed that 80 percent of workers surveyed said they needed additional training in family planning.

These assessments highlighted the need to launch a major and comprehensive training program. The training needs are staggering and there is a palpable sense of urgency to "catch up" after years of minimal attention to training.

3.2 Overall Achievements and Concerns

3.2.1 Outputs to Date

A total of 7,311 personnel was expected to be trained as of the end of December 1992, if all scheduled training activities were to take place. This compares with a goal of 10,982 personnel at the end of the same time period. The shortfall reflects the failure to train any NGO trainees over this period (see below).

Despite the lag in the start of training of NGOs, much has been accomplished in training over the last two years. Training courses are being implemented. The rudiments of a DOH training system are now in place, and it will be possible to make improvements and refinements in the training efforts. The lessons learned and systems developed should also be applicable to the NGO sector, when it begins to implement training.

Still, because of the massive nature of the undertaking, much remains to be done. Moreover, with the dynamic process of devolution, the training element of the PFPP program, as well as other program elements, will face temporary and transitional disequilibrium.

3.2.2 Concerns

Lack of Training Targets and Strategy

Although the training plan is impressive in terms of numbers, it does not reflect a considered strategy.

National training targets do not appear to be based on current contraceptive use and projected demand by method. For example, the training plan calls for the training of 1,622 surgeons and nurses in surgical contraception. This number appears quite high, in light of the estimated demand of 40,000

for VSCs in 1994.¹² When newly trained physicians are added to physicians already trained to provide VSCs, the total case load per physician might be as low as two a month — clearly an inefficient use of valuable trained resources.¹³ Likewise, training plans in IUD insertions appear not to be based on client need. Plans anticipate making IUD training available for all clinical providers — doctors, nurses, and midwives. This could result in training too many providers and a situation in which theoretically few providers would be doing a sufficient number of insertions to keep up their skill levels. Thus, it would be more efficient to train fewer providers; in this case, each would do a higher number of insertions and thus retain his/her proficiency, assuring quality care. Conversely, too little attention may be given training in temporary methods, given that the majority of potential users will initially be spacers. Nurses and midwives need to be sensitive to the individual requirements of women for the temporary methods, must know how to take accurate histories, must know how to present advantages and disadvantages of different methods, and must know how to track all women in the family planning program to assure that the rate of drop-outs due to dissatisfaction with family planning methods is minimal.

In addition, training plans do not appear to have been tailored to meet specific geographic needs. Different clinics and different settings will require different sets of skills, depending on the characteristics of the population (such as demand, existing contraceptive prevalence, type of method preferred, etc.), on the policy directions of the program (i.e., to promote more effective methods), and on the level of health risk among the population. Moreover, no plans exist on how the newly trained personnel will be assigned to existing and new service delivery points (see Section 2.2.2). Nor is there a computerized system in place at the national level to track trainees, training courses, trainers, supervisors, or changes in personnel deployment. Such a system would significantly assist in assessing training needs and in the monitoring and evaluation of training.

Little effort seems to have been directed at ensuring that workers in each service category receive the type of training that is most appropriate for his or her job. For example, midwives without skills training could still do useful IECM work in counseling clients in the clinic and post-partum (at home) and thus should receive training appropriate to this type of contact.

Moreover, there is no strategy to train the large number of physicians, midwives, and nurses in private practice throughout the Philippines who could potentially be an important additional resource in providing family planning services.

Lack of National Training Standards

At present, no one set of training standards is in place to guide development of training courses and materials. Instead, different standards have been established by the various national and international family planning agencies in the Philippines. Although these sets of standards differ little from one another, this variation does cause confusion, diminishes efforts to improve quality of care, and tends to polarize the entire family planning training community.

¹²The estimate is based on 30,000 reported cases of surgical sterilizations performed in 1991 and an anticipated increase of 10 percent a year in the number of sterilizations performed.

¹³This figure was derived by dividing the expected 40,000 cases by 811 newly trained physicians (the remainder of those trained in VSC will be nurses), which would result in an annual average case load of 49 cases per year for newly trained physicians. This figure was then halved, to approximately 25 cases a year, since probably an equal number of already trained physicians will also be available to provide VSCs. Twenty-five cases a year works out to approximately 2 per month.

Delay in NGO Training

The reasons for this lack of activity in the NGO area are several. In part, misunderstandings slowed the agreement between EDF and PFPP. In addition, the procedures for reviewing training proposals are slow and inconsistent; accreditation requirements are either vague, confusing, or overly restrictive; and finally, there is a lack of consensus between the DOH and the NGOs on training standards and guidelines.

The failure to implement training for NGOs to date reflects primarily the difficulty that EDF has experienced with PFPP in working out a satisfactory agreement for training these staff. The PFPP did not provide enough specifics about training needs to enable EDF to develop a coherent implementation plan. Furthermore, the TS did not respond in a timely fashion to EDF's requests for clarification. When the agreement between EDF and PFPP was finally signed in August 1992, this at last paved the way for NGO training to get under way.

Other problems have further delayed training. For example, FPAP had wanted to develop an inter-agency training consortium composed of trainers and preceptors from the different agencies who would pool their skills and resources for more efficient and rationalized training implementation. Although this was and still is a good concept, the extended discussions about this concept further delayed the NGO training program.

In addition, the procedures at PFPP for reviewing training proposals (including procedures for grants, requests and review of proposals, memos of agreement, and other forms of contractual mechanisms including the release of funds) are slow and inconsistent. The problem may relate to the lack of a full-time PFPP staff member to backstop the training effort, help to ensure coordination between regional and provincial levels, assist in moving the budget request forms through the bureaucracy, and communicate any changes in program directions.

Finally, the aforementioned problems with accreditation for NGOs have further delayed the initiation of training (see Section 2.3.3). Because of the delays, it will be very difficult for the NGO sector to achieve either the overall training or the service targets set by the PFPP. Because of the important role that NGOs are expected to play in service delivery, any further delay in training will seriously compromise the impact and effectiveness of the FPAP and the PFPP.

3.3 Training Courses

3.3.1 Overview

General Parameters

The training program is very comprehensive, with over 14 different courses offered to different categories of workers. Fully developed sets of guidelines are in place for only two of the training courses; these, however, are good. Most of the other major courses have general and specific objectives, an outline of essential course content, and suggested methodology, duration, criteria for selection of participants, suggestions for evaluation, and a course schedule, but do not have fully developed guidelines.

General Concerns

To some degree, all of the courses address the health benefits of family planning. On the other hand, to ensure that training course content material is consistent with the overall strategy of the PFPP, the courses should have a more public health, client-oriented approach, i.e., with more information included on the benefits of family planning and the health risks of pregnancy. A major weakness, however, relates to medical standards. These have been set by FPS for the DOH program, whereas the NGOs have not set standards for their activities. Under the FPS standards, the course content material has a strong medical bias, rather than a preventive and public health approach. A medical approach fosters unnecessary medical barriers and influences the way in which providers perceive family planning clients, i.e., primarily as patients. Also, too little attention is directed to reasons and remedies for the high discontinuation rates. These errors should not be perpetuated in the NGO training.

Among these barriers is the national clinical standard that women must return to the clinic after the first month of use of oral contraceptives and subsequently receive only a three-month supply of pills, based on the assumption that they should return to the clinic four times a year for medical surveillance. This very conservative regulation, not justified by any epidemiological data, is practiced in fewer and fewer countries, is a disproportionate response to the very small risk of complications for women taking the pill, and is not cost effective. In certain cases, women with borderline high blood pressure, for example, or women older than 30, more frequent visits to the clinic may be advisable; but a policy requiring universal frequent repeat visits is likely to have a negative impact on program efficiency and sustainability.

Another key barrier is the belief that IUDs can be inserted only during menses. The Clinical Standards Committee of the TS, although pointing out that insertion should "preferably" take place during menstruation, has indicated that it can take place at any time during the cycle. This standard has not been communicated to the trainers, preceptors, trainees, and providers, however, and as a result many women are now being denied an IUD, particularly in the rural areas.

3.3.2 Specific Courses: Concerns

Training of Midwives

Although the midwife is perhaps the most important provider of family planning in the Philippines, a role well recognized by the PFPP, the basic pre-service training of midwives may or may not contain family planning. In cases in which no such training is included, this is an unfortunate omission. Midwives have the trust of the community and are likely to remain in their home territories. The women who elect to have midwives attend their deliveries can easily avail themselves of the family planning services that midwives can provide. Midwives perform additional roles as supervisors of volunteers and community workers and provide family planning outreach. Thus, the midwife is an ideal worker, when trained, and in an ideal place to provide family planning services and counseling.

In cases in which the basic comprehensive family planning course is not included in the pre-service curriculum, a good time to provide such training might be during the six-month gap between graduation and the time that results of the qualifying examination are received by the newly graduated midwife. These months are usually an uncertain period for recent graduates, with some perhaps finding another job in another field or volunteering in a hospital or clinic with the hope that they will eventually be hired.

Use of Training Time during Practicums

The basic five-week comprehensive course for nurses and midwives contains two weeks of theory and three full weeks of practicum. The equivalent course for physicians contains two weeks of theory, plus one full week of practicum. In both cases, trainees have very little practice during the afternoons, as opportunities for providing services are generally limited to the morning hours when most clients seek services. Thus, considerable time is wasted during the practicum part of the training.

Competency-Based Training

None of the training courses uses competency-based training techniques, a methodology that groups trainees according to their competency levels and graduates trainees from each course at the rate at which they can demonstrate a grasp of new material. This approach would be particularly suitable in clinical skills training, as skill levels vary considerably. Some nurses and midwives, for example, may require more than 15 IUD insertions to acquire competency whereas others will require significantly fewer. Competency-based training can reduce costs; encourage participation of more skilled providers, particularly those in private practice, as it cuts down on training time and thus the time that they must be away from their private practices; and alleviate the difficulty in finding enough clients to fulfill the patient-load requirements. Though such competency-based training requires more planning, it has proved to be cost effective in the long run.

"No Touch" Technique for Loading IUDs in Preparation for Insertion

Although all IUDs provided to the program through USAID are packaged to allow for a sterile "no touch" technique for loading IUDs, providers are not trained consistently in how to use this technique. The sterile packet, which contains both the CuT IUD and an insertion tube within a cellophane wrap, can be used two ways. If sterile gloves are available, the wrap can be opened, the IUD loaded into the insertion tube, and the IUD inserted into the client. If no gloves are available, as is often the case in the Philippines, the IUD can be loaded in the insertion tube without opening the packet, the packet opened, and then the IUD inserted into the client without the provider ever touching the IUD. This latter is the no touch technique.

The no touch technique is not included in the curriculum and trainees observed during the evaluation were not using the technique. Many trainees reported that they were unaware of this technique but said they would find it useful because they were often without sterile gloves. The no touch technique is not difficult to learn and could easily be incorporated in all relevant training programs.

Collaboration between the Association for Voluntary Surgical Contraception (AVSC) and the Johns Hopkins Program for International Education in Reproductive Health (JHPIEGO)

The current use of itinerant training teams for VSC services and training represents an important effort in expanding these services. The one precaution is to ensure that counselors are simultaneously trained at the same site. The collaborative effort between AVSC, which is providing VSC training for the public sector at Jose Fabella Hospital, and JHPIEGO, which is teaching VSC for private sector physicians at Mary Johnston Fertility Center, is also encouraging. These two U.S.-based organizations have agreed upon a common curriculum, which calls for training in both minilaparotomy and laparoscopy. At present, however, staff from the Philippines General Hospital

have not yet been included in training, although this is the site used by the Mary Johnston Fertility Center for performing minilaparotomy procedures. As planned, this training effort should focus on minilap and not the laparoscope procedure since the minilap procedure is a more practical procedure to expand to other levels of the system.

3.4 Equipment, Supplies, and Materials for Trained Personnel

3.4.1 Equipment and Supplies

No system has been established to ensure that equipment, supplies, and materials for each new trainee and at training sites will be available. In Region IV, for example, where 200 personnel will be trained in IUDs, there are only 65 new insertion kits. Moreover, many clinics are without the tables, lamps, and other basic equipment to permit correct IUD insertion procedures.¹⁴ Also, many clinical training sites have not been supplied with appropriate training materials — most noticeably, pelvic models are outmoded or absent. The JHPIEGO IUD training package, with its video, pelvic model for practice in IUD insertion, and slides depicting steps in the insertion of an IUD, would greatly enhance the prospects of successful training at these sites.

3.4.2 Materials

Although the PFPP has not yet set clear policies and standards for all training courses, some materials have been developed. With UNFPA support, the FPS developed and produced both a trainer's guide and a companion trainee's manual for the basic comprehensive course in family planning for physicians, nurses, and midwives and, more recently, a manual for the training of trainers at the provincial level.

The FPS materials are not being recommended by the TS for the forthcoming, long delayed NGO training, however. These materials are not perfect, but they are by far the most current materials in the program. The training component of the NGO sector should not be further delayed to develop new materials; materials exist.

3.5 Follow-up, Monitoring, and Supervision

The potential for long-term effectiveness of PFPP training efforts is hampered by the lack of training follow-up. No training course has been developed for the project monitoring teams at any level of the system: national, regional, provincial, municipal and district or for the NGOs. In addition, there is no plan as yet for the supervision of newly trained family planning workers. Nor has any decision been made as to whether those who provide training in service delivery will be the supervisors of the service providers or some other group, although, generally speaking, the most effective service delivery results when the trainers and supervisors are one and the same.

How local health boards become better informed on family planning and the importance of training, follow-up, and other program components has not been addressed.

¹⁴Locally made bamboo examination tables, which are available in some clinics, are more than adequate for use in the IUD procedure by newly trained staff.

Recommendations

for the DOH

1. **Human Resource Development** — DOH regional staff should be strengthened through training and technical support for their increased responsibility in family planning. The number of regional staff (including MIS and IECM specialists) involved in family planning monitoring at the LGU level should be increased (also listed in Chapter 1).¹⁵
2. National strategies for training and supervision should be completed (also listed in Chapter 1).
3. A program should be initiated to identify, recruit, train, and supply private sector medical institutions and individuals for family planning provision throughout the country (also listed in Chapters 1 and 4).¹⁶

for USAID

Training Strategy

1. USAID should encourage the DOH to develop a national training strategy, preferably before the start of the next project cycle.
2. A national training data base, including information on number of trainers, personnel trained, number of training courses, etc., should be established to help in the management and planning of training programs.
3. USAID should encourage the DOH to carry out a training needs assessment of all private practitioners and services. Information should also be gathered on professional health/medical associations to determine their roles in providing continuing education to their members.
4. An annual training coordination meeting should be held to review training progress, problems, and issues. Both private and government agencies should participate.
5. USAID should urge the PFPP to give maximum attention and support to the NGO training component to avoid any further delays and to assist the program in meeting its targets. The PFPP should review its procedures for grants, requests, and review of proposals, memos of agreement and other forms of contractual mechanisms including the release of funds, so that the implementation of the NGO training can proceed without further delay.

¹⁵This recommendation was among the five priority recommendations made to the secretary of health.

¹⁶This recommendation, and the one directly above, were in the second set of recommendations made to the secretary of health.

Training Standards

6. **USAID should encourage the establishment of uniform training standards that reflect the reality of training in the Philippines without compromising the quality of care.** This should be done by DOH, which should immediately review, revise, and merge the existing standards for training. The standards should be disseminated to the DOH, LGU, and NGO staffs. The standards should be reviewed on an annual basis or before, if the need arises. As part of the process, the mechanism for developing standards for training and training materials should be examined to identify if current problems with coordination and cooperation are due to personality, management, structural, or programmatic flaws.
7. **USAID should recommend to the DOH the removal of all unnecessary medical barriers to family planning.** All training materials, the national clinical standards, and service guidelines should all be screened to eliminate such barriers. The paper entitled *Eliminating Medical and Other Barriers* by Drs. James Shelton and Roy Jacobstein should be added to the PFPP library and used when appropriate for training courses.

Training Courses

8. **USAID should urge DOH that training course content material include more information on the benefits of family planning and the health risks of pregnancy, with more of a public health client-oriented approach.**
9. **USAID should suggest to the DOH that the pros and cons of training midwives in the full basic comprehensive family planning course directly after graduation be explored.** Such training could take place through on-the-job training or internships. Some other mechanism might also be explored by IMCCSDI, which has experience in training self-employed midwives.
10. **USAID should strongly encourage competency-based training wherever possible.** The effort should begin with a small pilot program in one region where competency-based training for both the surgical sterilization and basic comprehensive courses could be initiated and evaluated.
11. **USAID should urge the DOH to make some adjustment to the practicum segment of clinical training so that the time could be used more efficiently.** One solution might be that trainees begin their practicum during the second week of training, spending the morning in the clinic and the afternoon in the classroom. Alternatively, an effort could be made to provide structured learning experiences for the students during the practicum in the afternoon when there are few clients. Some examples of structured learning experiences include self-instructional modules, community outreach exercises, and classroom laboratory practice with pelvic models.
12. **USAID should continue to encourage focusing the surgical contraception course on the minilaparotomy procedure.**
13. **The no touch technique for IUD insertion should be included in all relevant courses.**

Equipment, Supplies, and Materials

14. **USAID should participate in an inventory of all equipment supplies and materials that are currently available for trained personnel and training sites. A similar assessment of NGO facilities should be undertaken. Based on these inventories, two options should be considered: one, equip those clinics that are considered to be in priority areas; two, if sufficient funds are unavailable to supply non-priority clinics, defer training for their staffs. This inventory will not only serve to help the DOH and LGUs but will help donor agencies to design more appropriate assistance projects.**
15. **Training courses should be enhanced with audio-visual and other graphic aids. A high priority should be given to the acquisition of new, improved pelvic models for IUD practice.**
16. **USAID should urge the DOH to employ the training modules currently in use by DOH staff in the NGO training as well.**

Follow-up, Monitoring, and Supervision

17. **USAID should strongly encourage the development of a plan for the supervision of newly trained family planning workers, including training modules modified to include this supervision (see also Recommendation 8 in Chapter 1).**
18. **As soon as possible, a training course should be developed and implemented for the project monitoring teams at all levels of the system: national, regional, provincial, municipal, and district. This same course should be offered to the NGOs.**
19. **A course should also be developed for the local health boards. This course would provide them with information on family planning and the importance of training, follow-up, and other program components. Additionally, it could serve as an introduction to the contents of the technical support packages and other available resources from DOH.**

4. IECM and Advocacy

4.1 Overview

The information, education, communication, and motivation component has been identified by the DOH as a key element in energizing the PFPP. Although IECM programs have languished in recent years, ongoing political changes in government and a renewed commitment to family planning have raised the visibility of such efforts and acknowledged their important role in the overall program. Similarly, although the infrastructure for an IECM program is in place, and public, private, and NGO agencies are currently active in providing both education and services, many gaps remain in both structure and implementation that need to be addressed before the IECM program can move rapidly ahead.

Support to IECM activities is provided by both USAID and UNFPA. Under their partnership, family planning IECM activities are divided into two major parts: the USAID contractor PCS is responsible for research, strategic planning, mass media, and the production of support materials; and UNFPA is responsible for training. Under this agreement, UNFPA is assisting the DOH to revise the interpersonal communication skills (ICS) training module developed by POPCOM (see Section 4.3.3).

Efforts are being made to develop a national IECM strategy, but the current DOH *IECM Strategy and Master Plan for the Philippine PFPP 1992-94* is still unofficial (i.e., it has not been formally adopted by the DOH). It has, however, been widely distributed. The DOH IECM strategy provides a good overall framework for operational planning, suggesting both messages and media. The operational plan, however, must take this many steps further, matching messages with particular media or interpersonal agents.

At the request of DOH, the PCS project has prepared a draft IECM strategy. This involved in-depth audience research to lay the basis for an audience-based IECM strategy. Although the draft strategy goes a long way toward segmenting audiences, it does not categorize them in terms of those who have expressed a desire to space or limit their families and those who have not; nor does it segment specifically by *reason* for non-use. It also places too much emphasis on health risks as a motivating factor for increasing prevalence. Much of the core material, particularly that dealing with a client-based marketing strategy, was not included in the government strategy paper. Audience research is key to segmentation.

The institutional structure with regard to IECM is somewhat unclear. The technical policy committees, the TS, and the FPS all have played roles in IECM, at times overlapping. At present, IECM supervision is carried out only as part of a regional monitoring and evaluation team, which is largely clinical in orientation. This is clearly not sufficient.

4.2 Strategy

4.2.1 Lack of Targeting

At present, little effort has been made within the PFPP to segment and target the potential users of family planning and to direct specific messages to them. Nonetheless, in the Philippines, there are

a number of categories that would probably be more receptive than others to using family planning. Considerable audience research, the foundation of any targeting effort, exists in the Philippines. In addition to the research carried out by PCS, other research efforts have been undertaken to examine the reproductive and contraceptive needs of the Philippine population. Project Star, Project Platypus, the recent UNFPA-sponsored family planning knowledge, attitudes, and practices (KAP) study, TRENDS, and the recent University of the Philippines Population Institute KAP study of Metro Manila are but a few examples of the many research studies already carried out. Additional information will become available from the 1990 census results and the 1993 Demographic and Health Survey study (see Section 5.1.1). Based on this research and additional smaller-scale, focus-group research to fill in any gaps, a segmented strategy can be developed.

4.2.2 A Proposed Targeting Strategy

Women

- **Women with Unmet Need.** Women with an "unmet need" for family planning may be defined as either those who express a desire for family planning but are not using it or those who are using family planning but who may stop for a variety of reasons. They can be segmented as follows:

- 1) women who have never tried family planning but who are now ready to adopt it;
- 2) women who have discontinued use but want to begin again; or
- 3) women who are currently using family planning but who are unhappy with either their method or the services provided at the clinic and are about to discontinue it.

In terms of women who may adopt family planning, the most likely candidates appear to be women at health risk. According to a recent World Bank study,¹⁷ approximately 70 percent of married women of reproductive age with health risks, but not using family planning, want to plan their families. Reaching these women and devising messages appropriate for them should be simple. In principle, informative messages, carefully rendered in local languages and presented by recognizable local experts should be sufficient to reach these high-priority audiences.

- **Female Non-Users Who Do Not Actively Oppose Family Planning.** A significant percentage of women who are not using family planning, do not want to but have no health risk (and therefore have spaced their children). These women may be resorting to abortion to control the size of their families, or may have long, but temporary periods of abstinences. Although they may be more difficult to reach and may be of a lesser priority than the women with unmet need, they should also receive information about family planning.

These women may change and begin to desire family planning at some point. For instance, if they are using abortion to control fertility, they are demonstrating their desire to control their fertility. Likewise, periods of temporary abstinence may change abruptly. In addition, if they are young women who are not yet married, they are presumably not yet dismissive of or opposed to family

¹⁷The World Bank, *New Directions in the Philippine Family Planning Program*, 1991.

planning. Although these women may not exhibit health risks, that will change for those under 20 if they marry and become pregnant at this young age.

For these more difficult audiences — i.e., for audiences with more complex or subtle needs (such as adolescents or women resorting to abortion) — ample research on which to base more sensitive campaigns already exists.

- **Female Non-Users Opposed to Family Planning.** Women and couples who do not want to use family planning should not be considered a priority of the program (although eventually, some IECM could be targeted to them). These women, often products of a conservative religious background, strongly influenced by the pro-natalist beliefs of their spouses, or very traditional in outlook, have been historically difficult to convince. They are often less educated than those who have adopted family planning; less exposed to an urban environment and its modern ways; and less susceptible to arguments for fertility control.

Male Audiences

Men play an important part in reproductive decision making, with discussions between husband and wife a key factor in contraceptive adoption and continuation. In the Philippines, some work has been done to reach this important audience, but it has been indirect. Industry-based programs, for example, may reach men, but that is because they just happen to make up the majority of the labor force. Likewise, the non-industry campaigns directed to men — primarily those promoting the use of condoms against AIDS — are unlikely to have an impact on family contraceptive behavior; condom use is only a fraction of one percent of total contraceptive use; and although condom sales are increasing, use is primarily for AIDS protection with non-married partners. The many other ways of reaching men — through the military, the police, industry, employment associations (such as for Jeepney drivers), etc. — need to be fully explored.

Young Unmarried Men and Women

Some efforts have been made to reach young unmarried men and women with population and reproductive education, but many more opportunities exist through youth groups, clubs, after-school activities, churches, etc. A good example of such educational efforts is the recently completed PCPD Multi-Media Campaign for Young People's Project, designed to disseminate messages about responsible sexual behavior to teenagers and young adults. In another project, the Multi-Service Youth Centers Project, PCPD is providing information to young people about responsible sexuality through outreach to organized groups. UNFPA has also been active in this area (see Proposed IECM Strategy at the end of the recommendations of this chapter).

4.3 Interpersonal Communication

4.3.1 Overview

Interpersonal communication is arguably the most important element of IECM in the Philippines. Because of the need to provide specialized information to the many different clients in the country, the intervention of a well-trained health worker or extension agent is indispensable. Indeed, the success of any IECM program depends on the existence of well-trained health workers or extension agents who can provide specialized information to the many different clients in the country. IECM

programs comprised of a strong clinic- and community-based interpersonal communication program and supported by mass media and print materials can provide the channels through which individualized, personalized family planning information can flow.

Interpersonal communication is the heart of the work of community-based workers and an important aspect of the efforts of clinic-based staff. In the case of both these cadres, mobilization of their interpersonal efforts has been stymied due to a number of constraints, described below.

4.3.2 Outreach Staff

Field-Level Workers

At the field level, three types of staff could be enlisted as part of a renewed IECM effort. These include two groups that were created under the OUTREACH program during the POPCOM years — full-time outreach workers (FTOW), who were paid staff under the program, and *barangay* supply point officer (BSPO), who were volunteers. In addition, there are the *barangay* health workers (BHW), who are currently part of the PFPP as family planning outreach workers.

Former OUTREACH Personnel — FTOWs and BSPOs. These two cadres form the basic structure for a community-based family planning interpersonal communication program. Under POPCOM, both groups were trained as multi-purpose community workers. Since the retirement of POPCOM from family planning services, neither the BSPOs or the FTOWs have been assimilated into the DOH program on a regular basis. Although in many municipalities they have been hired, this is by no means universal. Those who have been retained have not received any organized IECM training since their POPCOM days and need retraining particularly in the new, proposed IECM strategy, including information about the new, more effective family planning methods (see above and Proposed IECM Strategy at the end of this chapter). Most of these former POPCOM workers are doing many tasks, only one of which is family planning.

Barangay Health Worker. The BHWs have not received any in-depth IECM training, such as the ICS training, which was created specifically for nurses and midwives (see Section 4.3.3 below). The BHW has no well-defined workplan (i.e., with regard to a segmented audience, targets set for new adopters, or in relationship to the work of clinic-based staff), nor are they supervised according to any set of plans and targets. Furthermore, the BHW is a volunteer worker. Currently, the DOH guidelines do not permit the payment of incentives or the sale of contraceptives, although there is no reason why, under devolution and new municipal regulations, the BHWs could not receive a stipend or sell contraceptives.

Current Status of IECM Efforts

In 1990, the DOH renewed its commitment to IECM through the "Proposed Project to Support the Contribution of Local Governments to the Philippine Family Planning Program." Part of the approach is that family planning OUTREACH fieldworkers would have as their main tasks family planning IECM and service delivery. Implementation of this strategy, however, will require strategic planning, the recruitment of both community extension workers and supervisory personnel, and the reinstatement of a strong management structure and management procedures that assure not only the proper supervision of individual staff but improved collaboration among them.

At this point, these conditions are not in place. The relationship between fieldworkers and clinic staff is not clear. Nor do fieldworkers have performance targets set by management. Training and supervision are also unclear.

Little has been done to develop an **operational plan** for interpersonal communication that identifies roles and responsibilities for the FTOWs, BHWs, or the BSPOs or for local community organizations. Nor has any guidance been given as to how these groups might fit into the segmented communications strategy outlined above. No disciplined workplan has been developed within which these staff should work — one that includes door-to-door solicitation, follow-up visits, and organization of group discussions for gatherings of different types of audiences. Implementation of such a plan, however, would require strategic planning, the recruitment of both community extension workers and supervisory personnel, and the reinstatement of a strong management structure and management procedures that assure both adequate supervision of individual staff and improved collaboration among them.

Advent of Devolution

The former OUTREACH personnel have not yet been incorporated into an organizational structure that takes into account the emerging focus on fertility reduction and devolution. DOH planners have preferred to wait rather than to act, knowing that under devolution, local bodies will be responsible for the funding of any community outreach workers.

During the POPCOM years, municipalities and provinces had POPCOM population development officers, who were able to supervise the IECM efforts. Many of these positions are now vacant and it is unlikely that the new administrative structure planned under devolution will provide equal support. Although integrated health monitoring teams may be set up at the municipal level; although the local health board will certainly take an interest in family planning; and although the municipal health officer will be responsible for the operations of the family planning program, none of these agencies or individuals will have the time, background, or experience to manage a full-scale IECM effort.

Likewise, there is little evidence that local governments have the political determination to revive the community outreach aspect of the family planning program. A strong advocacy program will be necessary, not only to convince local bodies of the need for this kind of a family planning program but to suggest to them the most cost-effective type of intervention required to implement the program effectively (see Section 4.4 below).

Suggested Use of Existing Fieldworkers

If the FTOWs were reassimilated into the current family planning program, they might be important family planning promoters. They would, however, have to be retrained and reoriented in client-based family planning. They would have to be closely supervised. They would have to be paid for by local governments, which might be unwilling to pay for them to do family planning only. More study would be needed to establish whether reintegrating them into the program would be cost effective.

If BSPOs were to be retained under any new LGU scheme, the question arises as to whether they should be kept as volunteers. Worldwide, unless volunteers receive some kind of stipend, particularly one linked to performance, they are limited in effectiveness. FPOP currently uses community-based workers as volunteer family planning agents. These agents, however, do receive a stipend on the

basis of the number of new adopters recruited and receive half of the sale price of contraceptives sold (resupply of pills and condoms).

Administrative Issues

Currently, provinces and municipalities set performance targets according to the rate of natural increase of the population (e.g., 2 percent per year). Performance is not judged by new acceptors although increases in new acceptors can be linked largely to the effort of extension or outreach workers. The setting of realistic performance indicators for IECM personnel is an essential means of providing both motivation and performance standards for them as well as for providing program managers the means to evaluate their performance.

4.3.3 Clinic-Based Activities

IECM Training

The ICS module used to train nurses and midwives was developed in 1987 by the FPS, with assistance from PCS. This one-week course focuses on interpersonal skills and is important for deepening clinic staff's understanding of the socio-cultural context in which family planning information is given and in providing communication and counseling skills that are appropriate for both clinic-based and home encounters. Unfortunately, it focuses on treating all clients the same way, using generic interpersonal skills, rather than on tailoring communication for specific audiences and situations, i.e., for adolescent girls, large mixed audiences, small homogeneous audiences, first-time home visits, follow-up visits, etc. It includes nothing on workplans or supervision.

At the time of the evaluation, under the partnership agreement with USAID, UNFPA was assisting the TS to prepare a new manual based on the original POPCOM ICS manual. This manual, however, omitted some important issues. Specifically, discussions with those involved in preparing the new module suggested that, once again, workplans and supervision had not been included nor were there different sections for different categories of workers. All three refinements are important. Workplanning sets the management framework within which IECM staff are to operate: caseload definition, how to set priorities in client contact, how to record, maintain, and use client data, etc. Supervision guidelines give each supervisor a detailed protocol of what to evaluate and how to evaluate the performance of different worker categories. Tailoring materials to worker categories makes them more relevant and understandable.

Coordination of Courses

In principle, after their intensive five-week clinical training course, nurses and midwives immediately take the one-week IECM training course. This has not happened, however, on a regular basis. Of the 480 midwives in the country who have completed the basic comprehensive training in family planning, only 50 have received IECM/ICS training.

Part of the problem may lie in the training of trainers to provide IECM training. At present, FPS staff are expected to provide training in IECM skills to regional trainers. Priority appears to have been given to training regional trainers in the basic comprehensive training, however, and few at this level have been trained in IECM. Perhaps due to this lack of qualified trainers, training in ICS is not given immediately after the completion of the basic comprehensive training, but is delayed

sometimes until months later. Staff are often reluctant to return for these follow-up classes once they have completed their initial skills training.

With devolution, the problem may also arise that the LGUs will be averse to releasing clinic staffs for this training and to paying for it, if IECM training is seen as an additional cost.

IECM Activities

At the clinic level, the midwife is the key person in the family planning program. She is expected to provide some clinic-based IECM activities, outreach (i.e., home visit deliveries and follow-up in the afternoons), and to supervise BHWs and (perhaps) FTOWs. She, and other clinic-based staff, however, have little time to offer family planning counseling and education, since they are very busy with clinical activities.

Functional integration at the clinic level is an official policy of the DOH and represents an important method for identifying and motivating potential new adopters, drop-outs, and dissatisfied contraceptive users. Family planning is generally not integrated into other MCH services at the clinic level, however, and no mechanisms are in place for regular consultations with clients on family planning. There are no routine procedures for screening women who come into the clinic for non-family planning reasons (e.g., for immunizations for their children). Little or no time in clinic routines is set aside for personal counseling on family planning if a woman comes into the clinic for non-family planning reasons. Clinic management and patient flow are not designed for easy referral among preventive health services. MIS procedures are not management-based, permitting clinic staff at a glance to determine whether a woman has dropped out of the family planning program, for what reason, and when. This is particularly important, for if clinic staff periodically reviewed family planning records to determine which women have not come back for resupply of pills or periodic checks on IUDs, they could indicate to BHWs or other community-based staff who these women are and initiate a follow-up visit.

In addition, most formal family planning IECM is done within the context of pre-nuptial counseling. Although this is appropriate, it does not cover the wide range of IECM possibilities afforded by the clinic.

Methods according to Client Need

The current strategy of the DOH has been to present all methods to all women neutrally, although a better strategy would be to promote longer-lasting and more effective methods, particularly for those women who have achieved their desired family size. Although offering clients a choice of methods is a critical part of a good family planning program, some methods are more appropriate for particular groups of clients than others. Those who are having problems in taking the pill correctly might do better with an IUD. Likewise, women over 35 who have reached their desired number of children could be counseled to switch from temporary to longer-term methods.

In practice, this kind of client screening is often done, but the approach is not part of official strategy. If this client-based method orientation were taught to health workers, they would be better able to take client histories and propose the most effective method for each individual.

4.4 Population Advocacy

In addition to IECM activities directed to the target population, there is an increased role for advocacy activities in the country. After devolution, the responsibility for family planning services will be largely in the hands of LGUs — provinces, municipalities, chartered cities, and *barangays* — where elected and appointed officials will make difficult decisions concerning resource allocation. Because the PFPP has languished in recent years and political support has been low, and because local officials have never had to undertake local development planning on the scale envisioned now, it will be essential to mount an intensive advocacy campaign to explain the benefits of family planning — benefits that will accrue both to individual families and to communities and the nation.

POPCOM, which is responsible for the advocacy part of this program, has worked, primarily at the regional level, both with officials and on mass media. Some of the most successful advocacy efforts have been carried out under POPCOM auspices, including presentation of RAPID model applications to regional officials and regional IECM campaigns focusing on population issues and intended to reach community leaders with important demographic information, also an integral part of POPCOM programs. Additional opportunities exist in the area of lobbying of local interest groups (most notably women's groups) to promote programs of family planning, health, and welfare.

4.4.1 Policy Intervention at the Top Level

In collaboration with the Futures Group, POPCOM has used the RAPID model to elucidate population and demographic issues (i.e., high immigration, illegal settlements, areas of poverty and population density within more affluent, low-density zones, and so forth) at both the regional and the national levels. The major constraint to more frequent presentations has been a shortage of equipment (i.e., computers).

Furthermore, no effort has been made as yet to adapt the RAPID model for provincial and municipal audiences. This would require reformulation of national data and projections to include the many localized situations in the country; for example, some locales experience no population pressure whereas others have rapidly increasing squatter populations which strain the abilities of local authorities to provide services. Given the large data base required by the RAPID program, it is unlikely that the existing model could be redesigned to conform to the small data bases of local municipalities or even provinces. Rather, perhaps the *principles* of the model could be applied to these lower governmental levels, through training sessions that presented the same types of scenarios at the municipal level that are presented in the national RAPID presentations. Even if much of the presentation is qualitative, it would help to sensitize local officials to the persistent demographic demands on individuals, families, and communities.

FCS has worked with the Philippine Legislative Committee on Population and Development in conjunction with the University of the Philippines Population Institute and UNFPA to develop an intensive advocacy training course for provincial and municipal officials in four pilot provinces of the country. Results were unavailable at the time of this evaluation.

4.4.2 Mass Media

Since the inception of the program, mass media have provided an important channel for the transmission of family planning information and a number of local programs have integrated family planning themes into their formats (in sitcoms, news, and talk shows). POPCOM, for example, has

produced various forms of mass media, primarily at the regional level. POPCOM Region IV has produced radio programs for the general public, video programs for policymakers, and print material. One of the radio programs was on migration and encouraged non-Metro Manila residents to remain in their current locations (using local resources) rather than migrating to other places where employment opportunities were no better.

In another initiative, DOH, with the support of PCS, launched an "info-tainment" and organized and ran a gala to which popular film, television, and music stars were invited. The gala demonstrated that these popular stars subscribed to a number of social causes, among them family planning.

Regarding materials, a number of print materials have been produced — by POPCOM, DOH, and others — which merit particular interest. Of these, comic books that have been adapted for population and family planning themes may be the most effective. Comic books are popular in the Philippines. Although they are relatively expensive to develop and produce, they are read far more than individual technical leaflets.

Clinics appeared to have various materials on hand, but most of these could be substantially improved. For example, a family planning poster on population and development (not funded by PCS) was not well targeted; it presented the concept of demographic pressure and its implications on **community** health, education, and economics, not on these issues as they affected **family** life. Likewise, although good leaflets on each family planning method were available in all waiting rooms of clinics visited in the Cavite Region, none gave a comprehensive listing of all methods available. Such a leaflet would be a useful supplement to hand to a patient who is using another of the available MCH services. Third, some materials are too expensive and sophisticated for the clinic audiences for which they are intended. The DOH recently produced an excellent booklet on health care for families at health clinics. With its four-color graphics and glossy format, however, this booklet must have been an excessive drain on scarce resources. Furthermore, the detail and completeness of the text suggests that it was not the most useful tool for poorly educated, although literate families. Finally, materials have not been updated in accordance with more recent trends in IECM and a look at any wall of any clinic visited offered a view of the full range of **the** last 15 years of family planning history in the Philippines. This does not represent a very convincing approach and might be confusing to clients.

No concerted, deliberate, and orchestrated effort has been made to tap the full potential of the mass media. According to PCS, lack of headway reflects DOH concerns over the political sensitivity on family planning subject matter. PCS developed a mass media strategy as part of its overall draft strategy (see Section 4.1). In this strategy for each audience group identified (segmented), a media/interpersonal strategy was also identified. Ample professional and technical resources exist in the Philippines for both media development and production. PCS has identified a number of advertising agencies that could easily handle the development of social themes.

4.4.3 Organization of NGOs and Government Organizations

These groups represent many different interests, ranging from political action to promoting family planning within professional associations, all of which could contribute to a strong advocacy program. The involvement of women's coalitions and groups — of which there are many in the Philippines — is a particularly important component of advocacy. A number of women's groups are already active in family planning advocacy. The Women's Media Center, assisted by PCS, has made a strong effort to change the way adolescent sexuality is presented on television — attempting to remove negative

role models from popular series. The center also produces a program called "Woman Watch," which promotes many issues of interest to women, including family planning. If local women's coalitions, for example, could carry out a concerted lobbying campaign in a municipality for a more ambitious family planning program, it is likely that the municipality would be more susceptible to change.

Likewise, representation on municipal councils could be an important way to effect positive change. A new law requires that 40 percent of seats on local government councils be women. If all women's groups of a particular area were solid in their support for family planning, and if a member of these groups were to be included on the city council, that member could be a positive voice for family planning. Likewise, FPOP, all of whose 27 chapters include influential community leaders, both men and women, could run for membership on local councils.

The Advocacy Technical Committee of the DOH has made an effort to lay the groundwork for organizing NGOs and government organizations for social action in family planning but no coordinated, sustained effort has resulted as yet. The committee has been assembling an annotated critical list of possible advocacy interventions to support the promotion of family planning at the LGU level (requested by the evaluation team). This list is designed to form the basis of a plan of action, including projects that need funding. When the list is agreed upon by PCS, the DOH, and POPCOM, POPCOM should take responsibility for further advocacy planning.

4.4.4 Private Sector

The inadequate efforts to identify, recruit, and train private sector health professionals carries through to the IECM sphere. No concerted effort has been made to reach these groups with family planning information. The health associations mentioned at the end of Section 1.2.4 would be useful avenues through which to distribute print materials on family planning.

(Discussion of IECM activities in work-based programs and through social marketing is found in Chapter 2.)

Recommendations

for the DOH

- 1. Communication and Logistics** — The IECM program should be activated on television and radio. The latter should focus on informing women of the new family planning program with recently trained staff, improved, gentler oral contraceptives, and the new long-lasting IUD. The CARE network should be used to distribute existing IECM materials, which would be developed and printed under the PCS project.¹⁸
- 2. National strategies for IECM** should be promulgated.

¹⁸This was one of the five priority recommendations made to the secretary of health.

3. A program should be initiated to identify, recruit, train, and supply private sector medical institutions and individuals for family planning provision throughout the country (also listed in Chapters 1 and 3).¹⁹

for USAID

Overall Strategy

1. USAID should have PCS assist with the development of an IECM marketing strategy that targets groups that are the most likely candidates for new acceptors. Specifically, the strategy should focus primarily on women of reproductive age who are not using family planning but who have health risks and who have expressed an interest in beginning to use it.
2. USAID should also direct PCS to work with public and private sectors to reach men and unmarried men and women with population and family planning messages.
3. USAID should direct PCS to assist with the development of an operational plan reflecting the strategy proposed above. This would include a plan for each channel of communication — mass media, support media, and interpersonal communication.
4. Under this strategy, USAID should urge the DOH to give mass media immediacy and prominence. Radio and television campaigns should begin as soon as possible — particularly campaigns that inform the populace about the new, improved, and revitalized family planning program.
5. Under the strategy, USAID should also support the resuscitation of the interpersonal education component of the family planning program, modified where appropriate (based on OR findings).
6. USAID should assist with the restructuring of the IECM and advocacy components of the PFPP so that all activities — from research, planning, and development to implementation and evaluation — are given a well-defined institutional home. IECM should be carried out by the DOH and the NGOs and advocacy should be the responsibility of POPCOM and the NGOs.

Interpersonal Communication

7. USAID should help with the establishment of realistic performance indicators against which IECM personnel can measure their impact.
8. USAID should encourage the completion of the new ICS training module currently being developed by the TS, ensuring that the FPS, currently using a different module, provides its inputs.

¹⁹This and the recommendation directly above were among the second-level recommendations made to the secretary of health.

9. **USAID should recommend to the DOH that the basic comprehensive and ICS training courses be held sequentially. Such an arrangement would be more cost efficient and logical than the current one. One way to facilitate such a change would be to streamline the ICS course by focusing it exclusively on clinic-based and post-partum (at home) counseling.**
10. **USAID should support the functional integration of family planning and other MCH services at the clinic level, thus affording additional opportunities for family planning information to be presented.**
11. **USAID should urge the DOH to recast the IECM program message from promoting all methods neutrally to placing the emphasis on effective family planning methods in all IECM efforts.**

Advocacy

12. **USAID should support increased advocacy activities that would include education of elected LGU officials and their staff through training, conferences, and workshops; mass media coverage of population issues; lobbying of local officials by women's groups and other citizen organizations; and lobbying other organizations — such as radio and television networks and stations — to promote responsible sexuality and parenthood. A special effort should be made to include private sector health providers.**
13. **USAID should urge the DOH to undertake a careful review of all IECM materials currently in use and determine those that are appropriate for further use, given the likely shift in IECM strategy. For new materials, the focus should be on cost effectiveness; reduction in purchases of high-cost, relatively unproductive mass distribution items such as posters; and an increase in narrowly targeted materials such as leaflets for a particular audience.**

for the DOH and USAID

Proposed IECM Strategy

The setting of a clear IECM strategy is key to the success of IECM efforts. Such a strategy should have the following components:

1) **Segmentation of the audience:** Of those women who are at health risk, a significant percentage either are users or past users of family planning or have expressed a desire to space or limit their families. These women can further be divided by category. Of those women who would like to plan their families, but are currently not so doing, a certain proportion may not do so for **religious reasons**. If this is the case, they need to be told about **natural family planning**. If they are from the Muslim regions, they need to be told about the latest interpretations of Islam which do not contra-indicate family planning. If they do not adopt family planning because of **resistance from their husbands**, then information/motivation must be given to the latter. If they do not adopt because of **insufficient or erroneous information** about family planning, they need to be given appropriate information about various methods, particularly the new IUD and low-dose pills. This same approach should be aimed at women who would like to plan their families, have attempted to do so in the past,

but who have been unhappy with the method used. Finally, if women do not adopt because they do not know where to get a particular method or have had bad experiences with supply in the past, they can be provided information concerning the improved program and its services.

Women who are **currently using** family planning include a number of categories of IECM potential clients. First, there are those women who are currently using family planning, but who are increasingly unhappy with the method. They may be using the method incorrectly or have physical problems. Discussions with these women can correct usage, identify medical problems that need attention, and can suggest remedies and/or alternatives. Women who are currently using family planning and are happy with the method, but are thinking of having another child even though they may have many and/or poorly spaced children, need to be informed of the health risks and the advantages for spacing.

Among women who are **not using, do not want to use, and who do not exhibit any health risks**, there are those who are only **temporarily protected**. These are women who are in a period of abstinence who have yet to start their families, or have just begun. The latter are by far the larger number and are an important target group. They, too, can be subdivided. First are women who have no children but who want them. Although they can use family planning information, it is unlikely that they will be receptive to using a method at this time. Women who have had one or two children and appreciate the realities of child-bearing and -rearing are likely to be much more susceptible and should receive information on child spacing.

Women who are controlling their fertility through abortion (and who therefore show up in the statistics as women **not planning**) are in urgent need of information on family planning.

Men can also be divided into a number of categories, particularly by reason given for opposing family planning. For each reason, there is an appropriate answer, similar to those suggested above.

Audience research is key to segmentation. Considerable audience research exists in the Philippines and more information should be available in the near future (see Section 4.2.1). Based on this research and additional smaller-scale focus-group research to fill in any gaps, a segmented strategy can be developed.

2) **Operational strategy**: Once it is determined what are the various audiences to be reached and in what order of priority, it must be determined how to reach them. All media (including interpersonal communication) are not appropriate for all audiences and all subjects. The needs of unhappy current users of contraceptives can best be addressed by clinic staff. Potential new adopters are best reached by community outreach staff and by clinic staff who are providing **non-family-planning services**. A nurse who is attending the needs of a child is in a particularly advantageous role for at least raising the question of family planning. Men may best be reached through the mass media (since the MCH and family planning system is currently woman oriented in terms of clientele and service providers) or through specialized group settings (military, police, unions, workplace, etc.).

As suggested above, different media are appropriate for different themes and audiences. If one central campaign on responsible parenthood is considered important, then television may be the best medium for reaching men and youth. Radio, given its reach and dramatic impact, can be an important vehicle for talking to women about different methods — the rumors about them and information to dispel them. Leaflets on each individual method of family planning may be suitable for a waiting room, but one leaflet containing basic information on all methods and stressing new

product qualities and advantages can be an important communication tool for both community workers on routine rounds (i.e., oral rehydration therapy follow-up, malaria control, iodized salt distribution, etc.) and for the clinic worker who identifies a potential family planning acceptor in the course of **non-family-planning** service delivery.

Under the FPAP considerable progress has been made towards the development of this audience-based IECM strategy. The PCS draft IECM strategy adopts a **client-based** approach and goes far to segment the audience into many of the categories suggested above. It can and should be the basis on which a revised strategy and strategy guidelines should be based. This PCS strategy does not, however, segment audiences by those who have expressed a desire to space or limit their families and those who have not; nor does it segment specifically by **reason** for non-use. Such further segmentation, outlined in detail above, will help to make targeting even more precise. Finally, although the PCS strategy document acknowledges the client-based concept of targeting, it places too much emphasis on health risks. Although this is completely understandable because of the strong policy directions provided by DOH, the strategy should be reviewed to determine exactly for **whom** a health message is appropriate, as discussed above.

3) **Method strategy:** This strategy should include two elements. First, it must include a definition of product norms and standards: How many cycles of pills can be given to a woman at any given time; what should she do if she forgets one day? two days? Is a pelvic exam required before prescribing the pill? Can a woman under 25 years of age — a group with an insignificantly small incidence of serious side effects — be given a pill without a prescription and blood pressure check? Without the prescription but with blood pressure check? Is there any age below which sterilization should not be carried out?

The issue of NFP is an important one, since it features the new agreement reached between the DOH and the Church (see Section 2.2.2). If this agreement is to be honored and NFP is to be taken more seriously than it has in the past, a considerable effort will have to be initiated to set clear norms and standards for its use, to train health workers in its application, and to include it in all materials on contraceptive mix. The issue of standards is paramount, and DOH planners will have to determine: Which of the NFP methods should receive priority, if any? What are the norms for family follow-up? Some NFP groups recommend one visit every week for 12 weeks. Others suggest fewer. Some non-religious NFP groups agree willingly to the use of the condom during fertile periods; more conservative groups do not. Assuming that a considerable amount of repeat counseling is required, how will this be accomplished? Can the BHW or other outreach worker counsel in this method; or must the couple return to the health center? Some NFP groups insist on couple counseling: Is it realistic to assume that husbands will come 12 times to the clinic?

Second, the strategy should include method priorities: Can one openly promote sterilization to women with four or more children? with four or more children and over 35 years of age? Should the pill **and** the condom be promoted in areas with a significant number of AIDS cases? How can a health worker determine if a woman is at risk from AIDS, and should she promote a contraceptive **plus** condoms at all times?

A **program guide** should be prepared by the program. The model for this guide could be the USAID-sponsored guide used in the Dominican Republic (developed by University Research Corporation/Academy for Educational Development). The Dominican guide contains a section on audience segmentation and messages; on communication strategy (how to couch a particular family planning message within the socio-economic context of the client); on communication techniques

(how to use individual counseling, home visits, and group discussions to best advantage); on workplanning (how to manage a community IECM program); supervision; and training. This guide has many advantages: It serves as the central planning and management document for the project and therefore collects and consolidates all information in one place; it is the official family planning IECM document of the Dominican Republic to which all sectors — public, private, and NGO — contributed and thus feel they own; it has separate, separable sections for managers, fieldworkers, supervisors, and trainers, and thus is multi-purpose. As such it can serve as a model for the Philippine program which is at a similar stage of replanning its family planning program.

4) Geographical strategy: The DOH *Child Survival Situational Analysis: Family Planning Component*, July 1992, states that of the major target group — married couples of reproductive age — couples in marginal rural areas are the top priority, with couples in marginal urban areas second. Although it is important to reach populations that are generally underserved by all public services, it must be recognized that these people are the hardest to reach. They are often poorly educated, have little access to the modernizing factors of urban or semi-urban life, hold more traditional views, and are more scattered in their residential patterns. Reaching poor urban populations, often with birth rates as high as, if not higher than rural areas, is much easier. Population densities make community outreach and recontact with potential and existing users more possible. Mass and print media are more accessible. Positive role models (i.e., family planning acceptors) are more visible. It may be more **cost effective** for the family planning program to invest in these urban areas first, hoping to reach **large** numbers of people; then to extend to the more hard-to-reach areas at a time when information about the new, improved family planning program will be likely to have spread, at least informally, to these areas, making the task of IECM easier.

5. Monitoring, Evaluation, Research, and Logistics Management

5.1 Monitoring and Evaluation

5.1.1 Background

Monitoring: Management Information Systems

During the POPCOM years, evaluations consistently found fault with the operation of the management information systems. Just before the family planning component of the program was transferred to the DOH in the late 1980s, however, POPCOM appeared to have set up a strong MIS with adequate staff and computer support. This POPCOM MIS was never tested nationwide, however, and for several years, nothing was done in the Philippines to institute a national MIS.

From this void, a multitude of new systems (nine as described by a recent informal assessment carried out by the Family Planning Management Development [FPMD] project) has emerged, each at a different stage of completeness. None of the systems is fully complete or operational on a national basis, however.

As noted in Chapter 2, it is fair to say that no reliable MIS system is in place at present. Until such a system has been established, reports on numbers of users, new acceptors, coverage, and quality cannot be reliably cited as indicators of accomplishments, at either the macro or the micro level. The establishment of a quality MIS will provide managers at all levels with the national information necessary to permit the rational allocation of resources.

Evaluation

Evaluation of family planning impact has, in the past, relied on sample surveys. In the early days of the program (1972-1980), national acceptor surveys were conducted to evaluate how far people would have to walk to reach clinics, the length of continued practice of acceptors, failure rates, and reasons for discontinuation. More important, a series of quinquennial national demographic surveys spanning the 1968-1988 period provided a means of establishing benchmarks, as well as measuring the impacts of family planning use on fertility. These surveys also provided KAP-type information and were used in crafting informational materials, determining the contraceptive needs and preferences of couples, and identifying the reasons for adoption or discontinuation of contraceptive use. Data from the 1970, 1975, 1980, and 1990 censuses were also used to obtain information on population growth rates, fertility, mortality, and migration rates. Other surveys were done for specific purposes to augment these data sources. Fieldwork for the latest Demographic and Health Survey is scheduled to begin in April 1993 and results are expected in September.

5.1.2 Current Systems

Currently, two major MIS systems are in operation — one for public sector programs, the family health statistical information system (FHSIS) and the other, for NGO programs, the system developed by POPCOM in the late 1980s but never tested nationwide. In addition, in some locations, a variation of the FHSIS that relies on hand-tallied reports also collects DOH service delivery. Also,

other reports on specific issues are reported at regular intervals to the DOH. The various systems are described in more detail below.

- **Family Health Statistical Information System**

The FHSIS is the system for recording and reporting of family planning outputs of the DOH clinics. It has theoretically been in existence since 1990 but appears to be operational in only about 4 percent of the clinics.

As planned, the system is fairly simple, requiring reports on only five family planning indicators: new acceptors, current users, drop-outs, clinic visits, and referrals. For the past 18 months, a TS subcommittee has been reviewing national indicators. No decision has been made as yet, however, as to which indicators will be selected for measuring program impact, etc.

The accuracy of the few FHSIS reports that are generated on clinic outputs is often questionable. There is only one microcomputer per province and these computers frequently break down. Computer personnel are often absent or resign. Clinic staff have had little training in using the system and thus lack reporting skills. The FHSIS computer operator is saddled with processing all the health program statistics. The manpower failures and hardware breakdowns also result in delays in the submission of field reports and the collation of DOH family planning clinic reports.

The FHSIS is geared toward the needs of a centrally controlled program. As a facility-based system, it is not entirely suited to a community-based program such as family planning. Moreover, because the denominator is not known, the system cannot generate information on contraceptive prevalence rates. Nor can outreach efforts, such as IECM and follow-up activities, be recorded and reported. In view of this basic flaw, service providers may not take the initiative to exert efforts to conduct outreach activities.

The FHSIS is one of four DOH information sub-systems, all within the DOH Management Advisory Service. The other three gather information on hospitals, personnel, and financial service statistics.

It is not clear who will be responsible for overseeing the MIS under the devolved DOH.

- **Hand-Tallied Reporting**

Due to the computer problems associated with the FHSIS, DOH service providers often resort to hand tallying. This system, however, is more prone to error than is a computer-assisted system. These hand-tallied reports are regularly collected by the DOH family planning coordinators and used to supplement the reports being generated by the FHSIS.

- **Other DOH Reports**

Reports are also supposed to be submitted to the DOH on contraceptive and medical supplies on a quarterly basis and on the number of MCRAs on an annual basis. This last requirement, counting MCRAs, is expected to be an onerous burden for DOH midwives in view of their numerous other duties. At present, family planning service providers rely on the NEDA population projections as a guide in determining their target clientele.

- POPCOM MIS: NGO Reporting

As noted above, no unified MIS exists for both DOH and NGO operations. NGO outputs are recorded and reported using the POPCOM MIS, but the FHSIS makes no provision to incorporate NGO data. In principle, it should be easy to incorporate NGO reports submitted to rural health stations in the areas where NGOs operate. The FHSIS computer operator, however, is already overburdened with the task of processing all the health program statistics. Moreover, the software is not flexible enough to allow the encoding of non-DOH family planning service delivery outlets.

Another issue is that clients may be counted twice, once by the NGO system and then by the government system. This occurs because NGOs often report their outputs to the nearest DOH clinic in exchange for contraceptive supplies, thereby causing an unknown number of these outputs to be incorporated in the DOH family planning reports outputs.

A third issue is that the old POPCOM-MIS currently used by the NGOs and other government clinics (Department of Labor) is geared towards providing information needs for central planning, coordination, and evaluation. It provides more information than does the FHSIS, but it is a cumbersome system and needs streamlining.

5.1.3 Issues Common to Both the FHSIS and NGO MIS

Data Deficiencies

As noted above, neither the DOH nor the NGO information system provides good, reliable data. Rather, data reported in both are error prone due to double counting of NGO clients, unstandardized reporting of new acceptors and continuing users, and reporting errors arising from hand tallies. Unfortunately, health information system trouble-shooting teams have tended to focus more on procedures of reporting than on validation of outputs.

Lack of National Indicators

As noted above, the TS has yet to establish the essential indicators required to measure the performance of the PFPP. For example, information on the characteristics of the population that is eligible for family planning, on the quality of service provision, and on sustainability of programs is not collected. These data are important in identifying specific targets for IECM efforts, strategies for training service providers, and distribution of supplies and equipment.

With devolution, the need for national standards will become even more acute. Local officials (mayors and governors) have expressed a need for information on which to base their five-year plans for the social and economic programs for which they will be assuming responsibility. A unified MIS system with standard definitions will be essential to provide LGUs with the data necessary to meet program needs and to make long-range fiscal and operational plans. Without these indicators, program managers will not be able to measure quality or achievement of expansion objectives.

In short, the PFPP suffers from a lack of information on which to base management decisions and to make key course corrections. Family planning feedback information is rarely available for management decision making and strategic planning.

5.2 Research

Over the years, evaluations have acknowledged the outstanding accomplishments of Philippine demographers and of physicians during clinical trials, but have also noted the absence of a research strategy and of adequate operations research. The evaluators have expressed the opinion that these two omissions adversely affected the effectiveness of the Philippine program. They cited high drop-out rates and low modern contraceptive prevalence rates as problems that might have been solved or mitigated by timely OR.

5.3 Logistics, Contraceptives, and Equipment

5.3.1 General Impression and Current Status

Under the POPCOM-directed family planning program, the logistics system was consistently given the highest ratings. With the shift of responsibility for the family planning component to DOH, the performance of the logistics system declined rapidly — so rapidly, in fact, that most government organizations and NGO staff now cite lack of a dependable contraceptives logistics system as the single biggest cause for acceptor drop-outs and clinics' failures to meet CPR targets during the period 1988 to mid-1992.

Recently, however, the logistics system has largely recovered, albeit slowly in some regions. Under the Family Planning Logistics Management (FPLM) project, intensive training has been provided to DOH central and regional staff and to NGO staff. Together, the project and these various groups have designed a practical requisitioning and resupply system. Since there are no reliable service statistics from which to project contraceptive requirements (see Section 5.1.2), resupply is based on past quarterly use. The system has enough built-in flexibility at individual supply points to enable increased supply under special conditions — for example, an increase in staff trained to insert IUDs.

Government personnel at all levels expressed satisfaction with the new logistics system. Visits to warehouses and clinic storerooms revealed a very orderly system of storing and distributing contraceptives. NGOs, however, did not report the same satisfaction (see Section 5.3.2 below).

In late 1992, a new, three-year nine-month CARE cooperative agreement will begin to provide transportation and other vital support to the logistics system for the DOH and the NGOs. In addition, the agreement contains provision for CARE to provide support to non-family planning NGOs already in CARE's countrywide network in becoming involved in family planning motivation and services. This should strengthen the NGO system in general and should also enable CARE to respond better than its predecessors to other NGO contraceptive requirements.

5.3.2 Areas of Concern

One issue relates to the uncertain supplies for NGOs. NGOs often experience contraceptive stock-outs. They are required to obtain their supplies from the nearest DOH outlet. With the increasing DOH output per clinic, contraceptives allocated to the area are often prioritized for DOH rather than NGO needs. Local NGOs with national offices thus have to obtain supplies from their central warehouse and distribute these supplies to their own clinics.

Another concern is the inadequate supply of IUD kits, examining tables, and adequate light at *barangay* health stations. Most of the newly trained midwives, of whom there will be large numbers, will be assigned to these units, and yet the likelihood is that only just over 10 percent (or less than 12 in 100) will have these essential items. The midwives are in an excellent position to influence recently delivered mothers to accept an IUD when the latter return for their six-week post-partum examinations. If the midwives cannot deliver the method, however, they will soon lose their newly learned skills and the cost of training will be wasted. Moreover, the overall program will miss an opportunity to improve the method mix; lower the drop-out rate; provide greater client choice; reduce the number of abortions; increase quality, coverage and sustainability; and improve the program's cost effectiveness.

Generally speaking, minimum needs for various levels of service delivery facilities are not well known. The DOH list of needs for equipment and supplies is fairly long and ambitious and may include items that are not essential. In addition, no inventory has been taken of what is on hand at various facilities, either government or NGO. Such an inventory would not only serve to help the DOH and LGUs, but would help donor agencies to prepare more appropriate assistance projects.

Over the longer term, when the services component of the program becomes well established, an additional concern will be that the cost of the contraceptive portion of the program may overwhelm the rest of the USAID budget.

Recommendations

for USAID

MIS

1. USAID should urge the DOH to complete its national indicators review in the near future. These indicators of progress must be standardized for all service providers and changed to reflect the new program thrusts of quality service provision and the reduction of high health risk and unmet need for family planning services.
2. USAID should urge that these indicators be included in the FHSIS.
3. USAID should recommend that the FHSIS be improved according to those modifications recommended in the FPMD assessment, particularly those pertaining to improved computerization of recording systems at the provincial level.²⁰
4. USAID should play a prominent role in the resolution of the MIS issue, working to attain consensus that a modified FHSIS serve as the one MIS system in the Philippines. NGO data should be included in the FHSIS as rapidly as possible.
5. USAID should ensure that the MIS not be built into logistics management until *both* logistics and MIS are fully functional.

²⁰Since these changes are detailed in that assessment, they will not be listed here.

Research

1. USAID should urge the government and other donors to develop a priority list of 10 OR studies to be carried out before implementation of the new USAID family planning project.
2. USAID should encourage the DOH, Philippines universities, and donors to develop a national research agenda within the next year. In addition, mechanisms for better responding to research needs at national and local levels must be identified. Finally, similar mechanisms for appropriate management of research activities must be found.

Logistics

for the DOH

1. *Barangay* health stations with trained midwives that have not yet received the equipment and supplies needed to support IUD insertions should be provided with these supplies as soon as possible.

for USAID

1. A study should be carried out to determine the appropriateness of the DOH equipment list for clinics, particularly equipment needed for IUD insertions (i.e., tables, lamps, IUD kits, etc.). This could be done by an expert team, including two Philippine midwives, who could do a sample survey of those minimum equipment needs for IUD insertions at the *barangay* level. At the same time, a second survey team, including an expert on appropriate technology, should explore the cost of making examining tables locally, perhaps of bamboo. A midwife should also be a member of the second team to assess medical requirements. If the findings of both investigations are positive, budgets should be increased to cover this equipment.
2. A similar study of basic equipment requirements for NGO clinics should also be undertaken.
3. USAID should hire a consultant to participate in a one-time inventory of all equipment supplies and materials for every training site and for trained personnel (both DOH and NGO) to identify and prioritize needs. If sufficient funds are unavailable to supply non-priority clinics, training for their staffs should be deferred.
4. Procurement based on the aforementioned lists and inventory should be acted upon on a priority basis.

6. Strategy for the Future

6.1 Strategy for the Government

6.1.1 Principal Issues

If the target of reducing the country's population growth to 2 percent or less by the year 2000 is to be achieved, implementation of the entire family planning program will need to be accelerated — delivery of services, training, and the IECM program.

This in turn will require addressing four major issues currently facing the PFPP: (1) how to proceed with restructuring of the program's administration, (2) how to take advantage of the opportunities afforded by the devolution challenge, (3) how to free the program's IECM component from existing restrictions, and (4) how to revitalize the NGO network and resources.

1) Restructuring of the Program's Administration

The process of restructuring the management of the family planning program within DOH has already begun, under the leadership of the new secretary of health. With the initiation of the devolution process, it is even more important that the DOH speak with one voice to the many groups with which it deals on matters of family planning — from its regional staff and the LGUs to the NGOs and international donor community. The relationships between the DOH and POPCOM must also be dramatically improved if the ambitious integrated program desired by government and endorsed in this report is to succeed.

2) Taking Advantage of Devolution

Two other important management issues, less broad in scope than those cited above but with implications for the long-term success of the program, also need attention in the near future:

- upgrading the DOH regional staff for its new family planning responsibilities (evaluation, monitoring, and technical supervision) under devolution; and
- providing short-term intensive management training supervisory skills for midwives to ensure quality services and accurate data collection from their village health workers and family planning volunteers.

Without these two levels of management training (regional officers and midwives), there is grave danger that the program will perpetuate two of the major flaws of the POPCOM years — high drop-out rates for contraceptive users and low prevalence for modern contraceptive methods.

3) Freeing IECM of Restrictions

A strong IECM program will be essential to enlist new adopters at an increasing rate and to encourage current contraceptive users to continue with the program. The effort must have two focuses. It must be designed to improve the ability of service providers, fieldworkers, and clinical staff to encourage clients to use family planning. It must also increase the capacity of the IECM system

to advocate family planning to organizations and to the population at large through mass media and other methods.

4) Revitalizing NGO Network and Resources

With the PFPP anticipating that 35 percent of prevalence will be provided through NGOs, it will be essential to accelerate efforts to re-enlist NGOs as strong partners in the national family planning program. It is incumbent on the government to clear away the confusion surrounding the accreditation issue and to set training for NGO personnel in motion.

6.1.2 Principal Recommendations

The two sets of recommendations below comprise the strategy that was proposed to the secretary of health (see Appendix C) to address the key issues described above. Immediate attention should be directed to the first five. The following eleven are key actions that should be carried out simultaneously with the actions above.

Five Principal Recommendations

1. **Management and Organization.** The management of the DOH should be restructured so that the family planning program speaks with one voice to the regional offices, LGUs, NGOs, legislators, donors, and the community at large. This would require that the family planning program in the DOH be a unified command headed by a regular DOH employee.
2. **LGU Support.** The 5 to 10 LGUs most likely to accelerate their family planning programs should be selected, based on commitment of their leadership to promoting and supporting family planning. Negotiations should take place with each of the selected LGUs for their future commitment in terms of the staff, space, budget, transportation, advocacy support, and MIS data. In turn, a comprehensive package of training should be offered them, including family planning skills, clinical, as well as MIS, fiscal and resource management skills, computer for data base management, contraceptive supplies, and IECM materials. Finally, the DOH should offer to provide a clinical package of equipment essential for IUD insertion to all *barangay* health stations with trained midwives. Under DOH leadership, support for this initiative could be provided immediately by USAID and perhaps other donors as well.
3. **Communication and Logistics.** The IECM program should be activated on television and radio. The latter should focus on informing women of the new family planning program with recently trained staff, improved, gentler oral contraceptives, and the new long-lasting IUD. The CARE network should be used to distribute existing IECM materials, which would be developed and printed under the PCS project.
4. **Standards and Accreditation.** The new accreditation requirements should be waived for all NGOs that were accredited during the POPCOM years. The accreditation process should be completed for all remaining NGOs within the next six months. Training of NGO staff should begin immediately, employing the existing training modules now being used for the current training of DOH staff in family planning. USAID should be requested to modify the new EDF training cooperative agreement to enable NGO training to get under way rapidly.

5. **Human Resource Development.** DOH regional staff should be strengthened through training and technical support for their increased responsibility in family planning. The number of regional staff (including MIS and IECM specialists) involved in family planning monitoring at the LGU level should be increased.

Key Actions to be Carried out Simultaneously or Shortly Thereafter.

1. **Funding Support.** Policy discussions should be initiated with the secretaries of finance and budget and other appropriate offices (e.g., the legislature) to establish a budget line item for family planning.
2. **Devolution: Policy Setting.** The DOH should resume its mandated role of setting policy and establishing guidelines rather than delegating these authorities to the TS and the Technical Policy Committee. This will be key to a successful devolution of DOH resources to the LGU level. Technical assistance can be provided in this area.
3. **POPCOM-NEDA Discussion.** Policy discussions should continue between NEDA and POPCOM regarding a collaborative role to strengthen the devolution process.
4. **Training and Supervision Strategies.** National strategies for training and supervision should be completed.
5. **IECM Strategies.** National strategies for IECM should be promulgated.
6. **Accreditation Process.** The accreditation process for training and service institutions and individuals should be simplified.
7. **Clinical Standards.** Existing clinical manuals and guidelines should be reviewed to identify and eliminate all unnecessary medical barriers that inhibit quality family planning services. Technical assistance could be provided to assist in this area.
8. **Private Sector.** A program should be initiated to identify, recruit, train, and supply private sector medical institutions and individuals for family planning provision throughout the country.
9. **Equipment and Supplies for *Barangay* Health Stations.** *Barangay* health stations with trained midwives that have not yet received the equipment and supplies needed to support IUD insertions should be provided with these supplies as soon as possible.
10. **Technical Committees.** The technical policy committees should be dissolved. Instead, committee members and other experts can be called upon as needed as paid technical experts to support DOH standards and guidelines work.
11. **Technical Policy Committee on Advocacy.** The work of the Technical Policy Committee on Advocacy should be transferred to POPCOM in line with the latter's current responsibilities.

Although a new project is contemplated for 1994, no recommendations are made for revising any section of the FPAP to meet the programmatic needs of the next two years of implementation. As a well-designed project, and one that included in its original plan many of the recommendations contained in this report, the FPAP continues to provide an ideal context within which program reforms and restructuring can take place.

Support from A.I.D.

1. The Bureaus for Asia and for Research and Development (R&D) should provide financial and technical support to USAID/Manila as it seeks creative ways to utilize the ongoing project as a vehicle for additional funds for family planning. The importance of these funds is particularly critical, given the current unprecedented opportunities for family planning and population programs in the Philippines. For the short term, these funds should be made available through some suitable innovative funding mechanism.
2. The Bureaus for Asia and for R&D should look favorably upon increased funding for the new FPAP to take advantage of the opportunities presented by the enthusiasm and support for the devolution process.

(A complete list of the component-specific recommendations included in the report is provided in the Executive Summary.)

Appendices

Appendix A

Scope of Work

D. SPECIFIC QUESTIONS/ISSUES TO BE ADDRESSED

I. *Expansion of Service Delivery*

1. To what extent has the DOH communicated the new "health benefits" approach to family planning to other GOs, NGOs, and other partner agencies? How has this been internalized by the participating agencies in the PFPP?
2. Assess the appropriateness of the technical assistance provided by John Snow, Inc. to the Philippine NGO Council (PNGOC). How has this TA strengthened the ability of PNGOC to provide TA and grant support to other family planning NGOs.
3. To what extent are the local NGOs, including PNGOC, committed to addressing the issue of sustainability? What steps are they taking to lessen their dependence on donor financing?
4. Evaluate the appropriateness and effectiveness of the technical assistance provided by the Philippine Center for Population and Development (PCPD) concerning the industry-based family planning program.
5. Evaluate the collaborative arrangement between AVSC and JHPIEGO in the development and implementation of a revitalized VSC network.
6. Assess the commitment of the industries involved in the industry-based family planning program to continue the program after PCPD assistance ends.
7. Determine if the social marketing program is on the right track and discuss appropriateness of SOMARC TA and the Kabalikat/SOMARC partnership.
8. Are family planning services actually reaching clients who need and want them, as well as reaching women in high risk categories?

II. Training

1. Discuss the adequacy and responsiveness of current family planning training programs provided to DOH and participating agency personnel.
2. To what extent are training programs linked to Information, Education, Communication and Motivation (IECM) activities?
3. Discuss the appropriateness of the mechanisms which utilize the Economic Development Foundation (EDF) to manage training for the Family Planning Service of the DOH and the Training Consortium of the Technical Secretariat.
4. Assess the system for developing a participant training plan.

III. IECM

1. What is the extent and adequacy of IECM materials? Do the materials reflect the theme "health benefits of family planning"?
2. Does the IECM strategy, materials and training reflect the knowledge gained through the recently conducted IECM research?
3. Discuss the appropriateness and adequacy of the advocacy work being conducted by POPCOM, the Philippine Legislators' Committee on Population and Development, and the PNGOC.
4. Examine the effectiveness of using a Resident Advisor to assist the PFPP in developing effective IECM materials.

IV. CONTRACEPTIVES/LOGISTICS

1. Are the commodity distribution schemes appropriate and responsive to the needs of the program?
2. Is the level of technical assistance such that at the end of FPAP the DOH will be able to manage a contraceptive distribution system?
3. Assess the effectiveness of using a Resident Advisor to assist the PFPP develop an effective logistics system.

V. RESEARCH

1. Discuss the appropriateness of the types of research being carried out in the program and identify additional research opportunities.

VI. ORGANIZATIONAL ISSUES

1. To what extent has the creation of the Technical Secretariat facilitated the implementation of the Philippine Family Planning Program? Discuss what impact, if any, USAID resources have had on the Technical Secretariat.
2. Examine the role program technical committees have played in formulating policy, problem identification, problem resolution, and strategy formulation in each of their respective areas.
3. Identify steps taken by the DOH to integrate family planning into its maternal and child health services.
4. Examine how the Technical Secretariat has managed the coordination of the PFPP activities within the DOH and among the participating agencies.
5. Has the FPAP provided the appropriate types of technical assistance to facilitate revitalization of the PFPP program?
6. Examine the effectiveness of the role of USAID staff has played in managing the FPAP.

Appendix B

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Letter from USAID Director to Secretary of Health

After hearing the findings of the evaluation and devolution teams, the secretary of health requested them to send him a list of actions which he should take immediately to expand and accelerate the program. The team developed a list of five major actions plus eleven additional activities which also needed attention in the near future. The combined list was incorporated into the following letter which was signed by the USAID director:

October 27, 1992

The Honorable
 Juan M. Flavier, M.D., M.P.H.
 Secretary of Health
 Sar. Lazaro Hospital Compound
 Santa Cruz, Manila

Dear Secretary Flavier:

In response to your request that the USAID, Family Planning Evaluation/Devolution Team work out a prioritized list of actions/activities that you may consider implementing immediately, the Team identified the following major issues facing the Philippine Family Planning Program: (1) Managing the restructuring of the Program's administration, (2) Maximizing the devolution challenge, (3) Liberating the Program's Information, Education, Communication (IECM) component, and (4) Revitalizing the NGO network and resources.

In light of the foregoing, the Team has recommended that the following actions be undertaken expeditiously:

1. Management and Organization - Restructure the management of the Department of Health (DOH) so that the Family Planning Program speaks with one voice to the Regional Offices, LGUs, NGOs, donors and the community at large.
2. Service Delivery and Training - Select 5-10 LGUs most likely to accelerate their Family Planning Program. Selection criteria should be based on commitment of LGUs' leadership to promoting and supporting family planning. Negotiate with each of the selected LGUs for their future commitment in terms of the staff, space, budget, transportation, advocacy support and MIS data. In turn, offer a comprehensive package of training, including family planning skills, clinical, as well as MIS, fiscal and resource management skills, computer for data base management, contraceptive supplies, and IECM materials. Finally, DOH should offer to provide a clinical package of equipment essential for IUD insertion to all Barangay Health Stations with trained midwives. Under DOH leadership, support for this initiative could be provided immediately by USAID and perhaps other donors as well.
3. Communications and Logistics - Activate the IECM program on TV and radio. The latter should focus on informing women of the new Family Planning Program with recently trained staff, improved, gentler oral contraceptives and the new long lasting IUD. Use CARE network to distribute existing IECM materials developed and printed under the Johns Hopkins contract.
4. Standards and Accreditation - Waive new accreditation requirements for all NGOs which were accredited during the Population Commission (POPCOM) years. Complete accreditation process on all remaining NGOs within the next six months. Commence training of NGO staff immediately employing the existing training modules now being used for the current training of DOH staff in family planning. Request USAID to modify new Economic Development Foundation (EDF) Training Cooperative Agreement to enable NGO training to get underway rapidly.

5. Human Resource Development - Strengthen DOH regional staff through training and technical support for their increased responsibility in family planning. Increase number of regional staff (add MIS and IECM specialists) involved in family planning monitoring at the LGU level.

The Team also developed a longer list of key actions which they recommended be carried out simultaneously with the previous list or shortly afterward:

- Begin policy discussion with Secretaries of Finance and Budget and other appropriate offices to establish a budget line item for family planning.
- Activate DOH's mandated role of setting policy and establishing guidelines rather than delegating these authorities. This pro-active resumption of DOH responsibility is key to a successful devolution of DOH resources to the LGU level. Technical Assistance can be provided in this area.
- Continue policy discussions with NEDA/POPCOM regarding a collaborative role to maximize devolution process.
- Complete national strategies for training and supervision.
- Promulgate national strategies for IECM.
- Simplify accreditations process for training and service institutions and individuals.
- Review existing clinical manuals and guidelines to identify and eliminate all unnecessary medical barriers which inhibit the family planning program. Technical Assistance can be provided to assist in this area.
- Initiate program to identify, recruit, train and supply private sector medical institutions and individuals for family planning provision throughout the country.
- Provide the equipment and supplies necessary for those remaining Barangay Health Stations that have trained midwives to insert IUDs.
- Dissolve Technical Policy Committees. Call on committee members and other experts as needed as paid technical experts to support DOH standards and guidelines work.
- Transfer work of Technical Policy Committee on Advocacy to POPCOM in line with its current responsibilities.

We believe that the recommendations of the Evaluation Team are practicable and, if implemented, would go a long way toward meeting the challenge of family planning in the Philippines. I and my staff would be happy to discuss with you these suggestions and any technical or other assistance needed to support them.

In the very near future, a draft of a comprehensive report will be submitted to you describing the Team's findings and recommendations along with supporting documentation.

I thank you for your guidance and leadership in the very important activity of providing family planning services to all Filipino communities. My staff and I look forward to a continued productive collaboration.

Sincerely,
Thomas W. Stukel
Director