

**MIDTERM ASSESSMENT OF INTERMEDIATE
RESULT 2 OF STRATEGIC OBJECTIVE 3:
“NATIONAL SYSTEMS STRENGTHENED
TO PROMOTE AND SUPPORT
FAMILY PLANNING/MATERNAL AND
CHILD HEALTH PROGRAM”**

POPTECH Report No. 98-129-068
July 1998

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Prepared for

U.S. Agency for International Development
Bureau for Global Programs
Office of Population
Contract No. CCP-3024-Q-00-3012
Project No. 936-3024

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The observations, conclusions, and recommendations set forth in this document are those of the authors and do not represent the views or opinions of POPTECH, BHM International, The Futures Group International, or the staffs of these organizations.

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LIST OF ABBREVIATIONS

| | |
|-----------|--|
| ADPCN | Association of Deans of Philippine Colleges of Nursing |
| AMU | Average monthly use |
| ANE OR/TA | Asia and the Near East Operational Research/Technical Assistance Project |
| APSOM | Association of Philippine Schools of Midwifery |
| ASL | Approved stock level |
| AusAID | Australian Agency for International Development |
| AVSC | AVSC International |
| BHS | Barangay health stations |
| BHW | Barangay health worker |
| BSPO | Barangay Service Point Officer |
| BUCEN | Bureau of the Census |
| CA | Cooperating Agency |
| CBFPMIS | Community-Based Family Planning Management Information System |
| CBT | Competency-based training |
| CDF | Community development funds |
| CDLMIS | Contraceptive Distribution and Logistics Management Information System |
| CMC | College of Mass Communication |
| COF | Contraceptive order form |
| CPR | Contraceptive prevalence rate |
| CPT | Contraceptive procurement table |
| CYP | Couple years of protection |
| DA | Development Associates |
| DAP | Development Academy of the Philippines |
| DMPA | Depo-medroxy progesterone acetate |
| DOH | Department of Health |
| DTUR | Distribution to User Record |
| EDDS | Essential Drug Distribution System |
| EDF | Economic Development Foundation |
| FHSIS | Field Health Service Information System |
| FPLM | Family Planning Logistics Management Project |
| FP/MCH | Family planning/maternal and child health |
| FPORT | Family Planning Operations Research and Training Program |
| FP/RH | Family Planning/Reproductive Health |
| FPS | Family Planning Service |
| GOP | Government of the Philippines |
| HIS | Health Intelligence Service (DOH) |
| HMDTS | Health Manpower Development and Training Service |
| IDC | Institute of Development Communication |

| | |
|----------|---|
| ICPD | International Conference on Population and Development |
| IEC | Information, education, and communication |
| IECM | Information, education, communication, and motivation |
| IFHSP | Integrated Family Health Service Project |
| IFPMHP | Integrated Family Planning Maternal Health Program |
| IR | Intermediate result |
| JHPIEGO | Johns Hopkins Program for International Education in Reproductive Health |
| JHU/PCS | Johns Hopkins University/Population Communication Services |
| JICA | Japanese International Cooperation Agency |
| JSI/FPLM | John Snow, Inc./Family Planning Logistics Management |
| Kfw | Kreditanstalt fur Wiederaufbau (of Germany) |
| LAM | Lactational Amenorrhea Method |
| LGAMS | Local Government Assistance and Monitoring Service |
| LGE | Local government executive |
| LGEDDS | Local Government Essential Drug Distribution System |
| LGU | Local government unit |
| LPP | LGU Performance Program |
| MAS | Management Advisory Service |
| MCH | Maternal and child health |
| MHC | Main health center |
| MHO | Municipal health office |
| MIS | Management Information System |
| MSH | Management Sciences for Health |
| MWRA | Married women of reproductive age |
| NCC | National Communication Campaign |
| NDHS | National Demographic and Health Survey |
| NFP | Natural family planning |
| NGO | Nongovernmental organization |
| NSO | National Statistics Office |
| NTAT | National technical assistance team |
| OMS | Office for Management Services |
| OPHN | Office of Population, Health and Nutrition (USAID) |
| OPHS | Office of Public Health Services (DOH) |
| OR | Operations research |
| OSC | Office of Special Concerns (DOH) |
| OSEC | Office of the Secretary of Health |
| PC | Population Council |
| PFPP | Philippine Family Planning Program |
| PHO | Provincial health office |
| PIHES | Public Information and Health Education Service (DOH) |
| PLCPD | Philippine Legislators' Committee on Population and Development |
| PLS | Procurement and Logistics Service |

| | |
|---------|--|
| PMT | Project management team |
| POPCOM | Commission on Population |
| POPTECH | Population Technical Assistance Project |
| PPMP | Philippine Population Management Program |
| RAFT | Rapid assessment feedbacking team |
| RAPID | Resources for the Awareness of Population Impact on Development Project |
| RH | Reproductive health |
| RHO | Regional health office |
| RHU | Rural health unit |
| RHUN | Rural health unit nurse |
| RPO | Regional population office |
| RTAT | Regional technical assistance team |
| RTI | Reproductive tract infection |
| SA | Situational Analysis |
| SIM | Self-instructional module |
| SO | Strategic objective |
| SPSS | Statistical Program for the Social Sciences |
| SRA-MBN | Social Reform Agenda-Minimum Basic Needs |
| TA | Technical assistance |
| TFGI | The Futures Group International |
| TWG | Technical Working Group |
| UNFPA | United Nations Population Fund |
| U.P. | University of the Philippines |
| UPLB | University of the Philippines at Los Banos |
| USAID | United States Agency for International Development |
| USFDA | United States Food and Drug Administration |
| VSC | Voluntary surgical sterilization |
| WHSMMP | Women's Health and Safe Motherhood Project (World Bank) |

EXECUTIVE SUMMARY

Background

This is a midterm assessment of efforts to strengthen national systems to promote and support the family planning/maternal and child health (FP/MCH) program of the Philippines' Department of Health (DOH), and related advocacy activities of the Commission on Population (POPCOM). This is one of three Intermediate Results (IR) of the joint DOH-USAID Integrated Family Planning and Maternal Health Program (IFPMHP). The IR activities assist six major components: contraceptive distribution and logistics management information system (CDLMIS); information, education, and communication (IEC); training; research and technical support; program monitoring; and advocacy. The DOH's Office of Special Concerns (OSC) manages the first five components; POPCOM manages the sixth component. The U.S. Agency for International Development (USAID) supports the program in two ways: by a cash transfer based on performance, and by technical and financial assistance through agreements with U.S. cooperating agencies (CAs).

The IFPMHP began in 1994 and is slated to run through the year 2000. Annual benchmarks of program performance are jointly determined. A cash transfer from USAID to the DOH is based on successful completion of all benchmarks, an "all or nothing" system. Program sustainability is the centerpiece of activities aimed at having the DOH assume full operational responsibility for five major support functions by 1999 and for activities aimed at increasing the budget of the DOH/Family Planning Service (FPS) by 50 percent annually. The POPCOM is responsible for the sixth component, advocacy.

A four-person team spent five weeks in the Philippines, from February 16 to March 20, 1998, to assess the achievements of the program, including its design and management, and the roles of the CAs and of USAID. The Team reviewed documents; interviewed many DOH, POPCOM, USAID, and CA officials and other stakeholders, including academic researchers and program managers from local government units (LGUs); and visited several regions to observe programs in the field.

Major Findings and Conclusions

Program Achievements

National strategies for policy, IEC, training, operations research (OR), and management information systems (MIS) have been developed and approved; a population and development advocacy plan for POPCOM has been prepared. The DOH has increased staffing for the relevant components. The budget for DOH/FPS has increased by 50 percent annually, although it remains low. Most family planning/reproductive health (FP/RH) activities continue to rely heavily on international donor support, with USAID being the largest donor.

The CDLMIS works, ensuring adequate stocks of contraceptives throughout the health system. The CDLMIS may evolve into a larger essential drugs distribution system, with World Bank support increasing the CDLMIS potential for sustainability. A new training system based on self-instructional modules (SIMs) and competency-based training (CBT) has been designed and is now in the pilot-testing stage. National IEC campaigns have been planned and conducted each year since 1993; knowledge of modern contraceptives is nearly universal, as is knowledge of the sources of supply. A national advocacy strategy was designed to enlist the support of influential persons at the national, regional, and local levels. Four operations research studies are under way, with two more planned. The national and regional technical assistance teams (NTAT/RTAT) are staffed, and they provide support to the LGUs. The DOH has demonstrated its capacity to release LGU Performance Program (LPP) grants on schedule, with most LGUs receiving funds by the end of March each year.

Contraceptive prevalence with all methods, including modern methods, is rising, albeit slowly. Other key indicators also show progress, such as a declining total fertility rate, a reduction in infant and maternal mortality, and a decline in the percentage of births to high-risk women.

The CAs have provided strong technical leadership to assist the DOH and POPCOM in implementing the program. Some of the CAs have been given major implementation responsibilities as well. The challenge now is to learn how to reduce dependence on the CAs and how to shift responsibility to the DOH and POPCOM.

Despite these achievements, serious problems remain unsolved. It is unlikely that any of the five national support systems will be institutionalized within the DOH or will be sustainable without continued donor assistance for some years. Some of the support systems, such as the national communication campaign (NCC) and OR, are funded solely by donors and will likely languish without continuing donor funding. The transition of CDLMIS into a broader essential drugs distribution system is being pilot tested, but the outcome is not certain. Support for training will depend either on the ability of local health personnel to convince local government leaders to provide funds, or on donor funding. POPCOM is well on its way to programmatic sustainability in advocacy, but financial sustainability remains problematic.

Program Design

Overall, the program design seems reasonable and covers the essential national support systems. The design may be overly optimistic, however, about the capacity of the DOH to allocate sufficient personnel to assume full operational responsibility for the support systems by the year 2000 without some continuing donor assistance. The heavy reliance on the CAs for technical and financial assistance has accelerated a number of activities but has probably had a negative effect on enhancing program sustainability. The use of benchmarks has proved useful for increasing the staff and budget of the DOH/FPS and for expanding services, but the benchmarks have focused

on the quantity, not the quality of services. The strategies were well prepared, but their programmatic usefulness is uncertain. Financial sustainability is unlikely in the foreseeable future.

Program Management

Management of the overall Philippine Population Management Program (PPMP) rests with POPCOM. Management of the FP/RH program by the DOH has been through the OSC and FPS. With limited staffing of its own, FPS has relied heavily on CA technical and financial support to implement the program.

Staff members of USAID's Office of Population, Health, and Nutrition (OPHN) monitor progress, coordinate activities of the CAs, and coordinate with other donor agencies. The OPHN staff members are well trained and have close working relationships with the components of FPS.

The CAs shoulder a heavy responsibility for implementation performance. Their powerful role in helping the DOH develop and implement the national support programs is unquestionable. The challenge now is to determine how to make a smooth transition with the DOH assuming greater responsibility for implementing programs, and then to determine the timing for a phase-down or phase-out of each CA.

Future Needs and Directions

Program sustainability will remain the key issue for some time, especially financial sustainability. Technical assistance may be required for most of the support functions. The continued use of long-term U.S. institutional relationships is one alternative; no other reasonable alternative is readily apparent. Periodic short-term technical assistance may be preferable and cheaper. The focus for any follow-on activities should be to strengthen Philippine institutions, that is, to make greater use of the expertise of Philippine private sector organizations and Philippine nongovernmental organizations (NGOs) to assist the DOH and POPCOM.

Broadening the family planning program to include an array of other reproductive health interventions is clearly in line with recommendations of the International Conference on Population and Development and other international gatherings. However, such expansion creates a great risk that family planning programs, policies, staffs, and funding will be overwhelmed. The Philippine family planning systems should be solidly in place and functioning before the program is expanded to include elements of reproductive health. The DOH/OSC/FPS and field staff members are hard put to manage the existing program. Taking on significant additional reproductive health responsibilities might be too burdensome.

SUMMARY OF RECOMMENDATIONS

Chapter 2

1. Some technical and financial assistance beyond the year 2000 will be required to subsidize the national support functions. USAID, DOH, and POPCOM should begin discussions soon regarding future assistance and should give special thought to a greater role for the NGOs and the private sector as a means of reducing costs to the GOP.
2. Benchmarks should continue to be used to increase budget and staffing for DOH/FPS to ensure greater sustainability. There are potential benefits in rationalizing the budget in the context of devolution to clarify which functions are the responsibility of national, provincial, or municipal governmental authorities.
3. GOP political leadership at national and LGU levels needs to be willing to publicly and regularly support FP/RH and to allocate funds for the program.
4. USAID and the DOH should consider a change in the current “all or nothing” approach for funding, under which a minor failing can lead to loss of all funds. USAID and the DOH should explore methods of setting higher benchmarks to improve overall performance and pay on a proportional basis.
5. As part of the effort to achieve greater program sustainability, USAID and the DOH should begin a careful review of future technical assistance requirements and should determine whether Philippine institutions have the technical staff and the institutional capability to provide assistance without CA support. As part of the same review, USAID and the DOH should determine which CAs will be most helpful and what their respective roles are.

Chapter 3

6. A consensus-building workshop for the transition from CDLMIS to the Local Government Essential Drugs Distribution System (LGEDDS) should be conducted and should include representatives from the DOH, USAID, the World Bank, and the Family Planning Logistics Management Project (FPLM). The outcome of this workshop should be a plan and a time schedule for the transition, and should address the areas of concern detailed in section 3.3.6, as well as other relevant issues.
7. To sustain the CDLMIS at the current high level of performance until the transition to LGEDDS is complete, the FPLM (CDLMIS) project should be extended through the year 2000. This extension should be done in a phase-out approach, whereby staffing levels decline each year, and should be without the benefit of a resident expatriate advisor. The

project management function should be handled by a locally hired staff (new or existing) and with periodic technical and administrative support visits from FPLM/Washington. For example, in 1999, the project may operate with 75 percent of current staffing levels and with quarterly support visits from FPLM/Washington. In 2000, this effort could be reduced to 50 percent of current staff levels and trimesterly visits from the home office. The following activities should be incorporated into the work plan for the extension period:

- Monitor the progress of LGEDDS and facilitating the transition plan, as described in Chapter 3 (section 3.4.1).
 - Advocate the institutionalization of the freight-forwarding contract management and the forms procurement function within the FPS logistics section, or provide assistance to PLS in streamlining and managing this process.
 - Advocate inclusion of a logistics management module within the Health Manpower Development and Training Service (HMDTS) core training, the development of a “SIM” logistics module or perhaps both.
 - Develop, produce, and disseminate guidelines (possibly a wall chart) for stock management during short supply.
8. USAID should be represented on the LGEDDS steering committee until the transition from CDLMIS to LGEDDS is complete.
 9. The GOP should assume a small, but annually increasing, share of contraceptive procurement costs.

Chapter 4

Although the contributions of past national communication campaigns to the Philippine Family Planning Program (PFPP) have been significant, the focus of succeeding communication campaigns should be modified for implementation at provincial levels and below.

10. Recognition should increase so that the campaigns are associated with the DOH rather than with Johns Hopkins University/Population Communications Services (JHU/PCS).
11. The DOH should be seen as the manager of these campaigns; thus DOH leadership at local levels must be made more visible.

12. In the remaining years of the project, the DOH Public Information and Health Education Service (PIHES) and HMDTS must be mainstreamed into the management and implementation of the communication campaigns.
13. Responsibility must increasingly be transferred to the appropriate DOH unit, such as FPS, in order to ensure a smooth transfer of expertise and skills, including the management and disposition of IEC funds (in respect to the national communication campaign [NCC]). This transfer would require either a waiver for JHU/PCS to subcontract with the DOH or a more direct grant from USAID to the DOH.
14. The DOH and USAID need to discuss the role, the concept, and the modality of present (and future) technical assistance provided by CAs (such as the assistance provided by JHU/PCS and The Futures Group [TFG]), in IEC and advocacy in the light of sustainability and institutionalization.
15. The DOH and USAID may wish to look into the possibility of using local (national) CAs from the private sector in the next program cycle.
16. The campaign thrust should shift from the national level to the regional level and below.
17. Campaign thrust should address the unmet needs of the 3.0 million women at high risk in identified provinces in the country. (Focus should be on the 85 LGUs covered by the LPP.)
18. Messages should seek to dispel rumors about FP and to explain the side effects of various FP methods. Messages should also provide information about the advantages and benefits of FP to the health of the family, mother, and child. Socio-cultural research should be used to collect information on rumors and misconceptions about FP and FP methods.
19. Two campaigns of shorter duration each (e.g., one month) instead of a single campaign lasting four months (August to November yearly) should be mounted to ensure a reinforcing effect on target groups.
20. The first campaign should be managed by JHU/PCS, with PIHES assisting (job coaching), while the second campaign should be managed by PIHES, with JHU/PCS providing technical assistance (hands-on training).
21. Campaigns should focus at the regional/LGU levels, with community mobilization and participation being given more emphasis and with mass media support reinforcing community interventions and personal counseling.
22. Given the work load of the DOH, multi-agency participation should be encouraged during the learning period.

23. The DOH must assign a responsible division (such as FPS) that can continue IEC work after technical assistance has been phased out.
24. POPCOM regional offices and the Philippine Information Agency (PIA), which have networks at regional levels, should participate actively in the campaigns.
25. Strategic communication training for LGUs should be linked to efforts to strengthen teaching institutions that can systematically assist the DOH in the longer term.
26. The use of educational institutions at the provincial level should be stressed, as should the use of those institutions already being developed by JHU/PCS, such as the Institute of Development Communication (IDC) of the University of the Philippines at Los Banos (UPLB) and the College of Mass Communication (CMC) at the University of the Philippines (U.P.) at Diliman.
27. The role and responsibility of HMDTS in IEC training must be clarified.
28. Coordination of various USAID-funded technical assistance (TA) projects should be a priority. For impact, advocacy interventions under the Policy/Advocacy Project should be synchronized with the campaign periods (August to November).
29. The link with service delivery at LGU levels should be strengthened, with clearer, more concrete interventions and follow-ups than has formerly been done.
30. IEC materials should support FP counseling.
31. Generic materials on FP with multi-purpose use should continue to be produced periodically, and should be widely disseminated in relevant dialects.
32. Following an inventory and review of existing materials, relevant materials should be reprinted and stocks in medical facilities and in other service delivery points should be replenished on a regular basis.
33. New materials addressing side effects and misconceptions about FP should be designed and produced. Budgetary provision for reprinting and regular replenishment of materials should be set aside.
34. On the pilot Integrated Family Health Service Project (IFHSP), the use of the FP logo should be reconsidered, as its design has always been associated with FP, and the logo does not reflect the intent of the integrated package of information services on family health. Alternatively, the FP logo could be redesigned somewhat to include brief texts or symbols linking FP to the child survival information and to services within the context of family health.

Chapter 5

35. POPCOM, in close collaboration with the DOH, should immediately begin to plan, organize, and implement training courses for LGU health officials in advocacy and in public presentation of budgetary requirements in order to ensure adequate funds for health programs, including training.
36. USAID should encourage the DOH to assume greater responsibility for coordinating the support of international donors to follow a standardized DOH-determined training curriculum for FP/RH in all LGUs, colleges of nursing, and schools of midwifery.
37. To reduce costs and increase the efficiency of FP/RH training, the DOH should review, update, and reissue the selection criteria for trainees. The DOH and LGU health officials should provide a more careful screening of candidates to ensure that those who receive training are willing to provide all FP methods.
38. With the natural family planning (NFP) method now included in the SIM/CBT system, the DOH, in collaboration with local research institutions, should undertake a careful study of NFP to ascertain its real family planning protection so that health staff members present a fair and accurate assessment of method effectiveness to clients.
39. The DOH's new FP/RH program encompasses 10 elements. The DOH should monitor implementation and should use OR as needed to determine if the health service providers are able to effectively deliver all elements of the program without decreasing FP services.
40. The DOH should publicize widely, throughout public and NGO health facilities, clear guidelines for accreditation of institutions, curriculums, and service providers. The DOH should assist the Association of Deans of Philippine Colleges of Nursing (ADPCN) and the Association of Philippine Schools of Midwifery (APSOM) to resolve outstanding issues regarding accreditation of the 27 nursing and midwifery institutions that are assisted by the Johns Hopkins Program for International Education in Reproductive Health (JHPIEGO).
41. A review of the future need and role of CAs in the training process should begin soon between USAID and DOH.

Chapter 6

42. The Family Planning Operations Research and Training (FPORT) Program is meeting the benchmarks of training staff members in 30 LGUs to manage OR projects and to conduct OR intervention projects on cross-cutting issues in selected LGUs. It should also focus on

the provision of skills to the national DOH-FPS research staff before the end of the project cycle.

43. The DOH-FPS must decide whether it is seriously pursuing the institutionalization of OR within its structure. To do so calls for trained personnel who allot full-time attention to imparting OR skills to the regional staff, as well as to transforming OR results into issues and lessons for policies and programs. Given the current limitations on staff, the DOH should focus on training its research staff members to serve as research program managers and use the academic community to carry out OR.
44. Because of the increasing demand for OR skills, the DOH-FPS research staff, in collaboration with the FPORT program staff, should work out other mechanisms with the LGUs and the regions for imparting OR skills and for using the OR results to improve program operations and advocacy to LGEs. The LGU program managers, as well as local researchers who have undergone the OR process, may be tapped as resource persons and encouraged to share with their colleagues through research, through visits to their health facilities, and even through other modes of learning.
45. Despite having the 1993 clinical guidelines for reference, a number of health providers continue to exhibit misconceptions and inadequate understanding about family planning. Therefore, in addition to distributing the newly revised manual during the competency-based training, the DOH, with MSH assistance, should develop more effective ways of disseminating the material to field staff members, especially to those who have been trained in the old basic or comprehensive family planning course.
46. Given the perceived value of the technical contribution provided by the NTAT to RTAT and LGUs, the DOH should consider changing the status of NTAT from an ad hoc body to a more permanent body within the DOH.
47. New NTAT members should receive hands-on experience and training from more skilled NTAT members before being sent to the regions to provide training to the RTAT.
48. The DOH should develop mechanisms to regularly accredit or to assess the facilitating skills of the NTAT presenters and the format of their training activities. Such assessment would help improve the NTAT's capability to impart technical skills and to assist the RTAT in various aspects of FP and other health services.

Chapter 7

49. The DOH should identify a stable, permanent unit or body that will assume the responsibility for coordinating, monitoring, and providing technical support as well as of

the institutionalization and advocacy of the varied data-gathering schemes of the new MIS strategy.

50. Because of the varied administrative experiences in the conduct of the cluster survey, operational guidelines should be developed at the LGU level for smoothly implementing this research.
51. The DOH/FPS needs to review the various models of masterlisting at the LGUs to complement program/service statistics. However, integrative masterlisting should be considered so that other significant household members are identified (e.g., adolescents, male partners, young children), as well as to maximize the efforts of the overburdened health volunteers.
52. Training should continue to be provided to LGU health providers and even LGEs on program and population-based data use to enhance their appreciation and ability to use their own data for planning, programs, decision making, and advocacy to LGEs and other sectors of their social milieu.

Chapter 8

53. The Policy Project has provided timely TA in many areas, particularly in developing one national and 15 regional RAPID models. The Policy Project should ensure in its 1998-1999 work plans that its assistance to POPCOM focuses on (1) providing training to new staff members as well as retraining to those trained in 1994, and (2) helping Regional Population Officers (RPOs) in adapting the RAPID model for provincial and municipal advocacy use (see 8.3.1 and 8.3.2 in Chapter 8 of the report).

At another level, but complementing POPCOM's work, assistance to the Philippines Legislators' Committee on Population and Development (PLCPD) should be increased and should focus on two essential related activities: (1) training new staff members in effective advocacy techniques, effective writing skills, and the use of appropriate presentation equipment, including desktop publishing software programs; and (2) reaching the newly elected legislators to advocate passage of the population bill, among others. In both POPCOM and PLCPD, institutional capacity-building through focused technical assistance in these two particular areas will be more meaningful.

54. RAPID presentations and related advocacy initiatives, such as those undertaken by POPCOM and PLCPD under the Policy Project, should be made, whenever feasible, to coincide with the annual FP communication campaign periods to achieve the greatest synergistic effect. These initiatives, however, should be directed to national as well as to local executives and local legislators to encourage them to advocate for translating

commitments to allocation of funds for PFPP activities or to set aside a portion from their community development funds (CDFs) in support of PFPP.

55. Given the fact that a policy project and an advocacy project funded by the United Nations Population Fund/Manila (UNFPA/Manila) are also implemented by POPCOM, policy and advocacy activities should be carefully orchestrated to ensure that technical assistance provided by TFG and the UNFPA will mutually reinforce each other at field level. To this end, a mechanism should be set up, such as meetings held at regular intervals (similar to the first inter-project meeting conducted by DOH in January 1998), to share information and experiences in order to improve the quality of advocacy implementation.
56. As long as the present modality of providing TA through CAs is maintained, the issue of sustainability will remain a problem. There will be a need for POPCOM to discuss with DOH and USAID the concept and modality of TA being currently provided by CAs (such as JHU/PCS and TFG), in IEC and advocacy, and to find ways of making institutionalization and sustainability more achievable.

CHAPTER 1 INTRODUCTION AND BACKGROUND

1.1 USAID's Strategic Objective for Population and Health in the Philippines

The goal of USAID/Philippines (USAID/P) is to support the effort of the Government of the Philippines (GOP) to achieve the status of a newly industrialized democratic country by the year 2000. To achieve the overall goal, USAID/P supports six Strategic Objectives (SOs) and two Special Objectives. Nearly half of the annual USAID/P budget is allocated to SO 3: Reduced Population Growth Rate and Improved Maternal and Child Health.

SO 3 has three components or intermediate results designed to (1) increase *public sector* provision of FP/MCH services; (2) strengthen *national systems* such as programs involving contraceptives distribution and logistics management, training, information, education and communications, research, advocacy, and management information; and (3) increase *private sector* provision of contraceptives and services.

What began in 1994 as the six-year joint project of the USAID-Department of Health Integrated Family Planning Maternal Health Program (IFPMHP) was re-engineered by USAID in 1996 to become SO 3. Funding for SO 3 comes from three sources: \$65 million from USAID/P; the peso equivalent of \$26 million from the DOH; and \$62 million from USAID/Washington, for a total of \$153 million.

1.2 The Department of Health's Involvement in FP/MCH Services

From the inception of the Philippine population program in 1970 until 1988, POPCOM was responsible for managing the implementation of the family planning program. In 1988, the POPCOM Board of Commissioners voted to transfer the FP program to the DOH. The DOH, while traditionally employing health workers and managing a nationwide network of hospitals and clinics, was responsible for managing the FP program from 1988 to 1991. As a result of the Local Government Act of 1991, the GOP devolved (decentralized) health programs, shifting responsibility for planning, managing, financing, and evaluating health services to over one hundred provincial and city LGUs and thousands of municipal LGUs. The LGU health staff and facilities now provide most health services. Provinces provide services directly through provincial and district hospitals. Municipalities are responsible for rural health units (RHUs) and Barangay health stations (BHS). Cities provide services through hospitals and health centers.

The DOH still retains important functions that are essential to overall success of the national FP/MCH program, such as establishing standards; monitoring; providing technical assistance to LGU health personnel; and maintaining national programs for CDLMIS, training, IEC, advocacy, research, program monitoring and management information systems. Shifting from a centralized

system to the newly devolved system has created a number of problems for both the DOH and the LGUs, such as a need to transfer health personnel to LGUs; a dependence on LGU officials for funds; and a lack of uniformity among LGU officials regarding pay levels for health staff, travel funds for field monitoring, and, most important, priorities for the delivery of FP/MCH services.

The public sector in the Philippines continues to provide contraceptives and related services to more than 70 percent of users of modern contraceptives and is expected to remain the main supplier in the foreseeable future.

1.3 The Commission on Population

POPCOM is responsible for overall management of the PPMP, of which the FP/RH program is a component. POPCOM's primary functions are policy formulation and analysis, integration of population variables into the planning process at national and local levels, advocacy, technical assistance to LGUs, and overall coordination and monitoring of the PPMP.

1.4 Scope of Work for the Assessment

This assessment focuses on Intermediate Result 2 (IR 2)—national systems strengthened to promote and support the FP/MCH program—and has the following purposes:

1. To review and assess the process of IR 2 implementation and to make recommendations for whatever revisions might be required to achieve the IR objectives and indicators.
2. To assess the appropriateness of IR 2 administrative and management arrangements, by both the GOP and the USAID staff, and to make recommendations for any changes that are needed.
3. To review the appropriateness and the achievement of annual benchmarks and to assess their effectiveness in helping attain the life-of-program indicators of the SO.
4. To review the work of the various CAs under IR 2 and to assess the appropriateness and effectiveness of the technical assistance they provide to their host country counterparts.
5. To assess the progress toward GOP sustainability of each of the national systems under IR 2.
6. To assess the need for continued support by USAID to the national systems in the period beyond year 2000.

1.5 Team Members and Methodology

The Population Technical Assistance Project contracted a four-person team to carry out the assessment. Team members included the following:

- Charles N. Johnson, M.A., M.P.H.—Team leader and training analyst.
- Steven Perry, M.A.—Logistics specialist.
- Pilar Ramos-Jimenez, Ph.D.—Research and management information systems specialist.
- Francisco H. Roque, M.A.—IEC and advocacy specialist.

The Team worked in the Philippines from February 16 to March 20, 1998. After a two-day team planning meeting, team members spent ten days in Manila interviewing officials of the DOH, POPCOM, NSO, USAID, and CAs. Team members then traveled to different parts of the Philippines to interview officials of regional, provincial, and local health and population offices, LGU executives, researchers from academic institutions, and staff members of training centers. Team members also visited a variety of hospitals, RHUs, and BHSs to observe the functioning of FP/MCH programs. In addition, team members reviewed a wide range of documents and data files to gain a better understanding of the program. A complete list of contacts is included as Appendix C. A list of the major documents reviewed is included as Appendix B.

The Team provided oral briefings on major findings and recommendations to the DOH, USAID, and CA staff members on March 19 and 20. A draft report was delivered to USAID on March 20. Comments and suggestions from DOH and USAID staff members were incorporated into the final report submitted to POPTECH in mid-April 1998.

CHAPTER 2 INTERMEDIATE RESULT 2: INDICATORS, PROGRAM ACHIEVEMENTS, AND MAJOR ISSUES

2.1 Background

In 1970, the GOP first enunciated a population policy and initiated a family planning program. While the program rationale has shifted over the years from demographics to reproductive health, a key component has always been to provide couples with the information and the means of controlling their fertility. Responsibility for family planning has shifted from POPCOM to the DOH and now to the LGUs.

Although political support has varied with each administration and bureaucratic responsibilities have changed, the program has achieved a measure of success. Recent surveys indicate that 30 percent of married couples use modern contraceptives, and 47 percent practice some form of fertility control. Results from unweighted cluster surveys indicate an average contraceptive prevalence for couples in the LGUs involved in the LPP of 56 percent, significantly higher than in the country as a whole. However, nearly 25 percent of married women wish to control their fertility but are not currently using any contraceptive; they constitute the “unmet need.” After nearly 30 years, the total FP/RH effort still relies on donor funding for almost all program activities, with the overwhelming share provided by USAID.

USAID and the DOH have identified six indicators to serve as the year 2000 goals of the program. The initial figures are for 1993, unless otherwise noted.

- Reduction in the total fertility rate of 4.1 percent in 1991 to 3.1 percent.
- Increase in the contraceptive prevalence rate (CPR) from 40.0 percent to 50.5 percent.
- Increase in the CPR for modern methods from 25.2 percent to 35.7 percent.
- Decrease in the infant mortality rate from 56.7 percent in 1990 to 41.2 percent.
- Decrease in the maternal mortality rate from 209 in 1990 to 190.
- Reduction in high-risk births from 62.4 percent to 56.0 percent.

Although annual surveys show progress toward reaching all six indicators, it is not yet clear that all of the indicators will be achieved by the year 2000, particularly the key indicators for the total fertility rate and the use of modern contraceptives.

The 1991 devolution act empowered LGUs and made them responsible for the delivery of health services. However, central government agencies including the DOH, POPCOM, and the NSO continue to play an important role in implementing family planning and in selected MCH programs. The central government agencies have key responsibilities for enunciating population policy; serving as advocate for the program; supervising contraceptive distribution and logistics management; planning and conducting national IEC campaigns; planning, implementing, and monitoring training; undertaking research and evaluation to monitor program progress; and providing technical assistance to regional, provincial, and local health organizations.

The Secretary of Health serves as the DOH project director for IFPMHP. Managerial responsibilities are delegated to the OSC assistant secretary who supervises the day-to-day operations of IFPMHP. An interagency IFPMHP steering committee was established to advise the secretary on broad policy issues, but has never met. Similarly, a national advisory committee composed of DOH office directors was established to assist the project manager; it has met only occasionally. A project management office manages the LPP component of the IFPMHP and provides technical and administrative support to the DOH. Its participation in the national service components under IR 2 is focused on coordination of benchmark setting, implementation planning, and monitoring of progress toward meeting established benchmarks.

USAID's OPHN Chief serves as overall team leader for management of SO 3. The SO 3 coach assists with day-to-day management and guides the IR team leaders. The USAID staff is responsible for planning and managing USAID funds, monitoring progress of each CA, and maintaining close liaison with DOH counterparts.

USAID has engaged 15 U.S. CAs to assist in strengthening the six national systems identified under IR 2. Each CA has a budget for technical assistance and a budget to implement activities for which there is little or no GOP funding available. Each CA is charged with helping each GOP entity to develop its staff to assume operational responsibility for program management. Developing the necessary GOP funding for program activities remains an area of great concern for the overall sustainability of the FP/RH program.

As an added incentive to the DOH, USAID provides an annual cash grant to the GOP on the basis of achievement of jointly agreed upon benchmarks of program performance. Following a joint review by the DOH and USAID of performance for each benchmark, equivalent peso funds from the Department of Budget and Management are transferred to the DOH, which in turn provides funds to those LGUs which have achieved their individual benchmarks. Funds are to be transferred by March and no later than June 30. The funds may augment existing LGU budgets for FP/Population/Child Survival/Nutrition. While not designed to pay for recurring costs, this cash grant may be allowed again in 1998 because of the continuing GOP austerity program.

2.2 Benchmarks

The purpose of IR 2 is to ensure that the DOH and POPCOM will be able to accomplish the following five IR 2 indicators by the year 2000:

- 2.2.1 Enhance program sustainability by having the DOH assume full operational responsibility by 1999 for the following support functions: contraceptive distribution and logistics management, training, IEC, research and evaluation, service delivery technical support, and program monitoring.
- 2.2.2 Enhance program sustainability by increasing the budget allocation for the DOH/FPS by at least 50 percent per year.
- 2.2.3 Enhance the capacity of the DOH to release annual LPP grants for LGU programs (from 0 LGUs in 1994 to 75 in 1999) by June of the following year.
- 2.2.4 Have the updated national PFPP strategy reviewed and jointly approved by POPCOM and the DOH by November 1996.
- 2.2.5 Improve the quality of family planning and of reproductive health services by establishing a competency-based training system in LGUs participating in LPP (from 0 LGUs in 1993 to 75 LGUs in 1999).

To accomplish these five indicators, USAID, DOH, POPCOM, and the CAs have jointly defined and agreed on a series of IR 2 activities. These activities and their accomplishments and problems are addressed in chapters 3–8 of this report. The remainder of this chapter focuses on some of the broader issues that are common to many of the six program elements or that relate to overall success of the GOP's national family planning and MCH program.

2.3 Findings and Conclusions

2.3.1 The DOH Assuming Operational Responsibility for Support Functions by 1999

The determination of operational responsibility lies at two levels: technical and financial. The results are different for each of the six national systems.

At the technical level, the joint benchmark to identify and assign an increasing number of personnel to the national office of each system has increased the number of staff members available to manage each system. For example, the 1997 benchmark required the DOH to install three professional staff members for CDLMIS, IEC, training, research, and MIS divisions.

Staffing for these divisions remains small even with recent additions, and the ability of each division to plan, implement, and monitor activities is limited.

At the financial level, there is little prospect that any of the national systems will be sustainable by the year 2000 without significant donor funding. Continued pressure through the annual benchmark system to increase funding will help alleviate some of the problem. LGU funding for health service delivery is expected to increase over time and may help reduce national costs for programs such as training. IR 3, while not within the scope of this evaluation, is designed to increase participation by the private sector, which should also help reduce national costs for the program.

2.3.2 DOH/FPS Budget Increased by at Least 50 Percent per Year

The DOH/FPS budget for its headquarters operations has increased by at least 50 percent each year, from P11 million in 1995 to an estimated P56 million in 1998. As a percentage of total expenditures on family planning, the annual FPS budget has grown each year from 1.3 percent in 1995 to an estimated 5 percent in 1998. The total Philippine contribution to family planning programs is larger, including expenditures by LGUs for local health facilities and staff, as well as DOH regional staff and programs.

The program is still largely financed by international donors, with USAID providing over 80 percent of the total budget, followed by UNFPA, Japanese International Cooperation Agency (JICA), and Australian Agency for International Development (AusAID). USAID supplies all of the contraceptives used in the program. Most of the existing donor projects for FP/RH/MCH will continue from 1998 to 2000. The amounts of future donor assistance are not known and will depend on each donor's resources and priorities, as well as on GOP performance and plans.

2.3.3 DOH Capacity Enhanced to Release Annual Grants to LGUs

A joint review by the DOH and USAID is scheduled in the final months of each year to determine if benchmarks have been met and if funds can be released for the LGU grants. The DOH's Project Management Office (PMO) established for IFPMHP is responsible for releasing funds to each LGU. The plan is to release funds by the end of March each year, with the end of June as the final deadline. Thus far, the PMO has been able to meet the March deadline for most LGUs; the June deadline has always been met. There is no reason to think the PMO will not be able to continue to meet deadlines.

2.3.4 Updated National PFPP Strategy Reviewed and Approved by the DOH and POPCOM

The *Philippine Family Planning Strategy, 1996-2000* was issued by the DOH in November 1996. The strategy envisions family planning to be a way of life for every man and woman of reproductive age with universal access to FP information and services. The strategy identifies the major barriers to increasing contraceptive prevalence at the individual level, namely fear of side effects, limited understanding of contraceptive methods, lack of support from influential individuals, and the comparatively low importance placed on contraception as compared to other goods. At the program level, opposition to modern contraceptives by religious groups, changes in program leadership, and the difficulties of devolution have limited program expansion.

The strategy is clear and concise; it both highlights the problems facing institutions involved in family planning and offers specific interventions for service expansion. Expanding government financing for FP and encouraging greater involvement of NGOs, and the private sector will increase the potential for sustainability.

USAID supported the development of the strategy by financing the technical assistance provided by TFG's Policy Project.

The strategy outlined seven steps the DOH would undertake to increase FP services:

- Increase and improve the use of modern methods.
- Focus on adolescents and the unmarried.
- Develop and implement an urban strategy.
- Re-establish the local level outreach system.
- Segment the market among DOH/LGUs, NGOs, and private sector providers.
- Use improved data collection and analysis for decision making.
- Increase the capability of LGUs to contribute to the financing of the Philippine Family Planning Program.

The strategy places FP within the broader context of reproductive health with the hope that doing so will help FP to better meet client needs and to improve the efficiency and effectiveness of service delivery. Challenges to integrated service delivery are noted, and the strategy attempts to deal with them. The strategy highlights the need to integrate the core support functions of service delivery from MIS, logistics, training, and IEC.

2.3.5 Competency-Based Training (CBT) Established at LGU Level to Improve Quality of Family Planning and Reproductive Health Services

Fifteen SIMs, which form the basis of the new CBT, have been prepared and pretested. Trainers in four regions have been trained, and pilot tests are currently under way in four provinces to test two models—one model relies on participants to complete the 15 SIMs on their own, and the other brings the participants together for guided reading and completion of the 15 SIMs. The number of trainers to be trained in the SIM/CBT process gives an idea of the work yet to be done to meet the IR 2 indicator. Following the pilot tests and evaluation, the DOH will have to determine which of the two models to adopt. Approximately 60 regional trainers in the remaining 12 regions will be trained in mid- to late-1998; these trainers will in turn train about 100 LGU-level trainers in 50 LGUs by the end of 1998. During 1999, an additional 50 LGU-level trainers will receive instruction in the new SIM/CBT approach. Following their instruction, the LGU trainers will begin to train health service providers. The entire SIM/CBT system is behind schedule, but the performance target may still be attainable.

The quality of FP/RH services may be improved if the SIM/CBT system is introduced by 1999 in the 75 LGUs participating in the LPP. However, since training of LGU service providers will not begin until 1999, there will be limited opportunity under IR 2 to assess the impact of training on the quality of services.

2.3.6 FP/RH Program Direction

The GOP, through POPCOM and the DOH, has developed various strategies to guide the program—strategies covering policy, IEC, training, OR, and MIS. Each strategy is well written, establishes goals, highlights problems to be addressed, and lays out what appears to be a sensible path to meet the goals.

Yet the results of the national FP/RH program have been modest. Only 30 percent of couples use modern contraceptives, despite nearly universal knowledge of FP methods and of where to obtain contraceptives. Forty-seven percent of couples practice some form of fertility regulation. Great numbers of health and population staff members have been trained, IEC campaigns have been undertaken, and a good logistics system has been established. But something is missing. Rumors and misconceptions are frequently cited as a major reason for nonuse or for discontinuation of modern methods. These issues have been cited repeatedly over two decades of program evaluations. If such misconceptions truly exist, then there is a major problem with training, counseling, and IEC campaigns. Clearly the current “lay low” approach to dealing with rumors and misconceptions is not effective. Failure of political leaders at the national and LGU levels to speak out publicly, frequently, and forcefully in support of the FP/RH program ill serves the interests of the many Filipino couples who want to limit or space their children. Unless some significant action is taken soon, the FP/RH program will languish.

2.3.7 Role of the Cooperating Agencies

USAID has used the services of more than 20 CAs to assist in implementing SO 3. For each of the six national support components, one CA has taken the lead in providing technical assistance and financial support to strengthen that component. Some CAs have large budgets for program implementation, especially in training, CDLMIS, and IEC.

The CAs have an important yet sometimes conflicting role. USAID provides them funds to achieve certain goals within a fairly short time frame. The CAs are to provide technical assistance to help develop systems and to train GOP staff to assume operational responsibility. At the same time, they oversee and manage the funds required to implement national programs. Thus, the dilemma for the CAs is whether to take a more technical advisory role and let GOP staff implement the programs, or to become program implementors.

The DOH and USAID have set benchmarks for achieving a certain level of institutional strengthening of central support systems that set dates for the phase-out or phase-down of CA support. Some flexibility should be built into the system so that achieving a benchmark does not take precedence over the long-term needs of the program. A gradual phase-down of CA support is preferable to a sudden cutoff. The key, as yet unanswered, question is how existing central support systems will be financed in the future. There is little possibility of financial sustainability in the foreseeable future.

2.3.8 Benchmarks

Enhancing the institutional technical and managerial capability of the DOH/FPS to assume operational responsibility for the support systems is a reasonable target for 2000, although financial sustainability is unlikely in the foreseeable future. Even technical and managerial institutionalization has many problems, the main one being the overextension of personnel at FPS. Many FPS staff members are covering several positions, and their continued availability for the support systems could change.

The benchmarks established by USAID and the DOH have helped increase the FPS budget significantly and have also helped increase the number of FPS technical staff members. Benchmarks have been quantitative and have had little bearing on the quality of services. Establishing benchmarks that focus on quality of services will be a challenge for the final years of SO 3 and in planning for any future assistance.

2.3.9 Program Ownership

Throughout the Team’s visit, officials of the DOH and other government offices, NGOs, and donors regularly spoke of “the UNFPA project,” the “JHU communications program,” the “USAID project,” the “World Bank project,” and so on.

There seems to be little public ownership and recognition that the national FP/RH programs should be identified as the DOH program to which donors contribute. This problem is more than semantics—it is a change of attitude, responsibility, and ownership by GOP officials, donors, and CAs.

2.3.10 GOP Management and Administrative Arrangements

Locating responsibility for IFPMHP within the OSC is appropriate because OSC is responsible for the DOH’s broader reproductive health activities. However, the PMO appears to have limited management and administrative responsibility other than releasing funds to the LGUs and serving as an executive secretariat and administrative coordinator for IR 2 national service components.

2.3.11 USAID Management and Administrative Arrangements

The USAID/OPHN staffing seems appropriate for satisfactorily monitoring IR 2 implementation. The office appears well staffed, and staff members are extremely knowledgeable on all aspects of IR 2. Coordinating the activities of all the CAs is a heavy burden and requires substantial staff time, particularly because many of the CA agreements are with USAID/Washington.

2.4 Recommendations

1. Some technical and financial assistance beyond the year 2000 will be required to subsidize the national support functions. USAID, DOH, and POPCOM should begin discussions soon regarding future assistance and should give special thought to a greater role for the NGOs and the private sector as a means of reducing costs to the GOP.
2. Benchmarks should continue to be used to increase budget and staffing for the DOH/FPS to ensure greater sustainability. There are potential benefits in rationalizing the budget in the context of devolution to clarify which functions are the responsibility of national, provincial, and municipal governmental authorities.
3. GOP political leadership at national and LGU levels needs to be willing to publicly and regularly support FP/RH and to allocate funds for the program.

4. USAID and the DOH should consider a change in the current “all or nothing” approach for funding, so that a minor failing will not lead to loss of all funds. USAID and the DOH should explore methods of setting higher benchmarks to improve overall performance and to pay on a proportional basis.

5. As part of the effort to achieve greater program sustainability, USAID and the DOH should begin to carefully review the requirements for future technical assistance and should determine whether Philippine institutions have the technical staff and institutional capability to provide assistance without CA support. As part of the same review, USAID and the DOH should determine which CAs will be most helpful and what their respective roles should be.

CHAPTER 3 CONTRACEPTIVE DISTRIBUTION AND LOGISTICS MANAGEMENT INFORMATION SYSTEMS (CDLMIS)

3.1 Background

Since 1991, USAID has provided assistance to the GOP/DOH for developing the CDLMIS. This assistance has been managed principally through a buy-in contract to JSI/FPLM, as well as through CARE Philippines between 1992 and 1996. The achievements to date are impressive. CDLMIS is widely credited as the most effective logistics system within the DOH and is largely institutionalized at all levels. Its success has prompted the DOH to look for ways to increase its utility by expanding from a contraceptives-only supply system to one that also delivers essential drugs. The focus of this component of the assessment is an analysis of the sustainability of the CDLMIS after the end of USAID assistance on December 31, 1998. More specifically, this assessment will address the current strengths of the system, issues to be resolved, and prospects for institutionalizing and sustaining the CDLMIS with DOH resources.

The effort to develop and institutionalize the CDLMIS has required not only designing and implementing its functional components, but also building its institutional foundations within the DOH, which previously had no staff or organizational home for family planning logistics. Initially, the DOH was required to depend on contracted staff and a resident expatriate advisor to implement the CDLMIS, but over time it created a niche within its existing structure from which contraceptive logistics could operate. Moreover, the DOH has needed to allocate and dedicate staff members to family planning logistics at a time when there has been a moratorium on creating new regular hire positions within the DOH. The devolution of health services also required the DOH to simultaneously build a consensus for CDLMIS within LGUs nationwide, and to identify, train, and motivate staff members within LGUs to implement the system. The focus of the past three years of USAID's FPLM project assistance has been to assist the DOH in its efforts to institutionalize and sustain CDLMIS at its high level of performance after 1998. A major determinant of the success of this effort will be the DOH's ability to finance the ongoing requirements of the CDLMIS, an ability which is complicated by the current economic crisis and by the GOP's need to significantly reduce the annual budget of the DOH.

This assessment will consider the following determinants of the DOH's ability to sustain the CDLMIS:

- **Performance:** How effective is the system now in ensuring contraceptive availability for clients? What are the inhibiting factors?
- **Personnel:** Is DOH staffing adequate, at all levels in the system, to perform the necessary logistics functions?

- **Training:** Are these personnel adequately trained to perform the functions assigned to them? Are there adequate resources and plans for new and refresher training in the future?
- **Funding:** Are there adequate financial resources available at both the central and local government levels to sustain the CDLMIS without donor assistance?
- **Organizational Coherence:** Are the various component areas of the distribution system effectively consolidated within the framework of the DOH?

The assessment will also address what can be done within the remaining period of the FPLM project to assist the DOH in ensuring the future viability of the CDLMIS upon which the PFPP depends.

3.2 Benchmarks

The DOH and USAID have agreed to two benchmarks for CDLMIS:

1. The DOH will assume full responsibility for FP contraceptive logistics management for the PFPP by the end of 1998.
2. Eighty percent of FP service delivery points will maintain at least a one-month supply of oral contraceptives and condoms by the second quarter of 1999.

Together these benchmarks address both the operational effectiveness and the long-term sustainability of the CDLMIS. These measures are both reasonable and balanced. However, it must be recognized that they are not always mutually supportive, and that an emphasis on achieving one may come at the expense of the other. For example, transferring the function of customs clearance and distribution from CARE to the DOH in 1996 was a positive step in terms of sustainability, but subsequent distribution problems have seriously compromised contraceptive availability at the distribution points.

Observations at the national, provincial, RHU, and BHS levels indicate that the use of benchmarks in logistics has focused efforts to improve performance and has contributed positively to the achievement of project goals.

3.3 Findings and Conclusions

In the past year, three consultant missions have assessed different aspects of contraceptive logistics in the Philippines. Moreover, FPLM/Philippines has produced periodic reports of its efforts and of the status of all initiatives to improve and institutionalize the CDLMIS. This

analysis focuses on sustainability rather than on descriptions of the design, development, and implementation of CDLMIS. However, it is important to note that the overall impression of this assessment is that the CDLMIS is a well-thought-out system that has been well implemented through an excellent training program. The system is particularly robust at the lower levels, where in-depth training has resulted in large cadres of skilled personnel implementing and monitoring contraceptive logistics. CDLMIS is also a highly centralized “push” logistics system that depends on central level staff to monitor reporting returns, encode them quickly, verify the reports and the encoding, calculate order quantities, and facilitate the distribution directly to the LGUs. However, DOH staffing at the central level, even with the newly allocated personnel, is extremely thin, particularly in terms of experienced managers.

3.3.1 CDLMIS Performance (Benchmark 2)

The most important indicator of the effectiveness of a family planning logistics system is continuous availability of contraceptives at the service delivery points. Benchmark 2 is the operational measurement of this indicator. Field observation at 28 Provincial Health Offices (PHOs), RHUs, NGOs, factory clinics, and BHSs found only one facility that did not have at least a one-month supply of pills and condoms. The most recent (June 1997) national level data from the CDLMIS indicates that 78 percent of facilities had at least a one-month supply of these contraceptives. Actual figures may be significantly higher; all nonreporting facilities are counted as negative values. These figures reflect the high level of performance of the CDLMIS. Furthermore, staff at lower levels demonstrated motivation and creativity in borrowing supplies from nearby facilities during times of short supply.

Although only one facility visited was under the one-month supply benchmark, several facilities, particularly in Region XI, had experienced stockouts in the second half of 1997 caused by delayed and missed shipments from the central level. Sarangani province had received only one of the four scheduled quarterly deliveries.

Distribution from the central level has deteriorated because of problems between the DOH /PLS, which manages the freight-forwarding contract for contraceptive distribution, and the freight forwarder, World Yokohama. World Yokohama claims that it did not receive timely payment for shipments made, that it exceeded its contractual level of working capital, and that it was unable to perform as scheduled. PLS acknowledged late payment and cited overburdened staff, government procedure, and competing priorities, as well as late or incorrect submission of paperwork by World Yokohama as reasons for the late payment. Furthermore, DOH staff members believe World Yokohama to be relatively inexperienced and underperforming. Regardless of cause, the result was nondelivery of a large number of quarterly contraceptive shipments to LGUs in 1997, which in turn required the DOH to request and receive funds from FPLM for emergency shipments to prevent stockouts.

Beginning in March 1998, Telicor, a well-regarded freight forwarder that has worked with the DOH in the past, will share the contract for contraceptive distribution with World Yokohama. The expectation is that this division of the contract will result in compliance with quarterly contraceptive shipment schedules, but performance will need to be monitored closely as this problem could prevent the achievement of the CDLMIS performance benchmark. Two other areas of concern for CDLMIS are described below.

One concern is the newly introduced customs regulations that mandate the DOH must pay cash for import duties and taxes on donated contraceptives before clearing them through customs. These duties and taxes add up to 23 percent of the total value of contraceptives, or an estimated 40 million pesos per year, compared to the total DOH/FPS budget of only 42.2 million pesos for 1998. Duties and taxes owed on contraceptives currently in port total more than 9.0 million pesos, which the FPS officer-in-charge is attempting to pay from the FPS budget while awaiting the results of an appeal made to the Office of the President to exempt donated health commodities from customs duties. In the meantime, the DOH has requested USAID to postpone the next shipment of contraceptives. JSI/FPLM and TFG/Policy Project staff members are working with DOH/FPS staff to develop strategies to resolve this issue over the medium and long term.

Another area of concern is the shortage of CDLMIS forms that was apparently caused by a mistake in communicating the forms component of FPS's annual procurement plan for 1998. The procurement plan was processed by the Management Advisory Service (MAS) before being submitted to PLS. Facilities in Regions VI and XI had shortages of DTURs and BHS worksheets. At the time of the assessment, many of the forms had not been printed or distributed, resulting in growing shortages of forms at the field level that in turn is negatively affecting contraceptive availability at service delivery points. In the short term, this problem was resolved through a DOH request to USAID, which resulted in an "emergency" procurement of forms now being distributed.

In conclusion, despite the continuing high level of performance of the CDLMIS, the system remains vulnerable to complications in areas outside the direct control of the logistics section and FPS. The long-term solution requires assistance to the logistics section and the PLS to improve the management of the procurement functions, as well as the requested exemption of donated contraceptives from the newly implemented customs regulations. These recent problems also highlight the importance of maintaining some level of donor assistance to address short-term constraints to contraceptive supply.

3.3.2 Contraceptive Procurement

All contraceptives distributed through the PFPP are donated; the average annual cost of these donations over the past five years has been more than \$3.6 million. Except for a brief period in the early 1990s when the UNFPA provided DepoProvera™, USAID has always been the sole provider of contraceptives to the PFPP for the public sector. The German group KfW provides

contraceptives to the DOH for DKT International to use in its condom and oral contraceptive social marketing program. Given that contraceptive costs exceed the annual DOH family planning budget by more than 300 percent at current levels, the prospects for localizing these costs are long-term at best. Family planning in the Philippines continues to rely heavily on donor technical and financial support, and there has been little or no political support for allocating GOP resources for contraceptive procurement. However, for the first time, the DOH/FPS has requested 10.0 million pesos for contraceptive procurement in 1999, plus an additional LGU contribution of 1.0 million pesos per region. The importance of these efforts exceeds the value of the contributions and should be closely monitored and supported.

3.3.3 Contraceptive Quality Assurance

Interviews with service providers revealed widely held concerns regarding both IUDs and Depo-medroxy progesterone acetate (DMPA), an injectable contraceptive. The CuT 380A IUDs demonstrated a high incidence of tarnishing of the copper wire and copper sleeves. While tarnishing does not impair effectiveness or lead to side effects, service delivery personnel consider tarnished units to be damaged and return them to the central level. Many service providers claimed that they were receiving DMPA vials containing less than the prescribed one ml., and they were opening a second vial to ensure that the injections contained a complete dosage. One provincial family planning coordinator ascribed the problem to loss of fluid from the syringe after tapping it to remove air bubbles caused by vigorously shaking of the vials, as recommended by the manufacturer, to dissolve the caking inside the vial.

3.3.4 Sustainability of the CDLMIS Within LGUs

The LGUs (including provincial, RHU/main health center or MHC, and BHS levels) are currently the most robust and sustainable link in the CDLMIS chain. The success of the system in ensuring contraceptive availability has motivated service providers and health care managers to carry out their CDLMIS tasks efficiently. Managers at the regional and LGU levels have assumed local ownership of the system, and implementing staff members demonstrate strong support for the CDLMIS. Key elements of the success and sustainability of CDLMIS include the following:

- **Design:** FPLM pilot tested four different models before selecting and implementing the most effective. FPLM staff members met with regional-level staff members to explain the benefits of bypassing the regions, and they built a consensus for the design. Implementing the push system and using delivery teams allows higher level, better-trained staff members to determine quantities to allocate to lower levels. The system relies on a total of five forms, and no more than two forms at a given level, which is crucial given the heavy data recording burdens from the Field Health Service Information Service (FHSIS) and other management information systems. Quarterly reporting from the LGUs to the central level has been facilitated by the use of courier services. Throughout, there has been attention to

detail regarding local capabilities and constraints. The system has been revised over time in accordance with lessons learned at lower levels.

- **Training:** The CDLMIS training program is widely recognized to be one of the most effective within the DOH. The program places a heavy emphasis on both formal and on-the-job training for large numbers of staff members, so that there is depth in skilled personnel in key areas such as delivery teams, monitoring, and training. Staff members who were interviewed demonstrated high levels of competency in completing their CDLMIS-related tasks.
- **Monitoring and Feedback:** More than 1,100 RHO and PHO FP coordinators and DOH representatives received a two-and-one-half-day training in CDLMIS monitoring. These staff members use a monitoring checklist to conduct periodic monitoring visits, and they receive quarterly feedback reports from the central level identifying problem areas and facilities that the monitoring teams use to address the problems before they have to deal with a stockout.

Although the CDLMIS is quite strong at the lower levels, areas of concern regarding future sustainability remain. First, no plan or budget allocation exists for the DOH to conduct further training at the RHU/MHC level; the DOH proposes to conduct only two delivery team trainings annually. Periodic training at all levels is required to sustain the effectiveness of the CDLMIS. Second, when the LPP ends, the current reliance on LPP funding in many of the LGUs may cause problems in transport and delivery team per diems. Finally, the CDLMIS is a “full supply” logistics system, and there are no set guidelines, outside of emergency orders, for PHOs and RHUs/MHCs on what to do during periods of short supply. As seen in Region XI in 1997, there are likely to be periods of nondelivery from the central level requiring efficient rationing of available stocks.

3.3.5 Sustainability of the CDLMIS at the Central Level

The proven effectiveness of the CDLMIS has provided a broad support base within the DOH, upon which institutionalization and sustainability can be built. Efforts to institutionalize CDLMIS within the DOH have been the focus of the past two years of FPLM’s intervention. A number of logistics functions previously handled either by CARE or by FPLM have been, or are now being, assumed by the DOH with assistance from FPLM. These include the following:

- Customs clearance of donated contraceptives.
- Management of the central level warehouse.
- Distribution from central to LGU level.

- CDLMIS training.
- Procurement of CDLMIS forms.
- Data encoding and database management.
- Annual contraceptive procurement table (CPT) preparation.

Other steps taken by JSI/FPLM to institutionalize CDLMIS at the central level include (1) the conversion of the LMIS software to the DOH standard (PowerBuilder) using a local contract with a limited service warranty, and (2) the development of a DOH CDLMIS training capability through the provision of training of trainers to 23 central and regional level staff members. Furthermore, in January 1998 the DOH/FPS merged the MIS and Logistics sections and allocated additional staff members to CDLMIS. While this is a positive step, not all staff members are yet available to fill the roles, and it will be some time before they are all trained in their new responsibilities.

The primary constraint to institutionalizing the CDLMIS has been the lack of central level staff counterparts to whom FPLM project staff members could transfer skills. Until the arrival of three data encoders from the MIS section in June 1997, the only DOH staff members available to transfer skills and responsibilities to were the Section Chief and the Database Operations Manager. FPLM has operated the system with a full-time resident advisor, six logistics program officers, an MIS advisor, data encoders, an accountant, and several support staff members. Transferring skills and responsibilities from the contract staff to the DOH staff was impossible without suitable replacements. CDLMIS is a highly centralized logistics system, and a major concern for the long-term viability of the system is the lack of depth in skilled personnel at the central level.

Other areas of concern for sustaining the CDLMIS at the central level include the following:

- **Dispersion of CDLMIS Functions:** Several key CDLMIS functions (distribution to LGUs, forms printing, and so on) are located outside the logistics section.
- **DOH Budget Cuts:** Because of the current economic crisis, all government budgets, including that of FPS, have been reduced by 25 percent, with half of the cuts to come from training and travel (per diems), both of which are key components of the CDLMIS.
- **Dependency on FPLM:** Recent problems with forms and distribution highlight the need for ongoing support to the DOH.
- **Premature Loss of Key FPLM Staff:** The resident advisor and three logistics program officers are leaving CDLMIS for the LGEDDS project six to eight months before the end of the FPLM contract, which will likely affect the effectiveness of the FPLM project.

3.3.6 The Local Government Essential Drugs Distribution System (LGEDDS)

The LGEDDS is the result of a request from the DOH to the World Bank–funded Women’s Health and Safe Motherhood Program (WHSMP) to leverage the success of the CDLMIS by expanding the contraceptives-only system to one that also includes seven essential drugs. This concept was piloted under CDLMIS in region VI’s essential drugs distribution system (EDDS). The expectation is that the contract will soon go to John Snow, Inc., and that the project will begin within the next two months. The plan is for LGEDDS to absorb CDLMIS, region by region, over a two-year implementation period between first quarter 1999 and first quarter 2001. LGEDDS is anticipated to be a positive step for the long-term sustainability of contraceptive logistics in the Philippines, but there are concerns that it may have negative short-term consequences for CDLMIS.

The most immediate of those concerns is the impact of the transfer to LGEDDS of four key CDLMIS staff members, including the resident advisor, before December 31, 1998, which is the completion date of FPLM’s project with USAID to support CDLMIS. Questions also exist regarding how closely LGEDDS will reflect the CDLMIS structure; whether contraceptive availability will suffer in the transition period; where LGEDDS will be located institutionally and physically; if and how CDLMIS and LGEDDS will share office space, equipment, and staff; and whether contraceptives will become second priority commodities in an EDDS.

Conversely, LGEDDS represents the best opportunity for sustaining contraceptive logistics with local resources. The GOP’s commitment to LGEDDS is demonstrated by its willingness to take a “hard loan” from the World Bank to fund this initiative, which in turn reflects the success of the CDLMIS in building a constituency within the DOH. Additional benefits of LGEDDS to CDLMIS include the following:

- Logistics training at grass root levels is two to three years old. Major retraining, which should take place under CDLMIS, will now be undertaken under LGEDDS.
- LGEDDS, through the inclusion of the MCH, nutrition, and TB programs, will greatly expand the potential funding base and the pool of personnel for sustaining contraceptive logistics.
- An essential drugs distribution system is ultimately much more attractive to the GOP and LGUs, upon which the system depends for allocated resources, than a family planning-only distribution system.

In conclusion, although CDLMIS has been largely institutionalized within the LGUs, there are not sufficient numbers of trained and motivated staff members at the central level for full institutionalization. Moreover, it is unlikely that a family planning-only logistics system will be financially sustainable in the long term. The priorities of the DOH and donor partners in contraceptive logistics management should be to do the following:

- Protect and sustain the CDLMIS until the end of the transition to LGEDDS.
- Support the development and implementation of LGEDDS.
- Facilitate a smooth transition from CDLMIS to LGEDDS.

3.4 Recommendations

6. A consensus-building workshop should be conducted for the transition from CDLMIS to LGEDDS, including representatives from the DOH, USAID, the World Bank, and FPLM. The outcome of this workshop should be a plan and time schedule for the transition, and should address the areas of concern detailed in section 3.3.6, as well as other relevant issues.
7. To sustain the CDLMIS at the current high level of performance until the transition to LGEDDS is complete, the FPLM (CDLMIS) project should be extended through the year 2000. This extension should be done in a phase-out approach, whereby staffing levels decline each year, and should be without the benefit of a resident expatriate advisor. The project management function should be handled by a locally hired staff (new or existing) and with periodic technical and administrative support visits from FPLM/Washington. For example, in 1999, the project may operate with 75 percent of current staffing levels and with quarterly support visits from FPLM/W. In 2000, this effort could be reduced to 50 percent of current staff levels and trimesterly visits from the home office. The following activities should be incorporated into the work plan for the extension period:
 - Monitor the progress of LGEDDS and facilitating the transition plan, as described in section 3.4.1.
 - Advocate the institutionalization of the freight-forwarding contract management and the forms procurement function within the FPS logistics section, or provide assistance to PLS in streamlining and managing this process.
 - Advocate the inclusion of a logistics management module within HMDTS core training, the development of a “SIM” logistics module, or perhaps both.
 - Develop, produce and disseminate guidelines (possibly a wall chart) for stock management during short supply.
8. USAID should be represented on the LGEDDS steering committee until the transition from CDLMIS to LGEDDS is complete.

9. The GOP should assume a small, but annually increasing, share of contraceptive procurement costs.

CHAPTER 4 INFORMATION, EDUCATION, AND COMMUNICATION (IEC)

4.1 Background

The IEC program is perceived by DOH staff members as an important, albeit supporting, intervention in family planning. It is undertaken by the DOH, with technical assistance from JHU/PCS. The purpose of the program is to increase use of FP services through a strategy that leads the public to greater awareness of the benefits of these services and of their availability. The implementation of a national communication campaign and the implementation of local LGU-specific IEC programs in participating LPP LGUs are major features of this program.

The national campaign has been conducted annually since 1993 through extensive use of mass media channels, and has been supported by small media and interpersonal contacts at selected LGUs. The goal of the campaign is to contribute to the DOH's efforts to bring about universal access to FP information and services. In August 1995, the *Communication Strategy for 1995–2000* was designed to guide IEC interventions. In response to devolution, an LGU-specific FP IEC strategy was developed and approved in 1996 to provide guidelines to planning and implementing activities by the LGUs participating under the LGU Performance Program (LPP) of IR 1.

4.2 Benchmarks

The DOH and USAID have agreed to two benchmarks for IEC:

1. A revised communications strategy will be implemented, focusing on LGUs produced and approved by June 1996.
2. A national communications program will be executed on a yearly basis.

Both benchmarks have been successfully met. Although the strategy required under Benchmark 1 has been met, and LGU-specific FP IEC plans are among the benchmarks required under IR 1, implementation of the IEC plans at the LGU level needs improvement. The achievement of Benchmark 2 is on track.

4.3 Findings and Conclusions

4.3.1 Communication Strategy for 1995–2000

An important document, the *Communication Strategy for 1995–2000*, written with the help of JHU/PCS, provides the overall guidance for a coordinated IEC intervention to the PFPP. The document discusses the lessons learned from implementing NCC–93 and it outlines the challenges that the PFPP, particularly the IEC component, should address. It lays down the broad communication goals of providing universal access to FP information and services and of enabling couples to arrive at decisions that are compatible with their beliefs, convictions, and capabilities to raise their families.

The *Communication Strategy* serves as the framework for implementing the annual national communication campaign. Interestingly, the communication goals do not address an important issue identified in the section titled “Challenges Ahead”—meeting the unmet needs for family planning of more than 3.0 million married women, including addressing the fear of side effects and any misconceptions about FP. According to JHU/PCS staff members, the campaign was deliberately designed to address the fear of side effects and the issue of rumors and misconceptions at the clinic level, and to do so through counseling and face-to-face communication, rather than in the mass media. This approach may explain why little emphasis is placed on side effects and misconceptions about FP in the yearly national communication campaigns. The distribution of comics on side effects will take place only during the first quarter of 1998. Comic book materials on each contraceptive method have been printed in major dialects and distributed. However, in field visits, assessment team members often found few, if any, comic books at the RHU/BHS level.

In conclusion, the *Communication Strategy* is an important document that provides the framework for national IEC interventions for the PFPP. As such, its use will need to be coordinated with the use of other related and equally important strategy documents (such as the revised *National Family Planning Strategy*, the *National Population and Development Advocacy Plan (1996–2000)*, and the *DOH National Training Strategy*) for greater effectiveness.

4.3.2 Implementation of the Annual National Communication Campaign

The centerpiece of IEC support to the FP program is the annual NCC, a media intervention that introduced and popularized the FP slogan “Kung sila’y mahal n’yo, magplano” (“If you love them, plan”). The campaign, which has been implemented yearly since 1993 over a period of 6.5 months (on average), was planned, executed, and paid for entirely by JHU/PCS.

Involvement from the DOH’s FPS, PIHES, and related units has been limited and has taken the form of participation in planning and coordination meetings, review and approval of campaign plans and materials, monitoring of campaign activities, and participation in training activities.

Despite several successful campaigns for DOH programs, PIHES has played a minor role in the campaigns driven by JHU/PCS. The HMDTS, a key DOH human resource development unit, has barely been involved in the planning and management of IEC training carried out under JHU/PCS supervision (such as the local government IEC capacity building on strategic communication for family health, the PFPP programs for journalists and other communicators, and the IFHSP “signage” project).

The yearly campaign is nationally orchestrated in Metro Manila with involvement of selected LGUs and media and health-related partner agencies operating in the regions and provinces. The campaign has made extensive use of selected mass media channels at both national and regional levels, reinforced by small media, including collateral (promotional) materials, and interpersonal contacts. The campaigns are conceptualized and executed by recognized national advertising agencies, with inputs from international as well as local media consultants and experts. At the end of each campaign period, a post-campaign evaluation is conducted with the results used as inputs for planning the next national campaign.

The annual campaign has been implemented in a systematic way since 1993. Nevertheless, a major concern is the planning and management of the campaign at the regional levels and below. While at the national level the planning and management is meticulous, the same level of detailed planning and management of the campaign at the regional level and below is somehow missing, as was evident in places visited by the assessment Team. The direct link between information and FP services at points of contact is unclear. The singing contest in Cebu that drew a big crowd, for instance, did not take advantage of opportunities to distribute low-cost, one-page IEC flyers listing names and addresses of health facilities and the different services offered, including FP, or to give a brief talk to encourage people to visit nearby health facilities. The tie-in between the NCC and mini-IEC campaigns conducted at the LGU level may provide a more coordinated IEC approach in the future, but the LGU efforts are at an incipient stage.

The messages and materials, including promotional materials, were prepared under supervision of JHU/PCS and the DOH, and were pretested by advertising specialists before mass production and airing. The messages between 1993 and 1995 were mainly generic, focusing on the health benefits of FP, the promotion of a fresh image for FP as a social norm, the credibility of service and information providers, and the safety and effectiveness of FP methods. From 1996 to 1997, while still carrying these messages, the materials focused on spousal communication, FP for everyone, the social and cultural safety and acceptability of FP methods, and choices in FP method. The issues of the fear of side effects and of rumors and misconceptions about FP, which have prevented a sizable number of married women of reproductive age (MWRA) with unmet needs from using modern contraceptives, was addressed in late 1997 and early 1998 with the publication in several major dialects of an illustrated booklet, *Esmeralda*, BHW. These issues have not received as much attention in the campaigns at regional and lower levels.

The types and the variety of IEC materials prepared between 1993 and 1997 are impressive. The quality of these materials is evidenced by the fact that JHU/PCS leaflets and related materials have

been reprinted in large quantity for distribution and have been used in medical facilities and health centers in various regions by the UNFPA-supported DOH Program on Reproductive Health.

The cost and duration of the annual communication campaign varied considerably from year to year. Table 1, below, provides a general picture of campaign expenditure by year. A comparison of campaign expenditure with the total budget of FPS for one year provides an interesting perspective on the issue of institutionalization and gives a sense of the magnitude of campaign funds. The budget allocation for a five-month-long 1998 campaign is P25 million (estimate), half of the total FPS budget (P50 million) for one year. The expenditure for a single NCC lasting four months (in 1995) is 8.6 times bigger than that of an entire 1997 IEC budget expenditure by FPS/IEC (P1.34 million).

In addition, a preliminary review of the total local expenditures on IEC and related activities from 1993 to 1997 showed that the NCC constituted over 65 percent (P97 million) of the total P149 million spent. This amount was followed by 12 percent spent locally on additional IEC materials (such as print, films, and promotional items).

The implication is that there is no way that this type of communication campaign can be replicated by FPS and PIHES combined without a massive infusion of funds, which raises questions about institutionalization and sustainability. In addition, the duration of the NCC and the amount of attention needed to supervise it (see Table 1) is too long for any DOH division to sustain, given the resources, the availability, and other responsibilities of DOH personnel at central and regional levels.

In conclusion, the NCC has been professionally planned and managed since 1993. Support communication materials have been well designed, particularly the radio and television commercials. The impact of the campaigns over the years is well documented. But the NCC as presently planned and managed will be difficult to implement and to be sustained by the DOH when the current JHU/PCS technical and financial assistance under IR 2 ceases in two years, given the limited resources and absorptive capacity of the DOH. But the basic sequence of implementing the campaigns (impact evaluation, planning, networking, NCC conceptualization, NCC organization, baseline survey, NCC implementation, and monitoring) can be adopted and used effectively, although on a much smaller scale. The lesson to be learned from this experience is that IEC is by no means a cheap intervention, and that the formula for health intervention, as far as IEC is concerned, will need to be seriously reviewed by the DOH and USAID and to be placed within the proper program perspective and absorptive capacity of DOH.

Table 1

**Campaign Dates and Duration, Geographic Coverage, and
Total Local Expenditure—1993 to 1998**

| Date and Duration | Geographic Coverage | Total Expenditure |
|--|--|--|
| 1. Aug 1993 to Mar 1994 (8 months) | Nationwide but with focus on 10 selected LGUs | \$1,036,521 (P25,913,025) |
| 2. Nov 1995 to Feb 1996 (4 months) | Nationwide | \$445,254 (P11,576,609) |
| 3. Nov 1996 to May 1997 (7 months) | Nationwide | \$319,054 (P8,295,400) |
| 4. Nov 1997 to Mar 1998 (5 months) | Nationwide, but with focus on 3 priority areas ¹ | \$808,218 (P26,671,180) |
| 5. Aug 1998 to Dec 1998 (5 months-estimate) | Nationwide | \$641,026 (estimate) (P25,000,000) |
| Total | | \$3,250,073 (P97,456,214) |

¹ Priority 1: Cordillera Autonomous Region, Ilocos, Bicol, Western Visayas, Central Visayas, Eastern Visayas, Western Mindanao, and Central Mindanao. Priority 2: Central Luzon, Southern Tagalog, Northern Mindanao, Southern Mindanao, and Autonomous Region of Muslim Mindanao. Priority 3: Cagayan Valley and CARAGA.

4.3.3 Capacity Building in Strategic Communication for Family Health for LGUs

Strategic communication training, coupled with the training for media practitioners perceived as “friendly to PFPP” (conducted in August and September 1997 in Tagaytay, Davao, Baguio, and Cebu cities), is a key communications intervention designed to assist information officers at LGU levels. The NCC follows the JHU/PCS communication model (known as the “P” process) developed out of JHU/PCS’s communication experiences in other countries. JHU/PCS is attempting to introduce the model into the country through its series of training activities on communication strategies for family health. The training interventions began in December 1996, and since then two other training activities have been undertaken. Four communication courses (communication strategies, monitoring and evaluation, financial and economics analysis, and project proposal preparation) are planned for 1998.

An important feature of this series of training is its emphasis on IEC program planning through the use of a computer-based interactive software called SCOPE. The goal of the training is to enhance the capability of LGUs to do IEC program planning and implementation for strategic communication in family health. The training initiatives are under the supervision of the Center for

Sustainable Local Development at the Development Academy of the Philippines (DAP), in collaboration with the IDC of UPLB and CMC of U.P. Diliman.

These training activities are also viewed by the JHU/PCS staff as IEC support to the implementation of the LGU-specific FP IEC strategy. So far about 100 people have participated in these communication courses. The training cost is prohibitive: P30,000 per participant. The high cost is largely due to the administrative cost of operating the courses at the DAP. To make the training available to a wider audience, the JHU/PCS funds about half of the participants, with a small counterpart contribution (mainly transportation costs) from participating LGUs. The other participants are sponsored by international organizations such as the UNFPA. An important development in this training is the approval in February 1998 given by the Commission on Higher Education to credit four courses planned for 1998 toward a master's degree program. This accreditation will be an incentive for LGUs to send their staff members to the courses.

The main difficulty with this training system is its heavy reliance on a sophisticated software (known as SCOPE) as a training tool. Most of the participants had little or no experience with computers. In many regions the availability of the right type of computers to run the software is also a concern when the trainees return to their places of assignment. The software is being further developed by JHU/PCS to enable users to input their own local data, but the enhanced version of this software is not likely to be available before the end of the JHU/PCS project in the Philippines. Finally, there is no involvement of DOH's HMDTS in this training initiative. JHU/PCS indicated that SCOPE has made the training program more attractive to participants because its learning process is engaging and because it is structured to have just three "planners" per computer, making the interaction among participants high.

In conclusion, the training method used to improve the capacity of LGUs in program planning and implementation of family health communication is innovative. However, to strengthen the national level (IEC training), the HMDTS would have benefited from the introduction of SCOPE as an innovative training tool and from its application to other DOH training activities.

4.3.4 Integrated Family Health Service Project (IFHSP)

In collaboration with the PFPP, JHU/PCS is piloting the IFHSP in four LGU areas to promote the availability of FP and referrals to child survival services currently being provided by hospitals, RHUs, and BHSs. The goal is to position FP as an integrated component of family health at the community level, thereby promoting FP as a "norm in basic health care." Central to the project concept and strategy is the use of the existing FP logo and slogan ("If you love them, plan") placed prominently in front of a health facility to generate demand for the essential package of FP and child survival information and services. The project was launched in early 1998 in four pilot LGUs: Iloilo City and Iloilo Province in the Visayas, Baguio City in Luzon, and South Cotabato in Mindanao. Health personnel from the four pilot areas completed orientation in March 1998.

In conclusion, while the concept of an integrated package of health services is good, there is concern over the use of the FP logo, which has been promoted since 1993. The FP logo does not convey the intent of the integrated package of information or of the services for family health and is open to misunderstanding within the community.

4.4 Recommendations

Although the contributions of past national communication campaigns to the PFPP have been significant, the focus of succeeding communication campaigns should be modified for implementation at provincial levels and below.

General Recommendations

10. Recognition should increase so that campaigns are associated with the DOH rather than with JHU/PCS.
11. The DOH should be seen as the manager of these campaigns; thus DOH leadership at local levels must be made more visible.
12. In the remaining years of the project, PIHES and HMDTS of the DOH must be mainstreamed into the management and implementation of the communication campaigns.
13. Responsibility must increasingly be transferred to the appropriate DOH unit, such as FPS, to ensure smooth transfer of expertise and skills, including the management and disposition of IEC funds (in respect to the NCC). This transfer would require either a waiver for JHU/PCS to subcontract with the DOH or a more direct grant from USAID to the DOH.
14. The DOH and USAID need to discuss the role, concept, and modality of present (and future) technical assistance provided by CAs (such as the assistance provided by JHU/PCS and TFGI), in IEC and advocacy in light of sustainability and institutionalization.
15. The DOH and USAID may wish to look into the possibility of using local (national) CAs from the private sector in the next program cycle.

Specific Recommendations

16. The campaign thrust should be shifted from the national to the regional level and below.

17. Campaign thrust should address the unmet needs of the 3.0 million women at high risk in identified provinces in the country. (Focus should be on the 85 LGUs covered by the LPP.)
18. Messages should seek to dispel rumors about FP and to explain the side effects of various FP methods. Messages should also provide information about the advantages and benefits of FP to the health of the family, mother, and child. Socio-cultural research should be used to collect information on rumors and misconceptions about FP and FP methods.
19. Two campaigns of shorter duration each (e.g., one month) instead of a single campaign lasting four months (August to November yearly) should be mounted to ensure a reinforcing effect on target groups.
20. The first campaign should be managed by JHU/PCS, with PIHES assisting (job coaching), while the second campaign should be managed by PIHES, with JHU/PCS providing technical assistance (hands-on training).
21. Campaigns should focus at the regional/LGU levels, with community mobilization and participation being given more emphasis and with mass media support reinforcing community interventions and personal counseling.
22. Given the work load of the DOH, multi-agency participation should be encouraged during the learning period.
23. The DOH must assign a responsible division (such as FPS) that can continue IEC work after technical assistance has been phased out.
24. POPCOM regional offices and the PIA, which have networks at regional levels, should participate actively in the campaigns.
25. Strategic communication training for LGUs should be linked to efforts to strengthen teaching institutions that can systematically assist the DOH in the longer term.
26. The use of educational institutions at the provincial level should be stressed, as should the use of those institutions already being developed by JHU/PCS, such as the IDC of UPLB and the CMC of U.P. at Diliman.
27. The role and responsibility of HMDTS in IEC training must be clarified.
28. Coordination of various USAID-funded TA projects should be a priority. For impact, advocacy interventions under the Policy/Advocacy Project should be synchronized with the campaign periods (August to November). While advocacy activities should continue to

take place year-round, the Policy/Advocacy Project should collaborate with the IEC program during its campaign period.

29. The link with service delivery at LGU levels should be strengthened, with clearer, more concrete interventions and follow-ups than has formerly been done.
30. IEC materials should support FP counseling.
31. Generic materials on FP with multi-purpose use should continue to be produced periodically, and should be widely disseminated in relevant dialects.
32. Following an inventory and review of existing materials, relevant materials should be reprinted and stocks in medical facilities and other service delivery points should be replenished on a regular basis.
33. New materials addressing side effects and misconceptions about FP should be designed and produced. Budgetary provision for reprinting and regular replenishment of materials should be set aside.
34. On the pilot IFHSP, the use of the FP logo should be reconsidered, as its design has always been associated with FP, and the logo does not reflect the intent of the integrated package of information services on family health. Alternatively, the FP logo could be redesigned somewhat to include brief texts or symbols linking FP to the child survival information and to services within the context of family health.

CHAPTER 5 TRAINING

5.1 Background

Having well-trained and motivated service providers has always been a key objective of the PFPP. Since the early 1970s, USAID and other donors have provided POPCOM, the DOH, and NGOs with substantial assistance for training health and family planning field workers. Literally hundreds of thousands of persons have received training. During the period of 1990 to 1995 alone, under the GOP-USAID Family Planning Assistance Project, nearly 61,000 health professionals were trained in family planning skills, clinic management, IEC, interpersonal communication skills, and counseling. Most of the training followed no clear training strategy and was not competency based.

In 1994, the DOH and USAID/P identified five serious problems affecting the training of FP service providers in both the public and private sectors:

- Too few personnel are fully trained in family planning.
- Lengthy training programs discourage participation by health care providers.
- Poor attendance by trainees and high attrition rates occur when sessions are not relevant to the development of FP skills.
- High levels of frustration among both trainers and trainees occur when inadequate numbers of method acceptors delay the development of clinical skills by trainees.
- Single-method training prepares service providers with competency in that method only.

To resolve these problems and to make training more relevant to service delivery, the new IFPMHP sought to focus training on the following:

- Implement humanistic, criterion-referenced, competency-based training (CBT).
- Revise accreditation activities under the existing board.
- Strengthen the FP certification program for health care workers.

The new system emphasizes the use of training models and case simulations, rather than actual patients, to develop clinical skills. The CBT approach was also designed to help the DOH achieve a more sustainable, less costly, and less donor-dependent form of training. The CBT approach

would respond to growing complaints from LGU officials that health personnel were spending too much time in training and not enough time providing health services.

The IFPMHP initially anticipated the following massive training of health workers:

- In-service training of 16,147 DOH/LGU FPS service delivery personnel.
- Pre-service FP training for 15,000 new graduates of schools of nursing and midwifery.
- Mid-level management training for 4,500 NGO managers involved in FP service delivery.
- Logistics management training for 2,500 LGU and NGO logistics staff members.
- VSC skills training for 6,390 DOH and NGO FPS providers.
- In-service FP training for 3,000 LGU staff members and 50,000 community volunteers.

When the USAID re-engineering process was initiated in 1996, the IFPMHP evolved into Strategic Objective 3. Specific training targets were excluded, and broader benchmarks for strengthening the national training system were adopted.

To assist the DOH in implementing the training component under IFPMHP and SO 3, USAID used the services of several CAs. Management Sciences for Health (MSH) and its subcontractors, Development Associates (DA) and Economic Development Foundation (EDF), provided TA and funds to develop the training strategy and the revised basic FP/RH curriculum, which includes use of SIMs and CBT for needed clinical training.

JHPIEGO provided technical assistance and funds for the development of clinical manuals for FP/RH and pre-service training of nurses and midwives in collaboration with ADPCN and APSOM. The USAID-funded JHPIEGO activities terminated February 28, 1998.

Access to Voluntary and Safe Contraception (AVSC) provides technical and financial support to develop facilities and to provide CBT in voluntary sterilization and counseling.

Each of the other IR 2 components include training, which is discussed in the context of the activities of each component.

5.2 Benchmarks

The DOH and USAID/P have agreed on five benchmarks for training:

1. By September 1996, the DOH would have developed and approved a training strategy for 1996–1999.
2. By June 1997, the DOH would have initiated implementation of a revised basic FP/RH curriculum using a CBT approach.
3. By December 1997, an enriched, integrated FP/RH curriculum for midwifery would be developed and implemented in 90 percent of midwifery schools.
4. By December 1997, an enriched, integrated FP/RH curriculum for nursing would be developed and implemented in 90 percent of nursing schools.
5. By December 1998, the new CBT for FP/RH will be established in 50 LGUs and 15 regions.

5.3 Findings and Conclusions

5.3.1 Training Strategy

The benchmark for a training strategy was reached on schedule when the *National Reproductive Health/Family Planning Training for the Philippines: A Training Strategy* was approved and published on September 20, 1996. This training strategy was developed by an interdepartmental Technical Working Group with the assistance of donors (USAID, UNFPA, and AusAID) and technical support from MSH and DA.

The strategy identifies the considerable numbers of untrained FP service providers already working in the devolved LGU health system and notes an alarmingly high estimated attrition rate of 25 percent among public sector health employees.

The strategy is a well-prepared and thoughtfully designed document. It attempts to balance the need for more effective and better quality training through a CBT approach, with efforts to develop a sustainable system that is within the financial capabilities of the DOH and LGUs. Key elements of the strategy include development of an institutional capability at the LGU level to manage FP/RH training programs, enhanced participation of physicians in communication and counseling skills training, and performance-based criteria for certification and accreditation. Because the new strategy is only in the early stages of implementation, it is too soon to comment on its effectiveness and the ultimate sustainability of the broad training programs it outlines. A major unanswered question is whether and to what extent LGU officials will budget funds for

training health workers. The new strategy offers an excellent opportunity to improve the quality of care, given the CBT focus of training.

5.3.2 Implementation of Competency-Based Training

The target for full implementation of a revised basic curriculum that addresses family planning and reproductive health using a CBT teaching approach is over a year behind schedule. With a great effort, the target may be reached by December 1998, 18 months behind schedule.

The training system for FP/RH has been fragmented, repetitive, and too long; the revised training system seeks to address these problems. An FP worker would need up to 11 separate courses to become fully qualified. To complete all courses would take several months. Since the courses are normally held at hotels or at the regional DOH training centers, costs include lodging and meals for the participants. Courses are not sequential, so the material is quite repetitive. Courses are not focused on skills development and are heavily trainer dependent. Following the didactic phase of training, participants work with a preceptor at a field site, often with a limited case load for developing skills such as IUD insertion. As a result, many workers are unable to attain certification. At present, training is highly centralized, with trainers provided by DOH headquarters or the regional training offices. Trainers are responsible for all DOH training courses, not just FP/RH, so scheduling remains a problem. Few LGUs have developed a solid group of trainers, and they thus remain dependent on the DOH. Many LGU officials are concerned with the cost of training and with the long periods of time that health staff members are absent from health centers to attend training courses.

DOH training staff is limited, with 6 trainers at DOH/FPS, 80 at the 16 regional offices, and approximately 280 at the LGU level (about 2 trainers per LGU).

CBT for health workers is not new. With assistance from AVSC, a CBT program of physicians and related health staff members for voluntary surgical contraception (VSC) has been used for some years with good results. The idea of extending the CBT system has been discussed for much of the 1990s among DOH, donor, and NGO staff members. Finally, a revised training strategy was approved in 1996. By early 1997, 15 SIMs that are key to implementation of the new training strategy were developed. In August 1997, the DOH approved plans to initiate a pretest and to plan for the pilot-test phase. Members of FPS/Training, MSH/DA/EDF, JHPIEGO, and AVSC participated in workshops and other meetings to develop each module.

The modules were pretested in late 1997 and modified based on the pretest results. LGU trainers and preceptors and DOH regional training office staff members from four provinces, Bulacan and La Union in Luzon and Eastern Samar and Northern Leyte in the Visayas, were trained in the new SIM system in January and February 1998.

A pilot phase will test two models for implementing the SIMs training. In the first model, 60 service providers (30 each from Bulacan and La Union) who have not previously taken the basic and comprehensive FP courses received copies of the SIMs in late February to begin a month of home reading. The participants will meet together in late March to take the posttests. Participants with a passing score of 85 percent on each SIM will then continue in mid-April with the CBT phase—five days of preclinical training and five days of clinical training.

In the second model, 15 untrained service providers from Eastern Samar and 15 from Northern Leyte provinces began three weeks of training in mid-March. The first week of this training is devoted to facilitated reading of the SIMs, followed by two weeks of CBT for those who pass all of the SIMs.

Instructors for the pilot phase consist of the previously trained LGU trainers and coordinators, the regional coordinator and trainer, and two FPS/Training trainers to serve as monitors.

The two models used in the pilot phase will be monitored and evaluated by the U.P. Population Institute. A final report with a recommendation of which model is most cost-effective and best suited to the Philippine milieu is due by the end of May. Assuming no major revisions are required for the SIMs, training of regional trainers in the remaining 12 regions could commence in June or July. To speed up the training process and to maximize the use of trainers, EDF plans to conduct two courses simultaneously.

The new training strategy uses an improved training methodology. The SIM system theoretically allows workers to study at their own pace. The CBT makes use of models and role playing to improve skills. The courses are sequential and focus on skills development. The strategy offers the potential for lowering training costs and reducing training time, two important factors in seeking financial assistance for training from LGU leaders.

However, the process is taking far longer than planned. After completion of the modules in early 1997, DOH approval for pretesting the SIMs was not obtained until August 1997, and approval for the pilot testing of the SIMS was issued in February 1998. Final DOH approval will happen only after the pilot test is completed and evaluated by mid-1998. The DOH will be hard pressed to complete the pilot-testing phase, make its evaluation and curriculum revisions, decide which SIM model to use, train trainers in the remaining 12 of 16 regions by late 1998, and then train staff members in 50 LGUs by the end of 1998.

The impact of the SIM/CBT program for FP/RH has been negligible because it is still in the testing stage. LGU trainers will probably not initiate SIM/CBT training until 1999, leaving only limited time for evaluation of its effectiveness and cost before the USAID project ends.

A continuing problem is the coordination of training among various units within the DOH and among the major donors (USAID, UNFPA, World Bank, and AusAID) to avoid overlap of training and to get all donors to follow one national training strategy.

There is no assurance yet that LGU leaders will allocate budget for the revised training strategy, even though there may be a reduction in time away from the health clinics for training and costs may be lower. This uncertainty is a major concern for sustainability of the FP/RH program. Training needs are now determined by each LGU, and funding should be included in the LPP.

There are continuing problems with local training. Public training sites are not always available, so costs are increased by renting space in hotels. Control over participant selection is limited because of the differing interests of the executives of each LGU. Costs of transportation to the training site are not always available.

A further concern is the potential dilution of FP within the DOH's new FP/RH approach, which encompasses 10 activities. With local health workers already responsible for a great variety of health activities, the FP/RH approach adds to that burden.

The SIM/CBT modules on communication and counseling should help individual health workers counteract rumors and misconceptions about contraceptives that are often cited as the reason for low use of modern methods and high dropout rates. However, since rumors and misconceptions about contraceptives have been given as reasons for low use over the past decades, it will be essential to monitor actual health worker counseling to make sure that the workers are not a part of the problem, rather than a solution.

The availability and use of pelvic models for IUD insertion practice appears to improve performance and to prepare field workers better when they actually meet clients in the clinic setting. Models for the 50 LPP LGUs have been ordered by MSH and are currently in the POPCOM warehouse awaiting distribution. The development of practicums in FP/RH for nursing and midwifery students under faculty supervision has provided a boost for training. The use of the models should allow workers to gain competency skills more quickly and to meet competency requirements working with fewer clients. This improvement is significant because many health centers do not have enough FP patients to allow each student to serve the 10 to 15 IUD patients now required for certification.

5.3.3 Implementation of Enriched, Integrated FP/RH Curriculum in the Midwifery Schools

The target for December 1997 was for the enriched, integrated FP/RH curriculum for midwifery to be developed and implemented in 90 percent of midwifery schools.

5.3.4 Implementation of Enriched, Integrated FP/RH Curriculum in the Nursing Schools

The target for December 1997 was for the enriched, integrated FP/RH curriculum to be developed and implemented in 90 percent of nursing schools.

Because the targets and activities for sections 5.3.3 and 5.3.4 are so closely intertwined, they will be discussed together.

The enriched, integrated FP/RH curriculum has been developed by the ADPCN and the APSOM, with technical assistance from JHPIEGO. Development of the new FP/RH curriculum has been under way, with JHPIEGO assistance, for nearly 10 years. Education skills courses were developed and conducted for selected faculty members after a survey found a strong need for faculty training in FP and CBT related to VSC programs. Training courses for VSC providers, developed with the assistance of AVSC, have used the CBT approach for some years .

A series of manuals on family planning for both instructors and students at nursing and midwifery schools were developed, tested, and published in the mid-1990s by ADPCN and APSOM, with the technical and financial assistance of JHPIEGO. The FP/RH component of the pre-service training of both nurses and midwives now follows the CBT approach. In theory, as the well-trained, newly graduated nurses and midwives become employed in the public or private sectors, the need for in-service training in FP/RH should be reduced. However, at present both nurses and midwives still need the basic and comprehensive FP courses to gain the clinical skills needed to be functional in the workplace. Since the faculty members also teach other courses, there may be some transfer of the CBT methodology.

According to the DOH 1996 FP, MCH, and Nutrition Status Report, instructors at 103 nursing and 94 midwifery schools had been trained in the new competency-based curriculum. ADPCN and APSOM, with JHPIEGO support, trained instructors in the new curriculum at 14 nursing and 13 midwifery schools. These institutions were selected because of institution and faculty interest and capability.

Staff members of both ADPCN and APSOM agreed on the timeliness, effectiveness, and high quality of the JHPIEGO assistance. USAID funding for the JHPIEGO office terminated at the end of February 1998, but project staff anticipate funding from the Dutch Government to work with ADPCN and APSOM on pre-service training for FP/RH.

As a special aid to service providers, a detailed "Clinical Standards Manual" has been developed with MSH technical and financial assistance for use by FP/RH service providers. Under current MSH plans, 15,000 copies will be printed and widely distributed in late March 1998 (12,000 copies funded by USAID and 3,000 copies by UNFPA). The aim is to give service providers an easy-to-read complete reference manual to supplement their formal and clinical training. The manual will supplement other materials for pre-service training of nurses and midwives and for in-service training programs for health workers.

Will the SIM/CBT and JHPIEGO in-service training courses be institutionalized and sustainable in the future? There is no firm answer yet. The political will and leadership of national and LGU officials will play an important role in determining the priority given to FP/RH and the funding provided for such programs. At the moment, the institutionalization process is in an early phase,

and financial sustainability is yet to be seriously discussed. Dependence on donor support remains high and will likely continue in the near future.

With LGU officials now responsible for providing health services, the need is great to train local health officials in advocacy and skillful presentation of the rationale for health programs in order to win support for budget requests. The lack of advocacy training will be a serious handicap for garnering larger LGU health resources for all program activities, including training.

5.3.5 Accreditation and Professional Certification

As part of its overall monitoring and standard setting responsibilities, the DOH/FPS created an ad hoc Accreditation Committee in 1996 to set criteria and to provide certification of training institutions for FP/RH. FPS has requested that the committee be institutionalized and its procedures publicized. The FPS Training Division serves as the secretariat for the committee. A similar ad hoc accreditation board was formed in the early 1990s, but lapsed in the mid-1990s. It accredited training institutions for FP training; a separate board dealt with certification for voluntary sterilization. The current accreditation committee was established in 1996 and provides accreditation for training institutions, training curriculum, and trainers. It does not provide certification for FP/RH service providers, which is a function of the Professional Regulations Commission. The committee is composed of five members selected from NGOs and one retired DOH employee. The committee aims to meet once each quarter. An application for certification is sent to the FPS/Training staff for review to make sure all necessary documentation is included, and then it is forwarded to the committee. At least one committee member is sent to observe training, check the qualifications of the trainers, check the facilities, and make a recommendation to FPS/Training. An institution is initially accredited for three years; later accreditations are for five years. Accreditation is for the comprehensive FP training and the specialized voluntary sterilization training programs.

To date, the committee has approved 10 applications and disapproved one. The applications have come mainly from NGOs and a few large teaching hospitals. No applications have been received from any DOH training institution, such as the Regional Training Centers. The committee faces several problems in meeting its responsibilities, especially a lack of funds for site visits, a limited time for members to undertake site reviews, and inadequate publicity to institutions on the need to get certified and the procedures to be followed.

Of special concern to USAID is the fate of 27 colleges of nursing and midwifery that received technical and financial support from JHPIEGO through ADPCN and APSOM. None has yet been accredited as a training institution. With assistance of the JHPIEGO office, some documentation has been forwarded to FPS/Training. However, with the closing of the JHPIEGO office at the end of February 1998, the staff of ADPCN and APSOM will have to assist the 27 schools with the accreditation process.

5.3.6 The Role of Health Manpower Development and Training Service (HMDTS)

The main functions of HMDTS are to serve as a clearing house for all DOH training and to manage all training with other DOH units providing technical specialists. In practice, its role and involvement in planning, designing, and implementing training are less clear, although HMDTS appears to be better coordinated and more involved at the regional training offices.

In response to the many complaints about a lack of coordination of training within various DOH offices and with international donors, the Secretary of Health issued Administrative Order No. 31 S. 1997 on December 10, 1997. It attempts to resolve some of the persistent problems facing the DOH regarding training: the overlapping of numerous training courses, the strong top-down approach to training, and the inefficient use of training resources. The order emphasizes the need to make training relevant to LGU needs and to focus on the actual competencies needed by health workers while minimizing the time workers are absent from their posts.

HMDTS is given a central role to ensure that training programs are integrated and that competencies are clearly defined. Further, HMDTS is responsible for coordinating all DOH training. Funding of integrated basic and refresher courses is to be incorporated into the HMDTS budget, rather than in the budgets of each DOH unit. HMDTS is given a role in helping ensure that donor training assistance is incorporated into existing integrated courses.

Since the Administrative Order is so new, it is not possible to comment on its impact on the integration and coordination of training programs within units of the DOH and with international donors. It appears to be a step in the right direction.

5.3.7 Benchmarks

Benchmarks now focus on quantity, that is, strategies approved, trainers trained, and training courses held in a certain number of LGUs. The more difficult benchmark to design and measure would focus on questions of quality: Are trained staff performing better? Are counselors answering questions about rumors? Has repetitiveness and overlap of training been eliminated? Is the cost of training declining? And are LGUs picking up a larger proportion of training costs?

5.3.8 Role of the Cooperating Agencies

Technical assistance and most of the funding for FP/RH training has been provided through the CAs, such as MSH, JHPIEGO, and AVSC. In general, staff members of DOH/FPS, ADPCN, and APSOM give high marks to the assistance. The CA involvement was originally designed to give each CA considerable financial power, as well as authority from USAID to take a major role in design and implementation of programs with the DOH. The line between a CA role as technical advisor and as program implementor was blurred. Each CA finds itself in a difficult position, facing demands from USAID to achieve a certain level of performance on the one hand, while

attempting to involve DOH counterparts in program implementation on the other hand. Some CAs appear to have struck a better balance than others.

5.3.9 Advocacy Training for LGU Health Officers

Since devolution, local government officials are responsible for providing funds for the LGU health programs. Health is seldom seen as a funding priority by the local officials, and health budgets suffer accordingly. Many LGU health officers have had little training in effective budget presentation and in good lobbying and advocacy techniques. POPCOM has proven effective at this type of advocacy and should be supported in this area.

5.4 Recommendations

35. POPCOM, in close collaboration with the DOH, should immediately begin to plan, organize, and implement training courses for LGU health officials in advocacy and in public presentation of budgetary requirements in order to ensure adequate funds for health programs, including training.
36. USAID should encourage the DOH to assume greater responsibility for coordinating the support of international donors to follow a standardized DOH-determined training curriculum for FP/RH in all LGUs, colleges of nursing, and schools of midwifery.
37. To reduce costs and increase the efficiency of FP/RH training, the DOH should review, update, and reissue the selection criteria for trainees. The DOH and LGU health officials should provide a more careful screening of candidates to ensure that those who receive training are willing to provide all FP methods.
38. With the natural family planning (NFP) method now included in the SIM/CBT system, the DOH, in collaboration with local research institutions, should undertake a careful study of NFP to ascertain its real family planning protection so that health staff members present a fair and accurate assessment of method effectiveness to clients.
39. The DOH's new FP/RH program encompasses 10 elements. The DOH should monitor implementation and should use OR as needed to determine if the health service providers are able to effectively deliver all elements of the program without decreasing FP services.
40. The DOH should publicize widely throughout public and NGO health facilities clear guidelines for accreditation of institutions, curriculums, and service providers. The DOH should assist ADPCN and APSOM to resolve outstanding issues regarding accreditation of the 27 JHPIEGO-assisted nursing and midwifery institutions.

41. A review of the future need and role of CAs in the training process should begin soon between USAID and DOH.

CHAPTER 6 RESEARCH AND TECHNICAL SUPPORT

6.1 Background

This section reviews three topics specified in the scope of work: (1) the research component of the PFPP, particularly the OR strategy; (2) the revised FP/MCH clinical guidelines and service standards or protocols; and (3) the NTAT and the RTAT.

6.2 Benchmarks

The DOH and USAID have agreed to five benchmarks for research and technical support:

1. Thirty (30) LPP/LGUs will have developed the capacity to manage and use OR studies on service delivery issues by December 1999.
2. Six OR studies on cross-cutting issues will have been conducted and their results disseminated by December 1999.
3. Three support DOH-FPS staff assigned in research will have completed on-the-job and other training for their support functions by November 1998.
4. National FP/MCH guidelines and service standards or protocols will have been reviewed, updated, and disseminated by December 1996.
5. The DOH will have developed a system for FP/MCH assistance to LGUs by April 1996 and will have implemented the system by June 1996.

6.2.1 Scope of Work and Cooperating Agencies

Four major questions were raised in the Scope of Work regarding research:

- (1) How effectively has the OR strategy developed and approved in 1996 been implemented by the DOH and the Population Council?
- (2) Have the findings of the four OR studies conducted since 1996 been used to improve program operations?
- (3) Is there a greater appreciation of the use of research findings for databased decision making by the LGU managers?

- (4) Has the capacity for managing FP/RH research been developed at the DOH and the LGUs? What measures have been taken by the Population Council to ensure that this capacity building succeeds?

The PFPP's research component was strengthened in 1996 as a result of the development of the OR Strategy. This strategy emphasizes the reproductive health approach to family planning and the development of the institutional capability of LGUs to undertake OR.

The Population Council's Asia and Near East Operations Research and Technical Assistance Project (ANE OR/TA) provides TA for OR.

The MSH—in collaboration with the Clinical Standards Technical Working Group (TWG) and reviewers from DOH-FPS, DOH-AIDS, AVSC, Philippine Federation of Natural Family Planning (PFNFP), UNFPA, and USAID—provided TA for the revision of the *Family Planning Clinical Standard Manual*. The Scope of Work asked about the effective use of the revised manual in the FP/MCH service delivery.

The IFPMHP NTAT is a DOH-POPCOM group that provides technical training and support to RTAT in planning, training, IEC, and logistics. The Scope of Work queried the effectiveness of these teams in providing technical support to LGUs.

6.3 Findings and Conclusions

6.3.1 Research Component

The Population Council initiated the ANE OR/TA Project in June 1992 with the objective of strengthening the in-country capability to undertake FP OR. The OR project, titled FPORT, conducted five diagnostic studies between June 1992 and July 1995 in collaboration with regional research organizations. FPORT engaged in a major TA activity, particularly the monitoring of use of the injectable contraceptive (DMPA) during the first phase of the DMPA reintroduction program. The Population Council also convened in 1996 a CYP working group composed of demographers, sociologists, and statisticians; it developed CYP conversion factors for six FP methods, which now serve as the basis for calculating CYP in the Philippine program.

The ANE OR/TA project's five-year contract was extended for an additional 30 months (from June 1995 until January 1998). This extension provided additional guidelines regarding the FPORT program's directions, reflecting specifically the 1994 ICPD reproductive health framework to family planning. Before the extension, a summary evaluation was undertaken, and the evaluation team recommended that the FPORT should undertake impact evaluation studies, develop institutional capacity within a few selected institutions, and test specific interventions. USAID/Washington approved a no-cost extension until July 31, 1998.

The USAID-DOH benchmark of training 30 LGUs was met in 1996. In fact, 35 FP program managers were trained in the basics of OR. The participants in the OR training workshops were chosen to represent provinces and cities identified by the DOH as those that showed the most potential in institutionalizing OR within their programs. It was reported that substantial efforts were made to extend TA to the LGUs with regard to project development. As discussed below, the assessment team found many examples of the effectiveness of the training workshops in making the program managers appreciate or use OR in their daily tasks or in evolving policy changes.

Four major project proposals were developed and eventually approved for funding: (1) Integrating RTI case management services within selected LGU health centers: An intervention study; (2) Training FP service providers in information-giving: An intervention study to enhance quality of care in the public health sector of Davao del Norte province; (3) Improving quality of care in FP/RH services of selected communities of Pangasinan province: An intervention study; and (4) Male involvement through reproductive health awareness in Bukidnon province: An intervention study. The Davao and Pangasinan projects are implemented in collaboration with AVSC, while the Institute of Reproductive Health of Georgetown University is providing substantial inputs to the male involvement project in Bukidnon.

Each of the foregoing projects touches on at least one of the cross-cutting issues of reproductive health, quality of care, and gender, which were earlier identified by the OR task force, a working group that was formed by the FPORT project. The OR task force includes representatives from the DOH, USAID, academic institutions, and the LGUs.

The RTI intervention study was completed in January 1998. The other three OR projects are making good progress toward the implementation of the research and intervention components. The project investigators are now in the process of finalizing their completion.

The FPORT program encountered a number of problems in conducting the foregoing studies. The process of project development tended to be more intensive, were more time-consuming, and required more TA than originally anticipated. There was difficulty in identifying competent researchers, especially in the provinces. Experienced researchers were overly committed, and the junior researchers often did not have the needed exposure to OR techniques, particularly implementation of field-level intervention. Familiarity with existing literature on cross-cutting issues was limited. Although collaborative approaches with other CAs had several benefits, collaboration required additional time from busy researchers for intra-project meetings and communication.

Meeting the expectations of various key stakeholders, particularly USAID, DOH, and the ANE OR/TA requires much time, because proposals must be reviewed by them. Each stakeholder makes its own comments and suggestions, and the administrative regulations of each agency must be considered. For example, USAID regulations disallow allocation for non-USFDA-approved drugs, but such allocation is a vital component of the intervention study of RTI case management.

Thus, funding sources from LGUs and drug companies had to be identified and negotiated, which again required time from the FPORT program and LGU staff members. The demands from different quarters often mean that various changes must be made in the original proposal. Thus negotiations with the research team and the LGU partner are undertaken before the final proposal is drawn.

The FPORT program staff members will have to address internal priorities of the various stakeholders at various phases of the project's life. These priorities include addressing progress reports, which are expected by the DOH and USAID; delay of promised LGU counterpart fund releases caused by bureaucratic problems; and multiple commitments of researchers at school and in research.

The staff of the Population Council consists of only three senior and three support staff members who are "striving always, in juggler-like style, to keep several balls (i.e., projects) in the air simultaneously." While each project may demand undivided attention, this kind of concentration is not possible because of the varied demands on the few personnel.

Despite the foregoing difficulties, FPORT program staff members concluded that the "process as a whole remains a rewarding one." They noted a high probability that the results of this study could make a significant contribution to reproductive health policies in the country, particularly in the area of RTI case management.

The national dissemination of the RTI study took place in January 1998, and it was attended by the Assistant Secretary of Health (who heads the OSC), the head of the STD/AIDS Unit, two USAID representatives, and the FPS staff, as well as program managers and researchers. It resulted in the reactivation of the RTI task force within the DOH. The Assistant Secretary of Health noted that the study was "extremely useful and path breaking," and the discussant from the WHSMP commented that "this will make them take a second look at the syndromic approach" in the implementation of their own projects. The DOH officials convened a meeting afterward to discuss the possible implications of the RTI project for DOH.

During site visits where the four OR intervention studies are conducted, observations by the assessment Team revealed positive results from the OR experience, not only among the researchers, but also among the program managers, LGU health providers, local officials, and regional DOH staff members. Program managers feel a sense of ownership of the research findings because they have been involved with their research partners at all stages, from the design and implementation to the use of the data. The participating health providers of the RTI project from Luzon and Mindanao found the training in Cagayan de Oro comprehensive and useful, unlike previous orientations on the topic. They also noted that they received several useful materials and sufficient logistical support (drugs and equipment) while conducting the project.

The program managers found that the "facilitative monitoring" of the FPORT program staff was helpful and kept them on their toes. OR also taught them to apply data for the effective

management of their programs. They noted that they have become more sensitive to their clients, who are mostly women, because they have gained more confidence in the way they deal with the women. They are also made more conscious of the women's privacy and reproductive rights. The managers think that women in their areas are more aware of RTIs. They do not get only "incidental" clients anymore, but because of their information campaign, women—and sometimes men—come to the health center for consultation regarding RTIs. Some LGU health officials have also pledged support to participating program managers beyond the project life by providing the needed drugs for RTIs.

The midwives interviewed from the experimental areas in Davao del Norte were excited to share that their training in the "GATHER" approach (GATHER is an acronym that represents six elements in family planning and reproductive health counseling) made them more confident in talking about FP to the women in their areas, and that now more women come to their BHSs for FP needs. The midwives claimed that they have become more sensitive to the feelings and needs of their clients. The presentation of results at every phase of the project through the Rapid Assessment Feedback Team (RAFT), which involved municipal, provincial, and regional health staff members, was viewed positively because action could be taken immediately to improve operations of the health facility and personnel.

In Pangasinan, the training of the Barangay Service Point Officers (BSPOs) and Supply Points (SPs) on the unmet need algorithm and referrals made by BSPOs are beginning to be acted on by SPs, while the data generated from the master list are providing the basis for the outreach workers' plan of activities. The male involvement project team in Bukidnon just completed its diagnostic phase, and the team is starting training with Georgetown University for male and couple FP advocates with an NGO agricultural cooperative. The selected ethnic community and the LGU are eager to participate in the training and other related activities of the OR project.

Similar problems cited by The Population Council were also mentioned by provincial program managers and researchers when they talked about the amount of the time required of them to focus on the demands of their projects. It was also pointed out that OR can be expensive because of hidden costs associated with several meetings and follow-up activities. Despite the demands of OR, all the participating LGU health providers have become better health providers and managers, and would like their colleagues to undergo similar experiences. The providers claimed that many colleagues have been asking when it will be their turn to receive OR training. The control communities in Davao del Norte are eager to have the same training inputs from AVSC, but they have been advised to wait until the experiment is completed. There is apprehension that support from this TA will no longer be available when the experiment is finished. The researchers also claimed that they find satisfaction in their collaboration with program managers and health workers. They feel that they are making a useful contribution to their communities because they can see immediate changes that are taking place as a result of their intervention studies.

The Population Council has addressed concerns about the dissemination and use of OR findings as they try several strategies, such as holding end-of-project dissemination seminars, and

distributing project documents that include final reports, executive summaries, research updates, policy briefs, and press releases.

The FPORT program is in the process of undertaking its fifth OR research on cross-cutting issues, particularly on the high usage of IUD in Region 10. This topic emanated from the results of a recent national study that showed unusually high usage of IUD in Region 10. IUD use throughout the country is extremely low (roughly 3 percent of all contraceptive users), despite substantial investment in training, IEC, and availability of IUDs nationwide. The purpose of the OR is to identify the factors related to the comparatively high rate of IUD use for possible replication in regions with low IUD use. The FPORT program intends to pursue critical issues in reproductive health in the future. As a result of a regional meeting on youth in Nepal, the FPORT staff is developing future OR projects on adolescent RH and sexuality. The staff members intend to continue working with POPCOM and the DOH, as well as with other regional agencies.

While the capacity for managing FP/RH research is being developed at the LGU level, the current DOH/FPS staff needs more hands-on training or immersion in OR projects. The staff members have had training in the principles and methods of OR from Population Council, as well as in research methodologies and in research dissemination and use from other local and foreign training institutions. Thus the staff needs to spend more time with the FPORT program staff to gain experience with the OR process. This collaboration is easier said than done. The FPORT staff is busy managing the four OR projects (and developing new studies). The head of the FPS research staff is also the component leader of RP 3 and, with the staff, has been assigned to assist in setting up the Reproductive Health Advisory Council, as well as to undertake a project on NFP. The previous head of the FPS research section has had more intensive exposure to OR and research, but is no longer assigned to that section. The FPS research staff may encounter serious difficulties in its effort to monitor and provide TA on OR to LGUs.

In conclusion, the FPORT program is meeting or even surpassing its benchmarks, despite limited staff and other constraints in managing the OR projects. Capacities are being developed at the LGU level, and there appears to be greater appreciation regarding the use of OR findings for decision making and program operations at the local and at the national levels. There is a need to transfer OR technology to FPS research staff members if they are to assume the responsibility of monitoring and developing LGU capability in this area. The constraints of holding multiple responsibilities at the DOH among the research staff will make the institutionalization of OR difficult.

6.3.2 Revised FP/MCH Clinical Guidelines and Service Standards or Protocols

Recent developments in contraceptive technology and the inclusion of the injectable contraceptive, NFP, LAM, and RH in the new training curriculum required an update and revision of the 1993 FP clinical standards manual. It took about one year for the manual to be modified after the 1996 approval for revision. The MSH and the technical working group spearheaded the

revision of the manual, which was to be circulated in 1997, but is still in press and is due to be issued in late March 1998. This publication is to be used as a reference in the field and for the training curriculum of health providers. In conclusion, the effectiveness of the revised manual can be assessed after its circulation this year.

6.3.3 The NTAT and RTAT

Since the last quarter of 1996, the NTAT has provided technical support and training to RTATs in the areas of planning, IEC, logistics, nutrition, and FP. The NTAT divided the regions into four clusters (two in Luzon, one in the Visayas, and one in Mindanao) and assigned some national DOH and POPCOM staff members to become part of an ad hoc body that provides technical assistance to RTATs on various topics. Some NTAT members are assigned to take care of two clusters. Regular NTAT meetings and a yearly schedule with RTATs have been prepared for various activities.

Some NTAT members perceived that their strengths lie in their ability to upgrade their own and the RTATs' technical skills, as well as in their capacity to build rapport between the national and regional staffs. They also bring together skilled staff members from different services. However, because of their assignments in the national headquarters and competing demands from their immediate supervisors, a number of NTAT members could not provide support for the regions. Among the primary roles of the DOH is to provide technical skills to the regions, but NTAT tasks seem to appear as add-ons to the current work load among those assigned to participate in the team.

The perceptions about NTAT from the site visits are generally favorable. During the RTAT training with LGUs in the south, some NTAT representatives were present and provided the needed support for the trainees to try out the skills obtained from the training provided earlier by the NTAT. Feedback to the assessment team indicated that the NTAT representatives who provided training were "workaholic" experts, because they achieved results and they came when they were "most needed." The NTAT's assistance in formulating comprehensive plans for LPP was perceived to be satisfactory. The NTAT members used adult education approaches and provided the RTAT with the needed experience. There is a perception of rapid turnover among NTAT staff members, although it may be a misperception according to one NTAT member. Assignments in two or more clusters and substitution in the event that superiors did not approve participation on NTAT tasks may have given the impression that rapid turnover is taking place among NTAT members. However, the NTAT replacements are perceived to be good, and they are present when requested to come. A few NTAT representatives were not as capable, and it was suggested that before they are sent to the regions, they should undergo rigorous training from other experienced and competent NTAT members.

Observations made during an NTAT training in one Luzon cluster noted that the NTAT was holding the training in a large, dimly lit room, with about 40 RTAT members. Multi-method

approaches were used in the training—lectures (which are at times too long), discussions, completing responses on colored paper, and occasional icebreakers. Still, the processing of the outcomes of the various exercises needed some improvement. It was unclear who assesses or provides feedback to the NTAT regarding their representatives' training format and presentation skills.

In conclusion, the NTAT and RTATs have been in place since 1996. Although the NTAT seems to make a useful technical contribution to the RTATs and LGUs, it is constrained by competing demands from the members' mother units. Because a number of NTAT staff members could not attend to their assigned clusters regularly, some RTATs have perceived a rapid turnover among NTAT members. Observations made during an NTAT training session for RTAT suggest that an assessment of the NTAT's training format and its representatives' presentation skills would be useful.

6.3.4 Sustainability

The intervention studies have demonstrated that OR is a useful tool for LGU program managers in various aspects of their work. A number of program managers would like OR training, but it is expensive because of time and financial requirements. If the training could be simplified and the cost reduced, some LGUs and local private donors might provide support for this undertaking.

The clinical guidelines and service standards and protocols manual should be continually updated by the DOH, because one of its major responsibilities is to provide national standards for health technology. The DOH should allocate a budget for the regular update of this manual.

The NTAT and RTAT are ad hoc entities that assume important functions that are expected of the DOH in a devolved system. The DOH should allocate institutional and financial support for the further enhancement of the skills and work environment of these technical groups.

6.4 Recommendations

42. The FPORT program is meeting the benchmarks of training staff members in 30 LGUs to manage OR projects and to conduct OR intervention projects on cross-cutting issues in selected LGUs. It should also focus on the provision of skills to the national DOH-FPS research staff before the end of the project cycle.
43. The DOH-FPS must decide whether it is seriously pursuing the institutionalization of OR within its structure. To do so calls for trained personnel who allot full-time attention to imparting OR skills to the regional staff, as well as to transforming OR results into issues and lessons for policies and programs. Given the current limitations on staff, the DOH

should focus on training its research staff members to serve as research program managers, and should use the academic community to carry out OR.

44. Because of the increasing demand for OR skills, the DOH-FPS research staff, in collaboration with the FPORT program staff, should work out other mechanisms with the LGUs and regions for imparting OR skills and for using the OR results to improve program operations and advocacy to LGEs. The LGU program managers, as well as local researchers who have undergone the OR process, may be tapped as resource persons and encouraged to share with their colleagues through research, through visits to their health facilities, and even through other modes of learning.

FP/MCH Guidelines and Service Standards and Protocols

45. Despite having the 1993 clinical guidelines for reference, a number of health providers continue to exhibit misconceptions and inadequate understanding about family planning. Therefore, apart from distributing the newly revised manual during the CBT, the DOH, with MSH assistance, should develop more effective ways of disseminating the material to field staff members, especially to those who have been trained in the old basic or comprehensive family planning course.

NTAT and RTAT

46. Given the perceived value of the technical contribution provided by the NTAT to RTAT and LGUs, the DOH should consider changing the status of NTAT from an ad hoc body to a more permanent body within the DOH.
47. New NTAT members should receive hands-on experience and training from more skilled NTAT members before being sent to the regions to provide training to the RTAT.
48. The DOH should develop mechanisms to regularly accredit or assess the facilitating skills of the NTAT presenters and the format of their training activities. Such assessment would help improve the NTAT's capability to impart technical skills and to assist the RTAT in various aspects of FP and other health services.

CHAPTER 7 PROGRAM MONITORING

7.1 Background

The DOH developed a new approach for monitoring FP, MCH, and nutrition services in 1996 as a response to the requirements of the post-devolution period. The new MIS strategy requires the collaboration of the DOH and the LGUs in the collection and use of information and in the cost sharing of health-care service. This approach is intended to reduce record keeping by frontline health service providers in the country. It uses various methods to collect information that is useful at different levels of the health care system.

The MIS strategy emphasizes (1) the use of program data for decision making at local levels; (2) the use of provincial cluster surveys to measure FP, MCH, and nutrition program performance from public, NGO, and commercial sectors; (3) the use of riders to NSO's Labor Force Survey; and (4) periodic demographic and health surveys to evaluate the program's impact on the population at the national level.

The MSH is the main CA providing technical support in the development and operation of the new MIS strategy. Other CAs that have provided MIS-related information and assistance include Population Council, JHU/PCS, JSI/FPLM, U.S. Bureau of the Census (BUCEN), and MACRO International.

7.2 Benchmarks

The DOH and USAID have agreed on three benchmarks for strengthening the national program monitoring system:

1. A yearly population-based FP survey will be conducted by the NSO.
2. A yearly national FP/MCH status report will be produced by the DOH/OPHS.
3. A national management system to monitor FP/MCH performance will be put in place by 1998.

This assessment of the new MIS strategy focuses on (1) the effectiveness of the DOH and MSH's approach to ensure that the new MIS, which was developed and approved in 1996, is in place in 1998 (a corollary item is the appropriateness and efficacy of the technical assistance extended by MSH to DOH on the new MIS); (2) the degree to which the various key players within the DOH are informed about or are on board with the new strategy; (3) the utility of the results of the FP surveys and the 1997 MCH rider survey to the various program stakeholders; (4) the effectiveness

of the BUCEN's technical assistance to NSO when conducting the annual FP surveys and when strengthening the administration of such surveys in the future; and (5) the progress toward institutionalization and sustainability of the various data-gathering mechanisms of the new MIS at the DOH and LGU levels.

7.3 Findings and Conclusions

7.3.1 The DOH and MSH's Approach to Installing the New MIS Strategy in 1998

The *MIS Strategy (1996–2000)* provided the framework and guidelines on how the new MIS strategy of the DOH should be implemented. The strategy identified information needed about FP, MCH, and nutrition by various tiers of the health system, and it determined the data collection methods and utility of the information that is to be gathered.

New roles and responsibilities were delineated when implementing the new MIS strategy. A functional Technical Work Group (TWG) on MIS was formed with representatives of the key stakeholders: DOH units (FPS, MCHS, NS, and HIS); USAID; and CAs (BUCEN, MSH, and Population Council). Existing agencies are used to carry out the tasks at different levels of the health system, that is, NSO for the national surveys (annual riders and the National Demographic Health Survey [NDHS]); LGUs and research or academic institutions for the provincial cluster surveys; the DOH and LGUs for the situation analysis; the DOH-HIS and LGUs for the nutrition surveys; the DOH-MCHS and LGUs for EPI master-listing; selected LGUs with the DOH and MSH for the community-based FP Monitoring Information System (CBFPMIS) master-listing; the DOH-FPS with the Population Council for OR; and MSH and the DOH-HIS for program data use and dissemination of the modified FHSIS.

In other words, new structures were created to collect and process program-based and population-based data. If appropriately used, the data generated from the various sources by existing entities are suitable for different levels of the health system.

Implementation of the new MIS strategy is generally on schedule. The FP and MCH rider surveys were conducted in 1997. In fact, the NSO 1997 report on the FP rider survey has been published, and the data set of the MCH rider was turned over in January 1998 to the DOH-MCHS for analysis and use. The 1998 NDHS (the National Demographic Survey and National Health Survey are combined because of resource constraints) is in the process of collecting data. Despite bureaucratic difficulties within LGUs, the provincial cluster surveys among 46 LPP-supported LGUs have been administered and disseminated to participating LGUs and at the national level. OR training for 30 LGUs, along with one OR intervention study, has been completed, and three projects are working toward completion. Other tasks, such as developing guidelines and software for the community-based FP monitoring, have been completed and piloted in two LGUs. EPI master-listing appears to be operational. The status report for 1996 of the FP, MCH, and nutrition has been circulated, and the 1997 status report is being prepared and will be completed in June

1998. Despite consistent complaints about delay resulting from devolution and work loads in frontline health centers, the modified FHSIS is being undertaken by LGUs and the regions. Pilot testing of data use of service and facility-based statistics is also taking place in four Bicol provinces. The client-based health information system, which entails developing software and computerizing facility-based data, is being undertaken in several health centers in Makati City at the NCR.

The MSH staff provided TA for the major components of the new MIS, including preparation or revision of (1) guidelines, questionnaires, and analysis of the cluster survey; (2) the FP questionnaire and the MCH questionnaire for the riders of the annual labor survey of NSO; (3) new health facility assessment instruments to monitor quality of care and to certify health centers; (4) community-based monitoring for FP; and (5) the 1996 FP and MCH status report. The MSH staff is also involved in preparing a research use manual for LGUs. Favorable feedback obtained from LGUs, RTATs, other DOH units, and related institutions indicate that the MSH provides appropriate technical support to the various components of the new MIS.

In conclusion, a new and appropriate MIS for the DOH and LGUs is being installed within schedule at various levels of the health system. The MSH assumes a major role in providing technical assistance to the various components of the new monitoring approach for FP, MCH, and nutrition services.

7.3.2 How Fully Informed Are the Key Players of the DOH and the LGUS About the New MIS Strategy?

The stakeholders of the DOH, particularly the units involved in the IFPMHP, are aware of the new MIS approach. The DOH has formed an MIS/TWG with representation from the vital program units. The TWG has circulated publications explaining the new MIS and its various components. They have included this explanation in their 1996 FP/MCH and Nutrition Status Report as a cross-cutting activity. All concerned units are cooperating in successfully implementing this new approach to the monitoring and information system. The NTAT also presents this new strategy during the orientation and training of RTATs in the different clusters. During the evaluators' site visits, the September 1997 IFPMHP update, which focuses on the MIS, was available in the regional and provincial offices. The LGUs involved in the cluster survey discussed their experiences and their learning about this data collection mode. The LGUs compared the outcomes of the cluster surveys with the national studies.

In conclusion, the key stakeholders of the DOH are well informed and are involved in the new MIS. This new approach has been disseminated at the regional and LGU levels. The outcomes of the surveys at the national and local levels have been used to assess the current performance and impact of FP, MCH, and nutrition services.

7.3.3 The Use of the Results of the Annual FP Surveys and the 1997 MCH Rider Survey to the Various Stakeholders

The major stakeholders of the annual FP survey have used the research outcomes to track the trends of contraceptive prevalence, contraceptive usage, sources of modern contraceptives, and high-risk pregnancies. They have also used the outcomes to set the program agenda for the coming year. The FP surveys are published and circulated to the regions. They have been used in determining how far the program is from attaining the benchmarks and what further action should be taken to enable the DOH to achieve the benchmarks under the IFPMHP. In preparing the indicators for the national surveys, pertinent DOH units worked closely with MSH and the NSO. The 1997 MCH rider survey tables were turned over by the NSO to the DOH in January 1998, and these tables are currently being analyzed and used for program planning by the MCH. The questions in the MCH rider survey did not follow the standards of the 1993 National Demographic Survey; thus the utility of the survey results was compromised.

In conclusion, the results of annual FP surveys have been useful to major stakeholders of the DOH and to some LGUs in assessing the impact of the FP, MCH, and nutrition services and in relating these services with their benchmarks.

7.3.4 Effectiveness of the BUCEN's Technical Assistance to the NSO in Annual and Future FP Surveys

The NSO found the assistance of the BUCEN consultants very useful, especially in developing the master sampling, because this aspect needs refinement until the year 2000. The task also includes mapping and household listing. There are few Filipino sampling experts. The BUCEN's specialist on master sampling was described as hardworking, and he worked closely with the NSO staff. Whenever the NSO requested the consultant's assistance, he would readily make himself available to the staff of the agency.

In conclusion, the BUCEN has provided the needed assistance to the NSO, particularly in designing the master sampling of the national FP and MCH surveys.

7.3.5 Progress Toward the Institutionalization and Sustainability of the Various Data-Gathering Mechanisms of the New MIS Strategy Within the DOH and the LGUS

The major stakeholders of DOH-IFPMHP expressed willingness to allocate budgets for the national rider surveys and the NDS that will be conducted by NSO after USAID assistance ends. Sustainability for these undertakings is reportedly possible for FPS and nutrition, but it is uncertain that MCHS will allocate funds from its budget, because of research methodological differences between the MCHS and the NSO. To ensure sustainability, the MCHS staff should follow worldwide standards and procedures relating to survey research, standards followed by the

World Health Organization, and should not insist on its own costly procedure of validating mother's recall or health card at the clinic. This procedure is now done in an attempt to make survey results more comparable to DOH administrative data.

A cluster survey in 46 LGUs by local research institutions (RIs) with the use of LPP funds demonstrated the survey's usefulness as a tool for planning and measuring performance. The cost of the cluster survey ranges from P150,000 (for the city) to P200,000 (for the province). In implementing cluster surveys, local research institutions experienced bureaucratic problems and delays with a number of LGUs because of varying procedures and varying understandings among LGU staff members about the research (i.e., it must undergo bidding, fund releases should be similar to infrastructure projects, and so forth). Many LGUs were not familiar with the administrative rules and procedures regarding commissioned studies. The bureaucratic requirements have resulted in delays in the administration of the cluster survey in a number of places. Some RIs were able to start early enough so that the outcomes could be presented to the LGUs before or during the planning and budget allocation. Others conducted their studies much later, so the utility of the research output for planning was not immediate. There were also some problems with the operational definitions of similar indicators to those used in the rider surveys. Some health providers would like to conduct the research themselves, noting that funds were available from the LPP. Delays in report writing took place because of the inability of a research institution to convince LGEs who wanted municipal-level analysis that such an analysis is not possible in the cluster survey design for the province.

The responses to cluster survey results from various sectors of the LGUs are generally favorable. The RIs that worked with LGUs gained both useful lessons and satisfaction in their partnership with LGUs. Some LGEs used the research outcomes for planning, and they pledged additional financial support for health programs to improve performance and even to finance future studies. Many LGUs would like to have regular cluster surveys with more indicators, but they recognized that this expansion is a costly undertaking for resource-strapped areas. Advocacy will continue to be a major part of efforts to institutionalize and sustain cluster surveys.

According to health providers in provinces and regions visited by the assessment Team, the modified FHSIS, although institutionalized at the LGUs, continues to face delays in submission of consolidated reports. Some LGU staff members still use the old format and set of indicators and submit the modified data requirements to the national office because they feel that the new version does not provide sufficient health information. Despite the simplified version, frontline providers claimed that the forms required many hours to complete, thus affecting their outreach and clinic services. Some regions are developing mechanisms to ensure regularity of report submission through their DOH representatives.

The OR, described in Chapter 6, is slowly making inroads into the management of LGU health-care facilities and personnel. Participating LGU program managers and RIs are better equipped than the DOH-FPS to use OR because of the intensity of their OR training and involvement. The SA is being used in planning at the LGU level, and the forms are undergoing modifications.

Master-listing schemes, such as the CBFPMIS in Pangasinan, show great promise in identifying and following up high-risk women and those with unmet need. The CBFPMIS is also demonstrating how BSPOs and the local population office can successfully collaborate with the local health office to meet women's demand for FP services. EPI master-listing is helping to track children for immunization, although this service is still facility-based and registry-dependent. The Social Reform Agenda-Minimum Basic Needs (SRA-MBN) data board provides visual master-listing of households in depressed municipalities, but it has inadvertently created social pressure and some problems for households with poorer health indicators. There is, however, concern that these various program-centered master-listing approaches would overburden community health workers and volunteers.

The enormous task of orchestrating the varied data-gathering schemes of the new MIS strategy and of consolidating research outcomes from these sources into an annual status report for FP, MCH, and nutrition is undertaken by an ad hoc TWG comprising members from various units and CAs.

Given the ad hoc or temporary stature of the TWG, its large task, the multiple responsibilities held by members, and the eventual withdrawal of technical assistance from MSH and other CAs, how can institutionalization of the complex components of the new MIS, especially at the LGU level, further progress or be fully realized? Which unit in the DOH should assume responsibility in coordinating these varied efforts on a day-to-day basis? Given the amount of advocacy and of technical assistance that are being generated from the various data collection approaches, which are just in the first stages of institutionalization among the LGUs, there is a need at the DOH for a more stable unit and for personnel who will take on the responsibility of coordination and technical assistance.

In conclusion, the national program monitoring system has attained its benchmarks and will most likely continue to do so in the remaining period of the USAID support. Among the various components of the new MIS, the national surveys and the FHSIS appear to be the most sustainable and institutionalized. More advocacy is needed for the integration of the cluster survey, OR, and other population-based approaches. The DOH also needs to identify a unit or body that will keep track of the varied data-gathering schemes of the new monitoring and information system and will extend technical assistance when needed.

7.4 Recommendations

49. The DOH should identify a stable and permanent unit or body that will assume the responsibility of coordinating, monitoring, and providing technical support as well as of the institutionalization and advocacy of the varied data-gathering schemes of the new MIS strategy.

50. Because of the varied administrative experiences in the conduct of the cluster survey, operational guidelines should be developed at the LGU level for smoothly implementing this research.
51. The various models of master-listing at the LGUs should be reviewed to complement program and service statistics. However, integrative master-listing should be considered when identifying other significant household members (adolescents, male partners, young children) as well as when maximizing efforts of the overburdened health volunteers.
52. Training should continue to be provided to LGU health providers and even LGEs on program and population-based data use to enhance their appreciation and ability to use their own data for planning, programs, decision making, and advocacy to LGEs and other sectors of their social mileux.

CHAPTER 8 ADVOCACY

8.1 Background

Over the past six years, the Philippine Population Management Program (PPMP) has enjoyed strong support from high-level policy makers. For instance, President F. Ramos has openly endorsed the program, and the DOH has stressed family planning as one of its key programs. While Congress has been more modest in its support, a number of important legislators, especially in the House of Representatives, have strongly supported the program. Advocacy to create a favorable policy and program environment for the PPMP is a key responsibility of POPCOM. POPCOM's advocacy program is intended to achieve greater understanding, acceptance, and support for population policies, including FP/RH policies, among influential persons at national, regional, and local levels.

With the passage of the Local Government Code in 1991, the responsibility of implementing the population and the FP program was transferred to the LGUs, with POPCOM providing guidance. Support for the program has shifted radically to the local chief executives. The LCEs and other local officials ultimately become the key persons in deciding the priorities for their constituencies. The role of advocacy is to make them appreciate the role of population and development in their local programs and to enlist their support for stronger FP programs.

Toward this end, POPCOM, with assistance of the TFG Policy Project, has developed and is implementing the National Population and Development Advocacy Plan (NPDAP) for the years 1996–2000. The NPDAP was approved by President Ramos and the POPCOM Board of Commissioners in July 1997. Key to implementing the plan is a survey of LGU commitment. Conducted in 1996 with assistance from the Policy Project, the survey of LGU commitment resulted in information about LGU officials' perception of priority problems. While almost 90 percent of LCEs perceived rapid population growth as a problem, population was ranked low when compared with other problems such as unemployment and poverty. To meet a benchmark requirement, POPCOM plans to conduct a similar survey, following the May 1998 election, to determine the thinking of newly elected officials and to measure their commitment to the population and FP program. While the Policy Project trained POPCOM staff members to analyze the survey data, a number of those trained have left POPCOM. Thus the Policy Project will again provide funding and TA for the 1998 survey. The survey results will form the basis of an advocacy plan to assist the newly elected officials to gain a better understanding of the relationship between population growth and the issues they perceive to be most important.

In 1996, in response to President Ramos' call, pledges of commitment to support the PPMP were given by members of POPCOM's Board of Commissioners, who were also heads of line ministries. POPCOM with assistance from the Policy Project and UNFPA has been working with the line agencies to integrate population concerns into their various programs and to translate

these pledges of commitment into specific annual activities supporting the population program. If the GOP follows through on these pledges, support for population and FP programs could be strengthened.

Following the development of a national RAPID model in 1994, and 15 regional RAPID models later, nearly 2,000 presentations have been made to national officials and LCEs at various levels. In 1997, the Policy Project assisted POPCOM to develop a newer version of the national and 15 regional RAPID models. POPCOM views these presentations as instrumental in building support for the FP program. Following development of these newer models, USAID is funding, through the Policy Project, implementation of advocacy activities in all regions in 1998 and 1999. In addition, the Policy Project supported advocacy initiatives to enhance the passage of the population bill and the 1996 and 1997 National Population Congresses.

The RAPID presentations were preceded by a series of training initiatives for POPCOM staff members that included training on survey analysis using the Statistical Program for the Social Sciences (SPSS), on presentation software, and on the application of RAPID models. In addition to support for POPCOM, support was also provided to the DOH and the Philippine Legislators' Committee on Population and Development (PLCPD). The Policy Project executed by TFGI has provided TA to POPCOM and to participating agencies when implementing these activities.

8.2 Benchmarks

The POPCOM, the DOH, and USAID have agreed to three benchmarks for advocacy:

1. A national population and development advocacy plan (1996–2000) will be developed and implemented, including advocacy for PFPP among professional associations.
2. The 1996 and 1998 post-election surveys will be conducted to measure commitment to PFPP at the LGU level.
3. The number of professional associations supporting FP will be increased from one in 1993 to seven in 1999.

The first benchmark has been achieved, and support to PFPP has been provided at the request of POPCOM and the DOH. Advocacy for PFPP among professional associations is part of the plan, and initial steps have been taken toward getting the associations' commitment.

A survey to measure the commitment to the PFPP of LCEs and other local officials elected during the 1992 election was successfully conducted by POPCOM with TA from TFGI in 1993. A second survey was conducted in 1996. The results were encouraging because, for the first time, POPCOM was able to determine the level of commitment of local executives and to define advocacy needs to change their perspectives about program priorities. The third survey will be

conducted following the May 1998 elections. The results of this survey will be useful in determining the priorities and the level of support to the PFPP of new LCEs.

Initial steps have been taken to achieve benchmark 3. Thus far, POPCOM and the Policy Project have been working with the Rotary Club, which has agreed to establish a speaker's bureau on population and development and to co-fund some advocacy activities.

8.3 Findings and Conclusions

POPCOM is the main agency responsible for advocacy initiatives. Within POPCOM, the lead division is the Information Management and Research Dissemination (IMRD) Division. Technical assistance has been provided (in various forms from technical advice to subcontract funds) by TFG, mainly to POPCOM and its Population Regional Offices, the DOH, and PLCPD.

The review will focus on four areas: TA for capacity-building, effectiveness of TA provided, dissemination of the national PFPP strategy, and impact on the policy environment.

8.3.1 Capacity Building

TFG has assisted POPCOM since the early 1990s in developing the early version of the RAPID model and in computer and presentation skills. In 1994, presentation equipment, such as portable notebook computers and overhead projectors, were provided. Since 1994, training was carried out to strengthen the advocacy skills of POPCOM central staff and RPOs. The training focused on (1) basic demography concepts and advocacy techniques; (2) principles and techniques in making presentations using the "Benefits-Cost" of FP model; (3) PowerPoint™ computer presentations; and (4) basic demographic concepts, projection, and the Spectrum Model.

While POPCOM staff members have become skillful in advocacy planning and implementation in the past few years, there remains a need to further strengthen the advocacy capacity at both the institutional and individual levels. The fast turnover of more experienced personnel within organizations such as POPCOM and PLCPD, as a result of transfers, promotions, and resignations, is a continuing concern at central and regional levels. The complete change of staff that occurred at PLCPD when the new Executive Director took over was a big setback to PLCPD. POPCOM staff members received advocacy training at various periods from 1991 to the present. Field level staff members have expressed the need for continuing education and retraining. The skills training needs identified include (1) basic demography and socio-economic analysis; (2) clear, effective writing, creative graphic presentations, and brief oral presentations; and (3) the use of the new generation of computers and software programs, including desktop publishing.

Although the RAM and hard disk capacity of computers provided by TFG have recently been upgraded, the problem of aging equipment often militates against a brief, effective, and succinct RAPID presentation. The slow speed (25 MHZ) of the computers and the frequently reported loss of data are major concerns. In one region visited, a RAPID presentation was done without the benefit of a computer. Breakdown of a computer during a presentation before local officials is often a major embarrassment. Staff members sometimes resort to the use of transparencies and flip charts. Although computer-based RAPID presentations have not failed to impress LCEs, concern for the need to use local data in speaking before provincial governors, municipal mayors, and other local level officials was expressed again and again in public forums with POPCOM officials.

In conclusion, capacity building is an important area for TA. Training and retraining of POPCOM and the PLCPD staff, plus replacing computers and presentation equipment, are major concerns that need to be addressed by the TFG Policy Project in the remaining years of the project. These capacity-building activities will need to be fast-tracked to enable POPCOM, especially its Regional Population Offices (RPOs), to take advantage of opportunities provided by the May 1998 elections for briefing the incoming sets of officials. This TA will be made more effective with the timely provision of appropriate computer and presentation equipment. Such equipment would also be valuable in helping staff members prepare to brief new legislators assuming their posts in Congress.

8.3.2 TA and Absorptive Capacity

The TA provided by TFG is well documented, and interviews at both POPCOM Central and RPOs visited by the assessment Team suggest that the interviewees were more than satisfied. They viewed the TA as necessary and relevant to their work. Field interviews by the assessment Team showed that the Policy Project has made a good impression and the assistance provided by TFG is much appreciated. In particular, the RAPID presentations have been rated positively and are seen by local officials as impressive. Some POPCOM RPOs and officials at LGU level and below, however, have commented that, although these presentations were useful, the contents of these RAPID presentations were not quite appropriate or relevant to them. It was felt that RAPID would make a deeper impression if data could be adapted to their province, city, or municipality. These comments have been made in past years but have not been addressed. The findings of a 1993 midterm evaluation of FP assistance to the Philippines (1993) are relevant and need to be repeated:

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 present 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. (p. 42)

The RPOs view the recent updating of 1 national and 15 regional RAPID models as a welcome step in improving advocacy interventions. However, the orientation of local officials using the revised regional RAPID models has been considerably delayed (by about five to six months after submission of proposals). The release of funds was made only in January and February 1998, and some RPOs have expressed concern about the timing of the orientation of officials and the likelihood of a change of officials after the May 1998 election.

Advocacy has been a key function of POPCOM for more than 20 years. The activities undertaken with TFG TA are clearly within POPCOM's mandate and can be continued beyond 1999 when the IFPMHP ends. However, in view of transfer or reassignment of personnel within the organization, replacements who are relatively junior may need to be trained, to carry out and sustain these activities. This training may be a major focus of TA by TFG in the remaining two years of the project.

In conclusion, the feedback from the field is encouraging. But a recurrent need is to adapt the principles of the RAPID presentation to assist LCEs at provincial and municipal levels. The impact of TA will be further enhanced if this often-expressed need is addressed in the last two years of the project.

8.3.3 Professional Associations Supporting FP

In addition to government organizations and NGOs supporting FP, professional and civic organizations are seen as important groups to reach through advocacy efforts. The TFG Policy Project plans to assist POPCOM in advocacy activities aimed at getting the support of at least seven professional or civic organizations before the end of the project. Initial steps are being taken (the Tagaytay Rotary Club has already committed itself to support PFPP in January 1998) to ensure that at least three organizations will support FP by the end of 1998. The other two organizations that have agreed in principle are the Philippine Obstetrics-Gynecological Society and the Integrated Midwives Association of the Philippines.

In conclusion, the support of professional and civic organizations for the PFPP is important. So far, two organizations (one in 1993 and one in 1998) have been tapped for PFPP support. TFG assistance should go beyond just helping POPCOM get a commitment from these groups to support PFPP and should look into ways of translating this commitment into concrete community-based action programs that include FP.

8.3.4 Impact on the Policy Environment

It is premature to say that TFG TA has made an impact on the policy environment. However, there are indications that advocacy activities may be influencing policy and support for the population program. At the national level, advocacy initiatives to push the population bills (House

Bill 9409 and Senate Bill 2012) through the House and the Senate almost succeeded. The bills have the full backing of President Ramos who certified them as urgent and priority. In his speeches in the country and in New York in November 1997, the president stressed the importance of these bills. The bills also have the endorsement of groups including the Center for Sustainable Development, the PLCPD, the staff from the Philippine Senate and House of Representatives, the Legislative Liaison System (composed of Department Legislative Liaison Officers), and the Social Development Council. The bills will be presented again during the 11th Congress. Another indication of a significant impact is the pledges of commitment to support the PPMP made to President Ramos in February 1996 by members of POPCOM's Board of Commissioners who head key line agencies. As a consequence of this commitment, a Committee on Policy and Advocacy was formed in 1997. The Committee was created to address the gaps in the policy making of the POPCOM Board. In an attempt to translate these pledges into specific actions, the Committee submitted a proposal to the Policy Project in March 1998. The proposal will strengthen and enhance the pledges of commitment to the PPMP and the support of the six POPCOM participating agencies that are board members. The Policy Project also trained several legislators to present RAPID and Cost-Benefit Models. The legislators now feel their presentations to other members of Congress have made an impact. POPCOM staff members have made at least two presentations of the RAPID model to President Ramos. POPCOM has routinely used PowerPoint and presentations skills transferred by the Policy Project to make a wide variety of presentations to the executive and legislative branches of the Philippine government.

At the LGU level, indications that advocacy is making an impact are more visible, as evidenced by the support of provincial governors for enacting ordinances and laws that support the creation of provincial population offices and structures, and by the allocation of funds for the PPMP. In La Union, most of the municipalities have committed additional funds for the traveling expenses of Municipal Population Workers (MPWs) and for financial incentives for the BSPOs. In Pangasinan, almost all municipalities have designated their MPWs, their honoraria or incentives given to BSPOs, and their additional funds to be committed for population activities. In RPO 2, the series of orientations resulted in the creation of Municipal Population Officers in the 92 municipalities in 1993 and 1994. Some LGUs have allocated a budget item to implement their local Population Management Program. The same support was seen in Region 11 when visited by the assessment Team. Other regions have expressed similar support.

In conclusion, there is little doubt that the TA provided by TFG is effective and has produced short-term gains. But to make an impact on a long term, the Policy Project will need to reconsider its priorities and to decide where to invest the major part of its resources. The RAPID presentation merely highlights the policy implications of demographic and socio-economic data on specific issues and concerns. A necessary follow-up action will be advocating support to PPMP by taking concrete measures or actions to make things happen. The pledges of commitment by six line agencies are one good example. Translation of these pledges into concrete contributions to PPMP, through focused and proactive advocacy, will be one measure of success.

8.4 Recommendations

53. The Policy Project has provided timely TA in many areas, particularly in developing 1 national and 15 regional RAPID models. The Policy Project should ensure in its 1998–1999 work plans that its assistance to POPCOM focuses on (1) providing training to new staff members, as well as retraining to those trained in 1994; and (2) helping RPOs in adapting the RAPID model for provincial and municipal advocacy use.

At another level, but complementing POPCOM's work, assistance to PLCPD should be increased and should focus on two essential, related activities: (1) training new staff members in effective advocacy techniques, effective writing skills, and the use of appropriate presentation equipment, including desktop publishing software programs; and (2) reaching the newly elected legislators to advocate the passage of the population bill, among others. In both POPCOM and PLCPD, institutional capacity-building through focused technical assistance in these two particular areas will be more meaningful.

54. RAPID presentations and related advocacy initiatives, such as those undertaken by POPCOM and PLCPD under the Policy Project, should be made, whenever feasible, to coincide with the annual FP communication campaign periods to achieve the greatest synergistic effect. These initiatives, however, should be directed to national as well as to local executives and local legislators to encourage them to advocate for translating commitments to allocation of funds for PFPP activities or to set aside a portion from their community development funds (CDFs) in support of PFPP.
55. Given the fact that a policy project and an advocacy project funded by UNFPA/Manila are also implemented by POPCOM, policy and advocacy activities should be carefully orchestrated to ensure that technical assistance provided by TFG and UNFPA mutually reinforce each other at field level. To this end, a mechanism should be set up, such as meetings held at regular intervals (similar to the first inter-project meeting conducted by the DOH in January 1998), to share information and experiences in order to improve the quality of advocacy implementation.
56. As long as the present modality of providing TA through CAs is maintained, the issue of sustainability will remain a problem. There will be a need for POPCOM to discuss with DOH and USAID the concept and modality of TA being currently provided by CAs (such as JHU/PCS and TFG), in IEC and advocacy, and to find ways of making institutionalization and sustainability more achievable.

CHAPTER 9 FUTURE NEEDS AND DIRECTIONS

Program sustainability, especially financial sustainability, will remain the key issue for some time. Technical assistance may be required for most of the support functions. The continued use of long-term U.S. institutional relationships is one alternative; no reasonable alternative is readily apparent unless USAID changes its mode of financing, perhaps by having direct bilateral agreements with the DOH and POPCOM. Periodic short-term technical assistance may be preferable and cheaper. The focus for follow-on activities, if any, should be to strengthen Philippine institutions by making greater use of the expertise of Philippine private sector organizations and Philippine nongovernmental organizations (NGOs) to assist the DOH and POPCOM in implementing the PPMP and PFPP. The Team recognizes that this may involve a change in USAID's mode of operations and financing.

Although broadening the family planning program to include an array of other reproductive health interventions is clearly in line with recommendations of the ICPD and other international gatherings, such expansion presents great risks that family planning programs, policies, staff, and funding will be buried. The Philippine family planning systems should be solidly in place and functioning before expanding the program to include elements of reproductive health. The DOH/OSC/FPS and field staff members are hard put to manage the existing program, much less to take on significant additional reproductive health responsibilities.

The absorptive capacity of all institutions assisted by CAs through the IFPMHP remains a concern and directly affects program sustainability. Staffing is limited in the national service units of the DOH; there is a hiring freeze, and severe budget reductions have been ordered. At the same time, the DOH and the CAs must cope with the dilemma of trying to meet deadlines and benchmarks while attempting to institutionalize sustainable programs. Balancing institutional absorptive capacity and program needs will continue to be a problem for which no easy solution is apparent.

Policy and advocacy strategies and activities should focus on increasing GOP funding for family planning at both the national and the LGU levels. This funding is crucial for program financial sustainability.

During the final two years of the IFPMHP, efforts should focus on transferring technologies to the DOH and POPCOM to better enable those institutions to manage and implement more effective programs in the future. The benchmark to increase both the budget and the staff for FPS should be continued for the remainder of the IFPMHP and into future agreements as well. This benchmark has been an effective tool to strengthen FPS and to increase funding.

One area of great concern is the slow increase in use of modern contraceptive methods. Rationales abound:

- Rumors and misconceptions about modern methods scare women.
- Staff members in health facilities, despite extensive training over decades, still emphasize the problems rather than the benefits of the modern methods.
- Little or no public advertising exists to offset negative publicity in the mass media by anti-family planning groups.
- Official responses to negative publicity are limited.
- A “lie-low” approach has been followed.

Training, IEC, and policy efforts should be focused and integrated to resolve the issues of rumors and misconceptions.

Benchmarks have focused correctly on quantity of services to support the expansion of FP/RH services through the LGUs. When planning assistance is beyond the term of the IFPMHP, USAID and the DOH should begin to identify more quality-oriented benchmarks as part of the overall effort to provide quality services to clients.

Efforts are well under way and should continue to develop a plan for the smooth transition from CDLMIS to LGEDDS. This transition represents the best hope for future sustainability.

Part of the IEC plan is a need to raise the visibility of the DOH and to decrease the visibility of JHU/PCS in national and LGU mass media campaigns. During the time remaining under the IFPMHP, and in planning for future assistance, USAID and the DOH should determine the need for future mass media campaigns and should reach an agreement on future financing. Additional support to expand and improve IEC activities at the LGU level will likely be needed for some time. Developing a stronger outreach network, in which IEC plays a central role, should be explored.

The technical expertise in OR among staff members of the research section of FPS should be strengthened so the staff can provide TA to the LGU staff. However, it is far preferable for FPS/Research to use available academic institutions to carry out OR, rather than to attempt to do in-house research.

Implementation of the new SIM/CBT training system will barely be completed in 50 LGUs by the end of the IFPMHP. Expanding the system to the remaining LGUs should be considered in future USAID support if the system proves to be practical, cost-effective, and efficient.

APPENDICES

APPENDIX A

Scope of Work

MID-TERM ASSESSMENT - INTERMEDIATE RESULT NO 2 STRATEGIC OBJECTIVE NO 3 USAID/PHILIPPINES

I INTRODUCTION

The goal of USAID/Philippines is to support the effort of the Government of the Philippines (GOP) to achieve the status of a newly industrialized democratic country by the year 2000. Towards this end, USAID/Philippines is supporting six major Strategic Objectives (SO) and two Special Objectives (SpO), as follows:

- SO 1 Broad-based Economic Growth in Mindanao
- SO 2 Improved National Systems in Trade and Investment
- SO 3 Reduced Fertility and Improved Maternal & Child Health (MCH)
- SO 4 Enhanced Management of Renewable Natural Resources
- SO 5 Reduced Emission of Greenhouse Gasses
- SO 6 Broadened Participation in the Formulation and Implementation of Public Policies in Selected Areas
- SpO Rapid Increase in HIV/AIDS Prevented
- SpO Assistance to Amerasians in the Philippines

USAID/Philippines is also on the leading edge of USAID's worldwide reengineering effort, having served as a successful experimental laboratory for the new results-oriented program approach and management. The Mission has shifted from a project orientation and has developed a country strategy based on SOs with clearly defined Intermediate Results (IRs), benchmarks and indicators that lead to the achievement of the overall Mission Goal to enable the Philippines to achieve the status of a newly industrialized democratic country by the year 2000.

II ASSESSMENT BACKGROUND

This assessment will focus on SO 3, and in particular, its IR 2 (National systems strengthened to promote and support the family planning/MCH program). The goal of SO 3 is Reduced Fertility Rate and Improved Maternal and Child Health. To attain this goal, the following ambitious but attainable indicators have been established jointly by USAID/Philippines and GOP Department of Health (DOH), to be achieved by the year 2000:

- 1 Total Fertility Rate will drop from 4.1 in 1991 to 3.1
- 2 Infant Mortality Rate will fall from 57 per 1,000 live births in 1990 to 49
- 3 Maternal Mortality Ratio will fall from 209/100,000 live births in 1990 to 190
- 4 Contraceptive Prevalence Rate (CPR) for all methods will increase from 40.0 percent in 1993 to 50.5 percent.
- 5 CPR for modern methods will increase from 25.2 percent in 1993 to 35.7 percent, and
- 6 Percent of births in high risk groups will fall from 62.4 percent to 56 percent.

Three IRs have been designed and developed jointly by USAID and DOH to achieve these SO results by February 28, 2000. They are:

- IR 1 Increased public sector provision of family planning/MCH services,
- IR 2 National systems strengthened to promote and support the family planning/MCH program, and
- IR 3 Increased private sector provision of family planning/MCH services

The primary USAID-funded program for the attainment of these SO/IR objectives and results is a \$153 million (\$65 million bilateral, \$62 million Global Bureau, and \$26 million GOP contribution), six-year, Integrated Family Planning Maternal Health Program (IFPMHP), which was initiated in 1994 prior to USAID's reengineering efforts and the design and development of the SO and its IRs. However, a new Results Framework, as mandated by USAID/W reengineering guidelines, was prepared in 1996, which superseded the IFPMHP Program Assistance and Approval Document (PAAD) and which sets forth how SO 3 will contribute to sustainable development in the Philippines, how each of the IRs will contribute to achievement of the SO results, and how the IRs themselves will be achieved. It also presents the measures and targets that will be used at the SO level, IR level, and activity level to manage the program in such a way as to maximize the chances of success and to determine whether the expected results have been achieved. A one-page spreadsheet summarizing the detailed Results Framework is attached to this Scope as an Annex.

The performance-based approach, developed jointly by USAID and DOH, under SO 3 is based on the successful experience with a similar performance-based approach under the previous USAID-funded program in the Philippines, the Child Survival Program. Under the SO 3 performance-based approach, DOH, Commission on Population (POPCOM), National Statistical Office (NSO) and the collaborating agencies must achieve certain benchmarks for IRs 1 and 2 (the public sector components of the program) each year in order for the GOP to receive an annual tranche of funds from USAID. This tranche is then available for grants to Local Government Units (LGUs) that have achieved the benchmarks and for DOH activities in family planning and MCH. Over the life of the program, \$29.2 million are budgeted for tranche disbursements. Tranche funds are not conditional on achievement of benchmarks under IR 3, the private sector component of the program.

A mid-term review of SO 3 and its IRs is being undertaken by USAID to determine if the SO is on target with regard to its stated goals for the year 2000 and to determine if any mid-course corrections or changes in program strategies or implementation approaches are warranted. This review is also intended to provide insights into future needs and potential strategies, including recommendations as to whether any of the present strategies are worthy of emulation or should be changed or dropped.

Because of the magnitude and complexity of the SO3 and the IRs, three separate assessments are planned, one for each IR. This scope of work relates to the assessment of IR 2.

III PURPOSE OF ASSESSMENT OF IR 2

Devolution has empowered the LGUs and made them responsible for the actual delivery of health services. Nevertheless, central government continues to play a key role in the implementation of family planning and selected maternal and child health programs. There are activities which are most efficiently and effectively provided from the national level to complement the delivery of services at the LGU level.

IR 2 ensures that national agencies such as DOH, POPCOM and NSO will be able to accomplish the following IR 2 indicators:

1. program sustainability enhanced by the DOH assuming full operational responsibility by 1999 for the following support functions: contraceptive distribution and logistics management, training, information/education/communication (IEC), research and evaluation, service delivery technical support, and program monitoring,
2. program sustainability enhanced by increased allocation of budget for the DOH/Family Planning Service (FPS) by at least 50 percent per year,
3. capacity of DOH to release annual LPP grants for LGU programs by June of the following year enhanced (from 0 LGUs in 1994 to 75 in 1999),
4. updated national PFPP strategy reviewed and jointly approved by POPCOM and DOH by November 1996, and
5. quality of family planning and reproductive health services improved through establishment of competency-based training system in LGUs participating in LPP (from 0 LGUs in 1993 to 75 LGUs in 1999).

To accomplish the above indicators, the activities under IR 2 are categorized under seven national systems, which are as follows:

A Contraceptive Distribution and Logistics Management System (CDLMIS)

Under CDLMIS, two benchmarks have been agreed to by USAID and the DOH:

1. DOH assumes full responsibility for FP contraceptive logistics management for the PFPP by the end of 1998,
2. 80 percent of FP service delivery points maintain at least a one-month supply of oral

contraceptives and condoms by the second quarter of 1999

The CDLMIS is implemented by the DOH/FPS with technical assistance from John Snow, Inc /Family Planning Logistics Management (JSI/FPLM) The CDLMIS has ensured the availability of oral contraceptives and condoms nationwide, and the IUD and the injectables at all service delivery points with appropriately trained health providers

A major breakthrough in terms of program sustainability was achieved in 1996 when the DOH started to assume full responsibility for the distribution of contraceptives nationwide, a function which until April 1996 had been carried out by CARE Philippines. A four-person logistics section at the DOH/FPS has been clearing contraceptive shipments through customs and with the help of a DOH forwarder, has made shipments to the LGUs starting July and August 1996. In mid-1997, DOH also assigned at least five staff to assume the MIS function of the system. They have been trained in encoding the logistics data coming from the LGUs and in data analysis

B IEC

Under IEC, two benchmarks have been agreed to between DOH and USAID

- 1 revised communications strategy focusing on LGUs produced and approved by June 1996, and
- 2 national communications programs executed on a yearly basis

The IEC program is undertaken by the DOH with technical assistance from Johns Hopkins University/Population Communication Services (JHU/PCS). A national communication campaign is conducted annually. In response to devolution, an LGU-Specific Family Planning IEC Strategy was approved in 1996. Thus, more localized IEC activities are planned and implemented by the LGUs participating under the LGU Performance Program (LPP) of IR 1

C Training

Under training, four benchmarks have been agreed to by the DOH and USAID

- 1 by September 1996, DOH would have developed and approved a training strategy for 1996-1999,
- 2 by June 1997, DOH would have initiated implementation of revised basic FP/RH curriculum using a competency-based teaching approach,
- 3 by December 1997, enriched, integrated FP/RH curriculum for midwifery developed and implemented in 90% of midwifery schools, and

- 4 by December 1997, enriched, integrated FP/RH curriculum for nursing developed and implemented in 90% of nursing schools

Family planning training in the PFPP is becoming competency-based. In 1996, as one of the benchmarks under IR 2, a new comprehensive, enriched, integrated family planning/reproductive health training strategy was approved. Management Sciences for Health (MSH) and Development Associates (DA) provided technical assistance. This strategy has divided the needed training into three levels. Level 1 deals with the reproductive system, fertility awareness, communication and counseling, and all reversible program contraceptives except the IUD. Level 2 provides instruction on the IUD, pelvic examination, syndromic management of sexually transmitted diseases, reproductive tract infection screening, HIV/AIDS, and adolescent sexuality. Level 3 covers surgical contraception and anesthesia. This new training strategy, which uses self-instructional modules and competency-based approaches, is being pilot-tested in selected LGUs during the latter half of 1997. Nationwide implementation will begin in 1998.

At the same time, USAID assistance, through JHPIEGO, in the pre-service training of nursing and midwives is ending this year. By the end of 1997, not less than 90 percent of the member schools affiliated with the Association of Deans of Philippines Colleges of Nursing (ADPCN) and the Association of Philippine Schools of Midwifery (APSOM) have at least one faculty member trained under the new, enriched, integrated, competency-based FP/RH curriculum.

D Research and technical support

Under research and technical support, four benchmarks have been agreed to by the DOH and USAID

- 1 national FP/MCH guidelines and service standards/protocols reviewed, updated and disseminated by December 1996,
- 2 30 LPP/LGUs have developed capacity to manage and utilize OR studies on service delivery issues by December 1999,
- 3 six operations research (OR) studies on cross-cutting issues conducted and their results disseminated by December 1999, and
- 4 system for FP/MCH assistance by DOH to LGUs developed by April 1996 and implemented by June 1996

DOH's post-devolution role should be focused on policy-making, standard-setting, monitoring and the provision of technical assistance to the LGUs. Through a contract with USAID, MSH is helping the DOH to assume this role. Thus, clinical standards manual were updated for family planning and MCH programs in 1996. Under the LPP, MSH helped the DOH in organizing national and regional technical assistance teams and in training those teams to be able to help the LGUs in planning, managing and evaluating their own family planning and MCH programs.

In research, the Population Council is helping the DOH in coordinating and monitoring an OR program. At least 30 LGU managers have been trained on OR and a few selected LGUs are implementing OR studies in partnership with locally-based academic research institutions.

E Program Monitoring

Under program monitoring, three benchmarks have been agreed to by the DOH and USAID

- 1 yearly population-based FP survey conducted by NSO,
- 2 yearly national FP/MCH status report produced by DOH,
- 3 a national management information system (MIS) to monitor FP/MCH performance in place by 1998

A new MIS strategy for the FP, MCH and nutrition programs was approved by the DOH in 1996. This strategy recognizes the unique information needs of the LGUs vis-a-vis the national government and vice versa, and therefore, the various data-gathering mechanisms appropriate for each level.

At the local level, the strategy recommends the use of the following mechanisms - the Field Health Service Information System (FHSIS), the situational analysis, cluster surveys, community-based masterlisting of clients, and the CDLMIS. MSH, the Population Council, JSI/FPLM and various academic research institutions around the country are assisting the DOH in developing the skills of the LGUs for program monitoring and data-based program planning and decision-making.

At the national level, the CDLMIS and national surveys are used to monitor program performance and outcome. The CDLMIS provide data on couple- year of protection (CYP). Annual surveys yield data on a host of program indicators. In 1995 and 1996, NSO conducted a family planning rider survey, which provided data on contraceptive prevalence, the share of the public and the private health facilities in the provision of services, incidence of high-risk childbearing, etc. In 1997, another rider survey was conducted, this time collecting both family planning and MCH data. In 1998, a Demographic and Health Survey will be conducted by NSO and Macro International, as a follow-on to a similar study in 1993.

The data coming from all these data-gathering mechanisms are the basis for an annual National FP/MCH/Nutrition Status Report prepared by the DOH, with assistance from MSH.

F Advocacy

Under advocacy, three benchmarks have been agreed to by the DOH, POPCOM and USAID

- 1 national population and development advocacy plan (1996-2000) developed and implemented, including advocacy for PFPP among professional associations,

- 2 1995 and 1998 post-election surveys conducted to measure commitment to PFPP at the LGU level, and
- 3 number of professional associations supporting FP increased from one in 1993 to seven in 1999

Advocacy to create a favorable policy and program environment for the Philippine Population Management Program (PPMP) is the responsibility of POPCOM. Such advocacy is intended to result in a greater understanding, acceptance and support for population policies, including FP/RH policies, among influentials at national, regional and local levels. Toward this end, POPCOM has developed and is implementing a PPMP advocacy plan. POPCOM is also conducting post-election surveys to measure the commitment of newly-elected officials to the population and family planning programs, a survey was conducted in 1996 and another one is planned after the 1998 election. The Policy Project of The Futures Group (TFG) provides technical assistance to POPCOM in implementing these activities.

Given all of the above, the specific purposes of the IR 2 evaluation are as follows:

- 1 review and assess the process of IR 2 implementation and make recommendations for whatever revisions that might be required to achieve the IR objectives and indicators,
- 2 assess the appropriateness of IR 2 administrative and management arrangements, both by the GOP and by the USAID staff, and make recommendations for needed changes, if necessary,
- 3 review the appropriateness and achievement of annual benchmarks and assess their effectiveness in helping attain the life-of-program indicators of the Strategic Objective,
- 4 review the work of the various Cooperating Agencies under IR 2 and assess the appropriateness and effectiveness of their technical assistance provided to the host country counterparts,
- 5 assess the progress towards GOP sustainability of each of the national systems under IR 2, and
- 6 assess the need for continued support by USAID to the national systems in the period beyond year 2000

IV SCOPE OF THE REVIEW

The evaluation will cover the period August 1, 1994, the date the IFPMHP was officially signed by the GOP, until the time of the review. The evaluation will cover all aspects of the national systems as funded by USAID.

V ISSUES/QUESTIONS TO BE ADDRESSED PER SYSTEM

A Contraceptive Logistics Management

- 1 How sustainable is the CDLMIS? What measures are being undertaken by JSI/FPLM to assist the DOH/FPS in being able to assume full responsibility for the system? How appropriate are these measures? How timely and effectively are these measures being implemented to assure full sustainability of the logistics functions by the time FPLM assistance ends in December 1998?
- 2 How effective are the DOH logistics staff and other staff involved in the logistics system in performing the functions assigned to them?
- 3 How are the various provincial and city LGUs nationwide being involved in the implementation of the contraceptive distribution system and what measures are being undertaken by the DOH and FPLM to ensure that the LGUs sustain and maintain their part of the system?
- 4 How responsive is the contraceptive procurement system in meeting the needs of the program?
- 5 Does the DOH have any concrete plans towards eventual absorption by the GOP of the cost for the procurement of the contraceptives required by the PFPP? If yes, what are these plans? If none, why not?
- 6 What should USAID's continuing role be in terms of contraceptive procurement?

B IEC

- 1 How effective have been the national communication campaigns in providing the needed IEC support to the PFPP?
- 2 As fear of side effects and concern for health continue to be among the most commonly cited reasons for non-use of contraceptives, what have the DOH and JHU/PCS done to address this problem? How effective have been these interventions, if any?
- 3 What measures are being undertaken by the JHU/PCS to assist the DOH in eventually assuming full responsibility for managing and sustaining the IEC system? How adequate are these measures?
- 4 How is the LGU-specific IEC strategy, which was approved in 1996, being operationalized by DOH and the JHU/PCS?
- 5 What types of technical assistance in IEC have been provided by JHU/PCS to the DOH and

the LGUs, and how appropriate and effective have they been?

C Training

- 1 How appropriate is the competency-based family planning/reproductive health training strategy for the Philippines family planning program?
- 2 How adequate has been the MSH/DA technical assistance to the DOH in development and implementing this competency-based training strategy?
- 3 What has been the impact of this new training strategy on the quality of care being provided by the trained health workers to the clients?
- 4 How does this competency-based training strategy ensure the institutionalization and sustainability of the training system at both national and LGU levels?
- 5 How effective has been the JHPIEGO technical assistance in improving the instructions on FP/RH in the nursing and midwifery schools nationwide?
- 6 How sustainable is the in-service FP/RH training under the ADPCN and APSOM?
- 7 What are the reasons for the non-certification by the DOH Training Accreditation Committee of the trainers in the 27 JHPIEGO-assisted training centers of the nursing and midwifery, after all these years (four years at least) What steps can be done to hasten this delayed process of accreditation?

D Research and Technical Support

- 1 How effectively has the OR strategy developed and approved in 1996 been implemented by the DOH and the Population Council?
- 2 Is the capacity for managing FP/RH research being developed at the DOH and the LGUs? What measures have the Population Council taken to ensure that this capacity-building succeeds?
- 3 Have the findings of the four OR studies conducted since 1996 been utilized to improve program operations?
- 4 Is there greater appreciation on the use of research findings for data-based decision-making by the LGU managers?
- 5 How effectively have the revised FP/MCH clinical guidelines and service standards/protocols developed and approved in 1996 been utilized to improve the quality of FP/MCH service

delivery?

- 6 Have the national technical assistance teams (NTAT) and the regional technical assistant teams (RTAT) been effective in providing technical assistance to the LGUs?

E MIS

- 1 How effectively has the new MIS strategy developed and approved in 1996 been implemented by the DOH and MSH to ensure that the new MIS is in place by 1998? How appropriate and effective has been the technical assistance provided by MSH to the DOH in the area of MIS?
- 2 How fully are the various key players within the DOH on board with this new strategy?
- 3 What progress has been made towards the institutionalization and sustainability of the various data-gathering mechanisms as per the MIS strategy within the DOH and the LGUs?
- 4 How useful have the results of the annual FP surveys and the 1997 MCH Rider Survey been to the various program stakeholders?
- 5 How effective has been the U S Bureau of Census technical assistance to the NSO in the conduct of the annual family planning surveys and in strengthening the conduct of such surveys in the future?

F Population Advocacy

- 1 What measures are being undertaken by TFG/Policy Project to ensure capacity-building within POPCOM and the LGUs in terms of population advocacy?
- 2 How effective has been the technical assistance provided by TFG/Policy Project in support of POPCOM? Are the activities undertaken with the Policy Project capable of being absorbed by POPCOM?
- 3 How effective has the TFG/Policy Project been in developing and then disseminating the updated national PFPP strategy?
- 4 Have the approaches undertaken by POPCOM and TFG/Policy Project had any impact on the Philippine policy environment?

VI. METHODOLOGY

The evaluation will rely on non-quantitative methods and will consist primarily of the following data-gathering techniques: review of project documents and reports, interviews with key individuals involved in policy-

making, program implementation and management, and field trips to project sites. No survey is expected to be undertaken for the evaluation, instead, secondary data sources will be analyzed.

Project documents to be reviewed include the following:

- 1) the Revised PFPP Strategy 1996-2000
- 2) the New Competency-based FP/RH Strategy,
- 3) the LGU-Specific IEC Strategy,
- 4) the Operations Research Strategy,
- 5) the New MIS Strategy,
- 6) the FP Clinical Standards Manual,
- 7) the Population and Development Advocacy Plan,
- 8) the various FP survey reports,
- 9) the annual benchmarks and the documentation requirements,
- 10) the annual DOH status reports,
- 11) The OPHN Briefing Book,
- 12) CA workplans,
- 13) monitoring reports, and
- 14) other relevant documents

The key individuals to be interviewed include relevant USAID staff in Manila and in Washington, D C , officials from the DOH, POPCOM, NSO, and selected LGUs, CA representatives, researchers from the academe

Site visits will be determined by the team, in collaboration with USAID, government counterparts and CA representatives

VII TEAM COMPOSITION

The evaluation will require a team of four technical experts:

- 1 Family Planning Specialist This person should have extensive experience either as a program manager of an international family planning program or as an evaluator of international family planning programs. He or she will serve as the team leader and will be responsible for putting together the evaluation report. At the same time, this person must also be experienced in family planning training, as he/she will be responsible for evaluating the training system (Expatriate)
- 2 IEC and Advocacy Specialist This person should have extensive experience in the design, implementation and evaluation of family planning and health communication programs. He/she will be responsible for evaluating the IEC and advocacy systems (Expatriate or CCN)
- 3 Research and Technical Support and MIS Specialist This person will be responsible for evaluating the research and MIS systems (Expatriate or CCN)

- 4 Contraceptive Management Specialist This person will be responsible for evaluating the contraceptive logistics system at both national and LGU levels (Expatriate)

The evaluation is expected to entail not more than 33 working days to be completed in two calendar months, with not more than 28 days spent in-country. This includes briefings and debriefings that the Team will provide for USAID and DOH/POPCOM/NSO. The team leader will be allowed to spend five working days in the U S to contact U S -based program participants (both USAID/Washington and CA representatives) to validate and/or clarify data collected in-country and to finalize the report. Data-gathering and all of the report writing up to the final draft (including consultations for report revision) should be completed in-country.

In-country work of the team will start on February 17 and end on March 20, 1998. A six-day work week is authorized with no premium pay.

VIII REPORTING REQUIREMENTS

The final report will be prepared by the Team Leader in the U S after receipt of USAID and DOH comments.

The evaluation report with tables and annexes should not exceed 50 pages. The report format will be as follows:

- 1 Executive Summary (to follow Project Evaluation Summary [PES] format) stating findings, conclusions and recommendations, not exceeding 3 pages,
- 2 Table of Contents,
- 3 Body of the Report which includes brief program description, the environment in which the project operated, a statement of the methodology used, major findings, conclusions and recommendations, and
- 4 Annexes, to include the evaluation scope of work, list of persons consulted, background supplemental materials useful for a fuller understanding of the report, an annotated bibliography of significant documents used or consulted, and a list of acronyms.

The timetable for reporting should be as follows:

- | | | |
|---|--|--------------------------|
| 1 | Team debriefing with copies of semi-final report | One day before departure |
| 2 | Review of report by Mission and DOH/Mission sends back directly to Team Leader | Two weeks |

- | | | |
|---|--|-----------|
| 3 | Team Leader revises report and submits to BHM | One week |
| 4 | Editing of report by BHM and returned to Mission for final clearance | Two weeks |
| 5 | Printing of report and submission to Mission in 25 copies | Two weeks |

VIII LOGISTICS

BHM/Futures is responsible for arranging travel, office space, secretarial/logistical support, and communications. In addition, the Team Leader is responsible for draft and final report development and reproduction as well as other eligible expenses associated with the completion of the midterm evaluation.

IX TERMS OF PAYMENT

Payment for professional services shall be based on actual workdays performed not to exceed the ceiling price as stated in the budget. Payment of Other Direct Costs up to a maximum of \$50,818.00 (plus 2% contingency) will be on an actual cost reimbursement basis subject to presentation of adequate supporting documentation.

To obtain payment, the contractor shall submit directly to the Office of Financial Management, USAID/Philippines, Standard Form (SF) 1034, in original and three copies together with the contractor's regular invoice citing the authority of this payment. Two (2) sets of SF 1034 are attached for Contractor's use.

APPENDIX B

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APPENDIX C

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Also in attendance were 46 heads of various departments and teachers
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Also in attendance were 69 heads and officials of various departments

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Appendix D

National Communication Campaigns: Identified Needs and Campaign Goals 1993–1998

| Identified Needs/Problems (NDS 1993) | Goals | | |
|--|--|---|---|
| | 1993/94 | | 1995 |
| <ol style="list-style-type: none"> 1. More than 3 million MWRAs have an unmet need for FP (because of fear of side effects among other reasons) and belong to the high risks category. 2. A major cause of death for women of childbearing age is pregnancy or childbirth. 3. Probability of dying is considerably higher for infants born less than 2 years apart than for those born after a birth interval of more than 2 years. | <ol style="list-style-type: none"> 1. To increase the number of new acceptors from 1.5M (1992) to 1.7M (by end of 1993). 2. To promote a fresh image for <ol style="list-style-type: none"> 2.1 family planning, 2.2 service and information providers, and 2.3 contraceptive methods. | | <ol style="list-style-type: none"> 1. To contribute to the DOH's efforts to achieve universal access to FP information and services. |
| Identified Needs/Problems (Casterline et al. & FPS studies 1995) | 1996 | 1997 | 1998 |
| <p>In addition to the needs in the NDS 1993 above, the following findings were identified:</p> <ol style="list-style-type: none"> 1. Husbands greatly influence the decision of their wives NOT to practice FP. 2. Fear of side effects continues to be a factor in nonpractice of FP. 3. That some of the FP methods have ill effects on the user is the main reason for the resistance, opposition, or indifference of clients toward FP. The most common misconceptions about FP is that FP methods have adverse effects on mother's health. | <ol style="list-style-type: none"> 1. Reduce high-risk births. 2. Increase spousal communication. 3. Increase perception of FP as a social norm. 4. Improve image of contraceptives and health service providers. 5. Combat rumors and misconceptions, and assist users to cope with side effects. | <ol style="list-style-type: none"> 1. Reduce high-risk births. 2. Increase spousal communication. 3. Foster acceptance of FP as a social norm. 4. Establish that health providers are credible sources of FP information and advice. 5. Encourage couples to choose a method suitable to them. | <ol style="list-style-type: none"> 1. Reduce high-risk births. 2. Increase the use of modern contraceptives. |

Appendix E

National Communication Campaigns by Year/Duration, Messages, Geographic Coverage, and Costs 1993–1998

| Date and Duration | Message(s) | Geographic Coverage | Total Expenditure |
|--|--|--------------------------------------|------------------------------|
| August 1993 to March 1994 (8 months) | <ol style="list-style-type: none"> 1. Health benefits of FP 2. Positive image of service providers 3. Safety and effectiveness of FP methods | Nationwide but with focus on 10 LGUs | \$1,036,521 (P25,913,025) |
| November 1995 to February 1996 (4 months) | <ol style="list-style-type: none"> 1. FP is safe, healthy, effective, and the natural thing to do. (for MCRAs) 2. FP helps in taking care of wife and family and is a demonstration of support for family and partner. (for husbands) 3. Quality of care is important to service providers. (for service and information providers) 4. FP helps everyone. (for influential persons) 5. FP methods are socially and culturally safe and acceptable. (for MCRAs) 6. Love can wait. (for youth) | Nationwide | \$445,254 (P11,576,609) |
| November 1996 to May 1997 (7 months) | <ol style="list-style-type: none"> 1. All modern FP methods are safe and effective ways of spacing births and avoiding unwanted pregnancy. 2. FP is a positive social norm. 3. FP is a conjugal decision and, therefore, spousal communication is a must. 4. Couples should choose a method that is suitable to them. 5. Service information providers are a credible source of correct FP information and advice. | Nationwide | \$319,054 (P8,295,400) |

| Date and Duration | Message(s) | Geographic Coverage | Total Expenditure |
|---|---|--|---|
| November 1997 to March 1998 (5 months) | <ol style="list-style-type: none"> 1. FP is a positive norm. 2. FP is a conjugal decision and, therefore, spousal communication is a must. 3. Couples should choose a method that is suitable to them. 4. Couples should consult a reliable FP service provider for proper advice. | Nationwide but with focus on three priority areas: Priority 1 CAR, Ilocos, Bicol, W. Visayas, Central Visayas, E. Visayas, W. Mindanao, and C. Mindanao Priority 2 C. Luzon, S. Tagalog, N. Mindanao, S. Mindanao, and ARIMM Priority 3 Cagayan Valley and CARAGA | \$808,218 (P26,671,180) |
| August 1998 to December 1998 (5 months tentative) | <ol style="list-style-type: none"> 1. Modern contraceptives are safe, healthy, and effective ways to space children and limit family size. 2. Couples can choose a FP method that is suitable to them. 3. FP is a positive social norm. 4. FP is a conjugal decision and, therefore, spousal communication is a must. | Nationwide | Estimated cost: \$641,026 (P25,000,000) |