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## EVALUATION

# USAID/Philippines: Performance Evaluation of the Family Planning and Maternal and Child Health Portfolio

**DECEMBER 2012**

This publication was produced at the request of the United States Agency for International Development. It was prepared independently by Pinar Senlet, David Megill, Jose Rodriguez, Jose Rafael Hernandez, Marilou Costello, Marita Castro Guevara, Nimfa Ogena, and Victor Agbayani through the GH Tech Bridge II Project.



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**DECEMBER 2012**

Global Health Technical Assistance Bridge II Project (GH Tech) USAID Contract No. AID-OAA-C-12-00027

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To all who are committed to improved family planning and maternal and child health in the Philippines, we offer these observations, analysis, and recommendations in the confidence that further progress will be realized through collective efforts.



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## ACRONYMS

ADP	Alternative delivery points
AMTSL	Active management of the third stage of labor
ARMM	Autonomous Region of Muslim Mindanao
BEmONC	Basic emergency obstetrics and newborn care
BTL	Bilateral tubal ligation
CA	Cooperating Agencies
CCT	Conditional cash transfer
CHAT	Community health action team
CHD	Center for Health Development
CHO	City Health Officer
CHT	Community Health Team
CPC	Country Program for Children
CPR	Contraceptive prevalence rate
CMNS	Caring for mothers and newborns in the community
CSR	Contraceptive self-reliance
DOH	Department of Health
DQC	Data quality check
DSWD	Department of Social Welfare and Development
EU	European Union
EINC	Essential intrapartum and newborn care
FBD	Facility-based delivery
FGD	Focus group discussion
FHS	Family Health Survey
FP	Family planning
FPS	Family Planning Survey
HealthGOV	Strengthening Local Governance in Health Project
HealthPRO	Health Promotion and Communication Project
HFEP	Health facility enhancement package
HPDP	Health Policy Development Project
ILHZ	Interlocal Health Zone
IPCC	Interpersonal communication and counseling
IUD	Intrauterine device
JICA	Japan International Cooperating Agency

LAM	Lactational amenorrhea method
LBK	Lakbay Buhay Kalusugan
LFS	Labor Force Survey
LGU	Local government unit
MCH	Maternal and child health
MCP	Maternity care package
MDG	Millennium Development Goal
MECA	Midwives for every community
MHO	Municipal health officer
MHSPSP	Mindanao Health Sector Policy Support Program
MMR	Maternal mortality ratio
MNCHN	Maternal, newborn, child health and nutrition
NFP	Natural family planning
NCDPC	National Center for Disease Prevention and Control
NCHP	National Center for Health Promotion
NDHS	National Demographic and Health Survey
NGO	Non-governmental organization
NHTS-PR	National Household Targeting System for Poverty Reduction
NSV	Non-scalpel vasectomy
PHO	Provincial health officer
POPCOM	Population Commission
PRISM2	Private Sector Mobilization for Family Health Project
RHU	Rural health unit
SBA	Skilled birth attendant
SDN	Service delivery network
SHIELD	Sustainable Health Improvement and Empowerment through Local Development Project
SMS	Short message service
SOW	Statement of work
TWG	Technical working group
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
WHO	World Health Organization
WHSMP	Women's Health and Safe Motherhood Programme
YAFS	Young Adult Fertility Survey

## EXECUTIVE SUMMARY

The U.S. Agency for International Development (USAID) in the Philippines contracted a third-party evaluation team to conduct a final performance evaluation of its family planning (FP) and maternal and child health (MCH) portfolio. The evaluation seeks to determine the extent to which the portfolio has met its overarching objectives of: (1) strengthened local government units (LGU) provision and management of health services, (2) expanded quality services by private and commercial providers, (3) increased appropriate healthy behaviors and practices, and (4) improved policy environment and financing of services. USAID's FP and MCH portfolio currently supports five projects which are focused in 30 provinces with a total population of over 37 million, around 40% of the population of the Philippines. The evaluation was conducted in two phases.

The purpose of the first phase of the evaluation was to review and analyze existing data and literature (recent studies and surveys, program and project reports, performance data, and similar documents) on the status of FP and MCH in the Philippines. Specifically, the evaluation's first phase generated provincial estimates of selected FP and MCH indicators from the 2006 *Family Planning Survey* (FPS) and 2011 *Family Health Survey* (FHS). It also estimated the coverage and reach of major USAID-funded interventions, measured by key indicators for each province.

The evaluation team conducted a quantitative analysis of seven key FP and MCH indicators for the individual USAID-assisted and non-assisted provinces. These were: (1) contraceptive prevalence rate (CPR) for modern methods, (2) pills' share of modern contraceptive use, (3) bilateral tubal ligation's (BTL) share of modern contraceptive use, (4) percent of modern contraceptive services provided by private sources, (5) percent of deliveries with skilled birth attendants (SBAs), (6) percent of facility-based deliveries (FBDs), and (7) percent of children under 5 years receiving vitamin A.

The provincial-level results were then used to summarize the significant differences for key indicators, in order to identify the provinces where the most progress was achieved and where the indicators significantly decreased. The 30 USAID-assisted provinces were further classified into high-input and low-input provinces based on the measured coverage of USAID interventions. Project-specific interventions and input indicators were used as a basis for ranking provinces. Eleven provinces that consistently received high levels of input from all projects were considered high-input provinces. The other 19 were considered low-input provinces. Table I presents the seven FP and MCH indicators in USAID-assisted and non-assisted provinces and statistically significant differences in estimates.

### FINDINGS AND CONCLUSIONS FROM EVALUATION PHASE I

According to the results of the analysis, between 2006 and 2011, the Philippines posted significant increases in five of seven selected indicators:

- Modern CPR increased by 1% (from 35.9% to 36.9%).
- Share of pills in modern contraceptive use increased by 7.4% (from 46.4% to 53.8%).
- Percent of deliveries with SBAs increased by 8.3% (from 63.9% to 72.2%).

- Percent of FBDs increased by 12% (from 42.4% to 55.2%).
- Percent of children under 5 years receiving vitamin A supplementation increased by 2.8% (from 78.4% to 81.3%).

However, BTL's share of modern contraceptive use declined 5.6%, from 28.9% to 23.3%. There was no significant change in the private sector's share in the provision of modern contraceptive services (from 22.9% in 2006 to 22.8% in 2011). It is worthwhile to note that the 7.4% increase in pill usage during the five-year period was partially offset by the 5.6% reduction in tubal ligations, thus implying a possible shift in FP method mix. While few provinces showed significant increases in modern CPR, increases in pill use are associated with fewer tubal ligations. This is observed in both USAID-assisted provinces (Bulacan, Davao del Sur, Isabela, and Negros Occidental) and non-assisted provinces (Cebu and Apayao).

The factors that contributed to the significant increase in modern CPR for non-assisted provinces may include (but are not limited to) the political will of local executives to implement FP programs; funding or other types of support received by LGUs from foreign donors, non-governmental organizations (NGOs), and civil society groups; access of LGUs to Department of Health (DOH) grants; and public-private partnerships in provision of FP supplies and services.

**Table 1: Changes in Estimates of Selected FP and MCH Indicators from the 2006 FPS and 2011 FHS Surveys in USAID-assisted and Non-USAID-assisted Provinces**

Provinces/ Project Inputs	Modern CPR	% share of pills in modern CPR	% share of BTL in modern CPR	% share of private sector	% of deliveries with SBAs	% of FBDs	% of children receiving Vit. A
<b>PHILIPPINES</b>							
2006 FPS	35.9	46.4	28.9	22.9	63.9	42.4	78.4
2011 FHS	36.9	53.8	23.3	22.8	72.2	55.2	81.3
<i>Difference</i>	<b>1.0</b>	<b>7.4</b>	<b>-5.6</b>	<b>-0.1</b>	<b>8.3</b>	<b>12.8</b>	<b>2.8</b>
<b>30 USAID-assisted</b>							
2006 FPS	36.5	47.8	26.5	22.0	55.8	35.1	78.4
2011 FHS	37.0	57.1	20.6	21.3	65.2	47.3	78.4
<i>Difference</i>	<b>0.50</b>	<b>9.3</b>	<b>-5.9</b>	<b>-0.70</b>	<b>9.4</b>	<b>12.1</b>	<b>0.0</b>
<b>High project inputs</b>							
2006 FPS	34.3	50.1	24.5	22.6	55.5	36.3	79.8
2011 FHS	35.2	57.9	19.3	21.7	65.7	51.2	81.7
<i>Difference</i>	<b>0.9</b>	<b>7.8</b>	<b>-5.2</b>	<b>0.9</b>	<b>10.2</b>	<b>14.9</b>	<b>1.90</b>
<b>Low project inputs</b>							
2006 FPS	38.2	46.2	28.0	21.6	56.1	34.1	77.2
2011 FHS	38.4	56.6	21.5	21.0	64.8	44.3	75.9
<i>Difference</i>	<b>0.20</b>	<b>10.5</b>	<b>-6.4</b>	<b>-0.40</b>	<b>8.7</b>	<b>10.1</b>	<b>-1.30</b>

Provinces/ Project Inputs	Modern CPR	% share of pills in modern CPR	% share of BTL in modern CPR	% share of private sector	% of deliveries with SBAs	% of FBDs	% of children receiving Vit. A
<b>Non-USAID-assisted</b>							
2006 FPS	35.4	45.3	30.7	23.6	69.6	47.6	78.5
2011 FHS	36.7	51.4	25.2	23.8	77.2	60.8	83.3
<i>Difference</i>	<b>1.3</b>	<b>6.0</b>	<b>-5.5</b>	<i>0.20</i>	<b>7.5</b>	<b>13.3</b>	<b>4.8</b>

Note: Statistically significant differences are in bold.

Based on these findings and analysis, the team concluded that:

- The majority of both USAID-assisted and non-USAID-assisted provinces show statistically significant increases in FBDs and deliveries with SBAs. These findings indicate that the DOH's policy of shifting to FBDs is being implemented and that USAID has been contributing to the implementation of the policy.
- In the context of the key FP indicator, modern CPR, there are significant improvements in four USAID-assisted and six non-USAID-assisted provinces. The increases indicate positive trends, but there is still much room for improvement.
- The majority of both USAID-assisted and non-USAID-assisted provinces also show increasing pill usage, while the share of female sterilization in the modern contraceptive method mix is declining. On a national level, the increase of share in pill use (7.4%) makes up for the decline in the share of female sterilization (-5.9%) and accounts for the small 1% increase in modern CPR. This finding indicates that as older women move beyond their fertile years, younger women in reproductive age groups opt for pills rather than sterilization.
- While more women are delivering at facilities, it seems that fewer women have access to postpartum FP services where they deliver. This is a missed opportunity, as the postpartum period represents an excellent chance to persuade many women to begin using a contraceptive.
- Among the 11 provinces which received high levels of USAID assistance, most have shown significant improvements in FP and MCH indicators. About nine achieved significant improvements in most or at least one of the key indicators (modern CPR, percentage of deliveries with SBAs, percentage of FBDs, and percentage of children receiving vitamin A). Although only 1 of these 11 provinces (Davao del Sur) showed an increase in modern CPR that was statistically significant at the 95% confidence level, another province (Capiz) had a significant increase at the 90% confidence level, and 6 more provinces either maintained the level of modern CPR or showed increases that were not significant.
- The analysis of the literature review for the 11 provinces that received high levels of support from USAID-funded projects helped the evaluation team begin validation of USAID/Philippines hypotheses on whether the convergence of USAID-assisted FP and MCH interventions in the same project sites contributed to improvements in key FP and MCH

indicators. Results indicated that the convergence of interventions contributed to improvements in FP and MCH, a finding further validated during Phase 2 of the evaluation.

The purposes of the second phase of the evaluation were twofold:

- Assess the impact of USAID-assisted interventions on 1) increased access and provision of quality FP and MCH services in the public and private sectors; 2) strengthened information dissemination of FP and MCH messages and promotion of healthy behaviors in FP and MCH; and 3) improved policy environment, relevant health systems, and financing for provision of FP and MCH services.
- Conduct in-depth analysis of the various factors and conditions, both in USAID-assisted and non-USAID-assisted provinces that contribute to or hinder the improvement of FP and MCH indicators.

The methodology and data sources for Phase 2 of the evaluation entailed:

- Review of background documents provided by USAID and the projects, as well as research studies, evaluation reports, DOH policy documents, and literature related to demand generation and provision of FP and MCH services.
- Structured interviews with a wide range of key informants both in Manila and in the field.
- Field visits to four provinces to gather qualitative data and validate data gathered from project reports and other sources.
- Four focus group discussions (FGDs) in each province to gain an in-depth understanding of key factors which contribute to or hinder improvements in FP and MCH programs.

## **FINDINGS, CONCLUSIONS, AND RECOMMENDATIONS FROM EVALUATION PHASE 2**

**Program design:** The program is spread out nationwide and covers 30 provinces from 14 regions and 3 island groups. In these provinces, USAID projects implemented more than 20 interventions to improve FP and MCH. The extent of coverage and level of intensity varied across provinces and did not always achieve the desired optimal convergence at the LGU level. Provinces in which all projects implemented relatively uniformly high levels of interventions achieved improvements in the CPR and MCH indicators. However, supply- and demand-generating interventions were not always synchronized at the LGU level.

The team recommends that future projects should focus on more municipalities and cities in fewer provinces clustered in fewer regions, to maximize synergies and logistical efficiencies and lead to greater impact. Likewise, the selection of provinces should consider the absorptive capacity of the LGU to accept interventions, as well as its political commitment to improve quality FP and MCH services. The team also recommends implementing fewer interventions and scaling up the best practices which have already shown results. Municipalities and cities, which exhibit political commitment and capacity apart from their provinces, should be direct beneficiaries of the technical assistance.

**Management and coordination:** USAID's management of the projects intended to maximize integration of the projects' interventions through close coordination. At the central level, USAID established regular coordination meetings among the projects, the DOH, and other

stakeholders for information sharing. At the field level, coordination among projects is not as strong, since projects have different deliverables and timelines.

The team recommends strengthening coordination among projects not only for information sharing but also for joint planning in order to integrate implementation of interventions. In order to better achieve this, USAID Contracting/Agreement Officer's representatives (C/AORs) should work as a team or a steering committee to oversee not only the individual implementation but also functional integration of the projects.

**Best practices in FP and MCH:** The team assessed the results of 20 interventions implemented by USAID-funded projects and identified four best practices that resulted in significant improvements in FP and MCH outcomes. These are:

- Enhancing community involvement through formation of Community Health Action Teams (CHATs). The CHAT model trained volunteers to provide basic FP and MCH information to the communities. CHATs identify couples and children with specific FP and MCH needs and refer them to appropriate facilities and service providers.
- Allowing midwives to provide life-saving practices and drugs. In the autonomous region of Muslim Mindanao (ARMM), a new policy allowed midwives to provide *active management of the third stage of labor* (AMTSL) and oxytocin without a physician's supervision. Midwives in the rest of the country outside the ARMM do not have the benefit of such a clear policy. USAID-funded interventions prioritized the training of the midwives in the above skills, which are highly recommended clinical practices designed to prevent postpartum hemorrhage.
- Introduction of postpartum IUDs. FBDs are steadily increasing in the country and will continue to increase in the future due to government's strong policy and implementation. Increasing numbers of women delivering in the facilities present a great opportunity for providing FP information and services. However, current provision of FP information and services during the postpartum period is weak. In a few health facilities in the ARMM, providers were trained to insert postpartum IUDs, which led to high acceptance rates that ranged from 40–50% of women who delivered.
- Accreditation of facilities by PhilHealth and enrollment of PhilHealth beneficiaries in the public and private sectors. The benefit packages offered by PhilHealth is a sustainable mechanism to fund FP and MCH services. The team observed that in visited sites, health managers at the LGU level took advantage of this financing opportunity and used PhilHealth funding to improve their facilities, procure supplies and commodities, and train their staff. However, many other local level managers were not aware of the financial opportunities provided by PhilHealth.

The team recommends that USAID assist in replicating and scaling up these best practices in the next project cycle. Prior to replication, USAID-funded projects should conduct a more thorough review and evaluation of these best practices to explore ways of implementing them more effectively and efficiently.

**Factors contributing to the improvement of FP and MCH indicators:** In addition to the cited best practices implemented by USAID-funded projects, the team identified various factors and conditions contributing to improvements in FP and MCH outcomes:

- Appropriate integration of services, such as FP with maternity care, helps to address a wider range of health needs of the clients and increases efficiency of the programs.
- Accreditation of facilities by PhilHealth for the maternity care package (MCP) and enrollment of PhilHealth beneficiaries is a sustainable financing mechanism to improve FP and MCH services, and is supported by national policies.
- Presence of a local champion and a good manager and leader can motivate other stakeholders, influence the adoption of desirable practices, and facilitate the mobilization of national and local resources.
- Political support at the national level ensures that FP and MCH will have a prominent place on the national agenda, and that adequate financial resources are allocated. Local policies support systems for delivering services and remove barriers to proper program implementation.
- A match between supply and demand of services is important. Where LGUs have trained providers and offer a wide range of FP methods and services, utilization of FP services is high and clients are better satisfied.

**Supply-related considerations:** In general, contraceptive use is high where facilities provide FP services, contraceptive commodities are available, and the population is correctly informed. However, the availability of contraceptive supplies is often unreliable and trained providers continue to be in short supply, especially for long-term and permanent methods at the LGUs. There is a bias among providers to recommend the pill, since it is the only method that is most likely to be available in the facilities and most providers are not trained in provision of long-term or permanent methods.

The team recommends that USAID support the DOH in standardizing and expanding its FP and MCH training capacity. There is a need to support the training of providers (facility-based and outreach workers) and program managers in FP and MCH. In addition to strengthening the services at the facilities, USAID should also promote alternative models such as mobile teams to increase access to long-acting and permanent FP methods.

**Demand-related considerations:** Survey results and the team findings indicate that there is high awareness of generic FP, as well as a demand for FP services, but knowledge of specific methods is low. A key issue in the media and print campaigns is the lack of method- and target-audience-specific messages (e.g., youth, men, and those with unmet needs). Another observed shortcoming is the failure to address the prevailing misconceptions and myths about FP side effects—important reasons why people are resistant to accepting specific methods.

USAID should seek to strengthen FP method-specific information through all channels of communication. Campaign messages—targeted to particular audiences and using various media—should inform the public about specific methods and focus on dispelling the myths and misconceptions attached to them. The advent and rapid growth of social media offers a great opportunity to launch campaigns that are target-audience specific as well as method specific. Demand generation interventions should focus on consistency and continuity of interpersonal communication and counseling (IPCC) training of the service providers. IPCC training should be method specific.

**FP service and information needs of the youth:** Surveys<sup>1</sup> have documented alarming trends in early sexual initiation and premarital sexual experience, which exposes youth to the risk of unplanned pregnancy and sexually transmitted diseases. These trends translate to increasing adolescent pregnancy and early childbearing, while there are limited services or information that addresses the reproductive needs of young adults. The majority of the teen mothers who were interviewed had no prior information or knowledge of human sexuality, pregnancy, and motherhood. Their sources of information on sexuality were mass media and social media. The youth were neither aware of facilities that offer services and information tailored to their needs nor likely to use facilities that serve adults.

The team recommends that USAID assist in developing a campaign that focuses on the risks of teen pregnancies, using mass media supported by social media. USAID should also assist in establishing a 24/7 hotline for FP and MCH information and counseling for adolescents. The team also recommends providing teen-friendly services utilizing peer educators. The Teen Centers the team observed in one of the provinces may be used as a model.

**Gender considerations:** In the Philippines, FP is seen as primarily the responsibility of women, with men playing passive roles. However, men are not averse to FP. Rather, they are interested in being involved in the FP decision-making process. Currently, FP programs focus almost exclusively on women, and men are rarely invited to attend community assemblies on FP. Yet many men consider FP important and would like to obtain information.

The team recommends that demand-generation interventions should promote male participation in FP. Information on male FP methods should be widely disseminated. Utilizing champions or satisfied users of vasectomy may help increase men's involvement in FP.

**Other essential questions:** The statement of work (SOW) for the assignment included two broad questions related to the FP and MCH situation in the Philippines:

*“Why has the country’s MMR remained at the same level in the past 15 years despite the significant increases in FBDs and in SBAs?”*

- In the Philippines, the policy to reduce the maternal mortality ratio (MMR) emphasizes increasing FBDs, not increasing the number of deliveries assisted by SBAs. Global experience in maternal health identifies SBAs as the single most critical intervention for reducing maternal deaths. The FBD approach assumes that SBAs and high quality services are available in all health facilities, which is not always the case.
- To improve access to emergency obstetric care, the DOH is investing in training SBAs in basic emergency obstetrics and newborn care (BEmONC). Although the training modules are standard, the quality and consistency of actual trainings are not monitored and numbers of providers trained are still low.
- FP is not fully recognized or positioned as a critical intervention to reduce the MMR. As a result, resources are skewed toward maternity services, not FP.
- As a result of inadequate access to FP, unwanted pregnancies are increasing, leading to unsafe abortions which then contribute to high maternal mortality.

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<sup>1</sup> Demographic and Health Surveys (DHS) and Young Adult Fertility and Sexuality Surveys (YAFS)

- Increases in high-risk teenage pregnancies also contribute to high maternal mortality.

*“Why has the CPR not increased more rapidly in the past 10 years?”*

- For at least two decades, government policies to support FP have been inconsistent.
- The transfer of responsibility of FP implementation from POPCOM to DOH diluted the focus on FP.
- Devolution of responsibility of health programs to LGUs also contributed to weakening of the FP program.
- Increasing demand for FP was not matched with quality services and adequate supply of contraceptive commodities.
- Finally, the Catholic Church’s opposition to many modern and effective FP methods continues to influence policymakers, program managers, and service providers, although it does not influence couples’ acceptance and use of FP.

# I. INTRODUCTION AND BACKGROUND

## USAID/PHILIPPINES HEALTH PORTFOLIO, PROGRAM STRATEGY, AND RESULTS FRAMEWORK

USAID/Philippines contracted a third-party evaluation team to conduct a final performance evaluation of its FP and MCH portfolio. The evaluation seeks to determine the extent the portfolio has met its overarching objectives. The SOW for the evaluation is found in Annex A.

The current USAID program is governed by a strategic objective agreement (SOAG) signed with the Government of the Philippines on September 27, 2006, with the following strategic objective: “Desired Family Size and Improved Health Sustainably Achieved.” To achieve this objective, the strategy focuses on four intermediate results:

- Local Government Units(LGU) provision and management of health services strengthened;
- Provision of quality services by private and commercial providers expanded;
- Appropriate healthy behaviors and practices increased; and,
- Policy environment and financing for provision of services improved

USAID is the leading donor of the FP program in the Philippines. FP is one of four priority programs supported by the U.S. Government. In the current project cycle (2006–2012), USAID provides an average of \$10.8 million annually for FP for an estimated total of \$64.7 million over six years. USAID also supports the MCH program of the Philippines with an average annual funding of \$2.0 million for an estimated total of \$12.2 million from 2006–2012. USAID’s FP and MCH portfolio currently supports five projects:

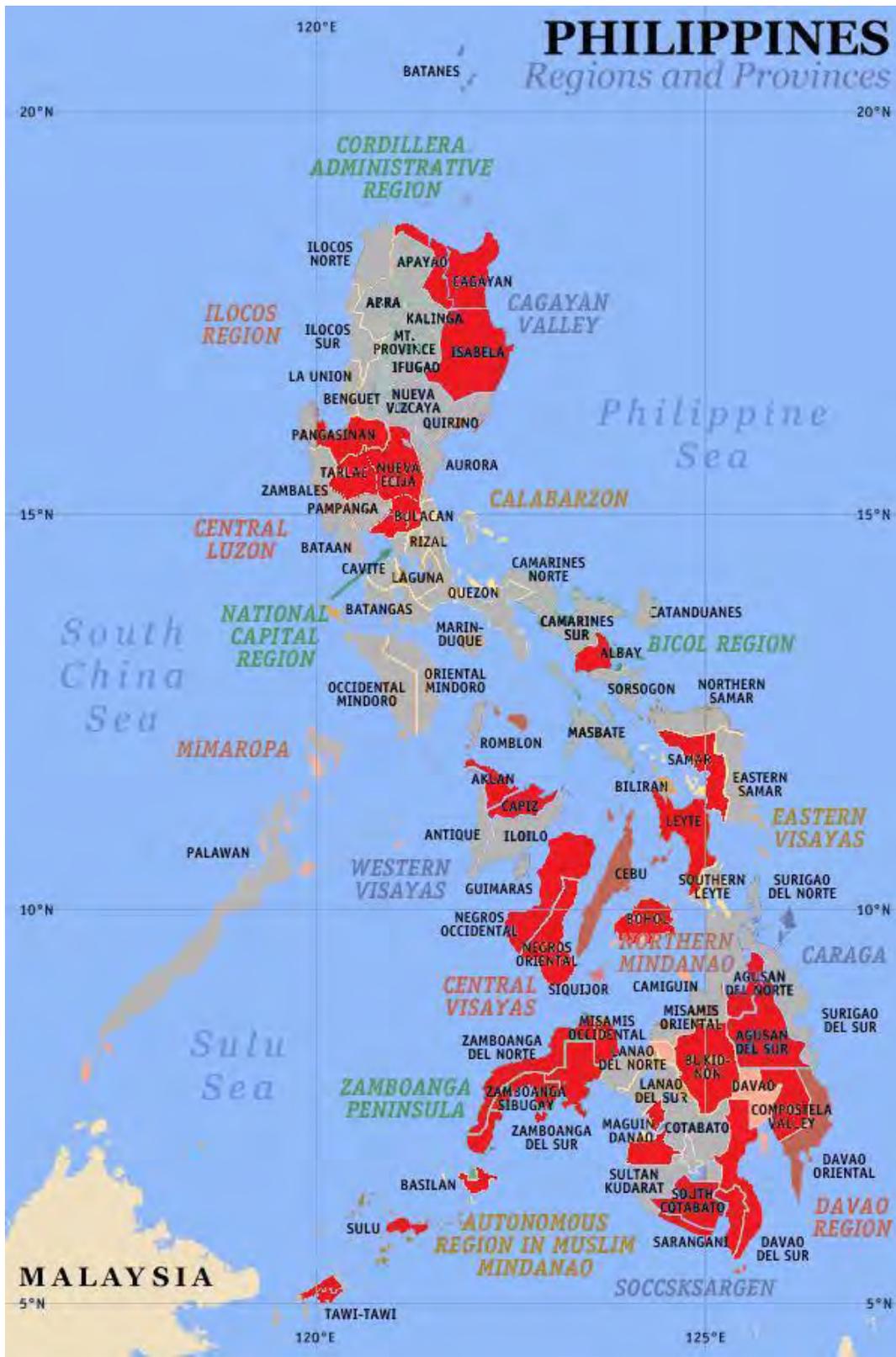
- Strengthening Local Governance in Health (HealthGOV)
- Sustainable Health Improvement and Empowerment through Local Development (SHIELD)
- Private Sector Mobilization for Family Health (PRISM2)
- Health Promotion and Communication (HealthPRO)
- Health Policy Development Project (HPDP)

A summary of all five projects is shown in table 2. Except for PRISM2, which covered 77 provinces and cities initially (now reduced to 36), USAID-assisted projects are operating in the same project sites. Twenty-five provinces are covered through HealthGov, and five provinces and one city for SHIELD in the ARMM. HealthPRO also works in 30 provinces, although the multimedia communication programs it helped develop have a national reach. HPDP has a national-level focus. The total 2010 population for the 30 USAID provinces (covered by the HealthGov and SHIELD projects) was 37,368,337, or 40.5% of the population of the Philippines. The evaluation investigated each project in the FP and MCH portfolio to determine what contribution each made to achievement of the aforementioned overarching intermediate results. Map 1 depicts the 30 USAID-assisted provinces. These provinces are spread across the entire country, covering all island groups and 14 of the country’s 17 regions.

**Table 2: Summary of USAID-funded Projects**

Project Name Implementing Partner	Dates	Funding Level (in US\$ million)	Planned Geographic Focus	Provincial Implementation as of 6/2012	Project Goal
HealthGov RTI	9/2006– 12/2012	T 28.521 FP 18.99 MCH 3.37 TB 3.02 HIV 2.73	25 provinces	25 provinces	Strengthen LGUs' commitment to health and enhance their capacity to provide, finance, and manage health services.
SHIELD HKI	9/2006– 12/2012	T 18.25 FP 11.56 MCH 3.99 TB 2.44	5 provinces and one city in ARMM	5 provinces and one city in ARMM	Achieve sustainable improvement of family health in communities in the ARMM.
PRISM2 Chemonics	10/2009– 10/2014	T. 23.27 FP 20.62 MCH 2.64	77 provinces and cities (reduced to 36 in 2012)	33 provinces 18 cities	Assist the DOH, DOLE, and the LGUs to mobilize private sector resources in the delivery of FP and MCH services and information.
HealthPRO URC	7/2007– 9/2012	T 14.97 FP 10.29 MCH 1.77 TB 2.43 HIV 0.37	30 provinces	25 provinces and ARMM region	Assist LGUs through the DOH and related agencies in enabling healthy practices through access to health information.
HPDP UP Econ Foundation	10/2007– 12/2012	T 11.05 FP 8.71 MCH 1.58 TB 0.32HIV 0.44	Nationwide		Establish supportive policies and financing environment for health programs and strengthen health policy formulation process for improved health sector.

**Map I: 30 USAID-assisted Provinces**



Legend: Provinces in red represent the provinces supported by the FP/MCH projects of USAID.

USAID’s development hypotheses are

- The convergence of USAID-supported FP interventions to strengthen public and private sector service delivery; health promotion; and health governance, systems, and health policy in the same project sites will significantly contribute to increases in the CPR.
- The convergence of USAID-supported MCH interventions to strengthen public and private sector service delivery; health promotion; and health governance, systems, and health policy in the same project sites will significantly contribute to increases in the following selected MCH indicators: percentage of deliveries assisted by SBAs, percentage of FBDs, and percentage of under-5 children given vitamin A supplementation.

## DEMOGRAPHIC TRENDS IN FAMILY PLANNING AND MATERNAL AND CHILD HEALTH

### Family Planning

- Compared to other countries in Asia, fertility in the Philippines is quite high. The total fertility rate in the country has barely changed from 3.2 (2006 FPS) to 3.1 (2011 FHS)—about three births per woman. This relatively unchanged high fertility level is partly due to the varying national policy on FP during the past two decades, which in turn has influenced women’s access to modern contraceptives. As expected, unmet need for FP remains relatively high at 19.3% in 2011 (11% for spacing and 9% for limiting) and the CPR barely increased from 35.9% (2006 FPS) to 36.9% (2011 FHS).
- The proportion of currently married women in the Philippines using any contraceptive method (total CPR) declined from 50.6% in 2006 to 48.9% in 2011 (see table 3). The proportion of pill users increased by 3.3% from 16.6 in 2006 to 19.8 in 2011. However, acceptors of female sterilization decreased by nearly two percentage points during the five-year period. Nevertheless, pills, female sterilization, and withdrawal remain the leading methods used. Less popular modern methods of FP are intrauterine devices (IUDs), injectables, male condoms, and the lactational amenorrhea method (LAM). There are about three married women using modern methods for every one traditional-method user in the Philippines. In addition, the proportion of women whose spouses were using withdrawal increased from 2006–2011, despite the overall decline in those using other traditional methods. Possible reason for such trends is the shift of unsatisfied users of calendar/rhythm/periodic abstinence to withdrawal, among others.

**Table 3: Percent Distribution of Currently Married Women by Current Contraceptive Method Used, Philippines (2006 FPS and 2011 FHS)**

Type of Method	2006 FPS	2011 FHS
<b>Any method</b>	50.6	48.9
<i>Modern methods</i>	35.9	36.9
Permanent methods	10.5	8.7
Female sterilization	10.4	8.6
Male sterilization	0.1	0.1

Type of Method	2006 FPS	2011 FHS
<b>Any method</b>	50.6	48.9
<i>Modern methods</i>	35.9	36.9
Supply method	25.1	27.5
Pill	16.6	19.8
IUD	4.1	3.1
Injectables	2.8	3.4
Male condom	1.6	1.2
Diaphragm/foam/jelly/cream	–	–
Natural FP method	0.3	0.6
Mucus/Billings/ovulation	–	–
Standard days method	–	0.1
Lactational amenorrhea method	0.2	0.5
<i>Traditional methods</i>	14.8	12.0
Calendar/rhythm/periodic abstinence	7.0	3.7
Withdrawal	7.3	8.2
Other methods	0.5	0.1
<b>No Method</b>	<b>49.4</b>	<b>51.1</b>

### Maternal and Child Health

A daunting challenge for the Philippines is to make further improvements on health services utilization and the health status of women and children by 2015, in consonance with the United Nations' Millennium Development Goals (MDG) relating to health. The country's MMR of 221 per 100,000 live births in 2011 from about 162 per 100,000 live births in 2006<sup>2</sup> is comparably high in relation to Southeast Asian countries. Despite major measurement issues in these MMR estimates, there is little chance that the Philippines would be able to attain the 2015 MDG target of 52. Nevertheless, the DOH in 2008 aimed to reduce maternal deaths with a policy shift to FBDs, although around a third of the births delivered at home in that year (56% of all births) were assisted by a SBA. FBDs increased to 55% in 2011 from 42% in 2006, while an SBA (a doctor, nurse, or midwife) assisted 72% of births in 2011 compared to 64% in 2006. The assistance of a skilled health professional at a birth is a very important indicator for determining readiness regarding emergency obstetric care.

Monitoring the levels and trends of infant and under-5 mortality rates are crucial in evaluating the progress of health programs. These indicators have shown little improvement over the years 2006–2011. The infant mortality rate has declined from 24 per 1,000 births in 2006 to 22 per 1,000 births in 2011. Under-5 mortality, on the other hand, has not significantly changed during the reference period. An important component of the government's child nutrition program is vitamin A supplementation to prevent night blindness and lower susceptibility to other

<sup>2</sup> The MMR of 221 in 2011 is not statistically different from the MMR of 162 in 2006.

infections of children 6–59 months of age. Vitamin A provision has slightly increased from 78.4% in 2006 to 81.0% in 2011. For other child health indicators in 2011, immunization coverage was good (85%), but exclusive breastfeeding was rather low (25%).

## **FAMILY PLANNING AND MATERNAL AND CHILD HEALTH CONTEXT**

National government support for FP has been inconsistent over the last 25 years, with both its level and focus shifting depending on the preferences of the national leadership. Health devolution dominated the 1990s, and high-level efforts to promote FP were slowed down by the new and fragmented structure of the health sector. The period of 2001–2010 was defined by the Government’s consistent support for the Catholic Church’s condemnation of contraception. Instead, natural family planning (NFP) was promoted, and commitment to other methods was lacking.

The FP program of the country began in the 1970s with the creation of the Commission on Population (POPCOM) by the national leadership, which viewed population management as a vital program in development. The POPCOM was responsible for both policy formulation and the implementation of the national government’s FP program. At about this time, USAID provided assistance and began a partnership with the POPCOM.

With the change in the national leadership in the mid-1980s, and after almost two decades at the helm of the FP program, the POPCOM became part of the DOH. From its inception, the POPCOM was solely responsible for FP policy, distribution of commodities, and demand generation. However, under DOH direction, the FP program became just one of several health programs and concerns. It was only recently that one of its original functions—that of increasing the demand for FP—was restored to the POPCOM.<sup>3</sup>

In 1991, the enactment of the Local Government Code (Republic Act No. 7160) gave the LGUs the responsibilities of delivering various basic services and managing facilities, in order to vest local government with greater autonomy. The LGUs assumed responsibility for the delivery of health services, including the maintenance and supervision of health facilities and personnel, while continuing to adhere to national health policies and standards.

The FP program suffered another setback under the new dispensation in 2001, which effectively defaulted on FP and relegated the greater part of policy formulation and program implementation to the unprepared LGUs. Prior to this, the national government had retained its vital role and function in policy direction, contraceptive commodity distribution, and service provider training. The weakened role of the national government has made FP primarily the responsibility of local government, subject to local government resources and the priorities of its leaders. Financing for FP has become less predictable as roughly 1,700 municipalities now make the decisions on the allocation of funds from the local Internal Revenue Allotments for health programs such as FP. In addition, the national health insurance (PhilHealth) coverage of FP remains sparse, although PhilHealth is the primary source of health protection for the poor through premiums paid by the LGUs on behalf of indigent families. The DOH has been able to

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<sup>3</sup> DOH AO No. 2012-009: “National Strategy Towards Reducing Unmet Need for Family planning as a Means to Achieving MGDs on Maternal Health” states that POPCOM “shall have a pivotal role of increasing demand for FP goods and services and providing an enabling environment for capacity building and advocacy.”

fill in some of the gaps in the past two years by instituting a system of performance-based central grants that can be used for contraceptive commodities.<sup>4</sup>

The Reproductive Health (RH) Bill seeks to establish a comprehensive and integrated national policy on reproductive health, and address the lack of a national policy providing for sexuality and reproductive health education in schools. The RH Bill has been in Philippine Congress since 1998—almost a decade and a half.

In contrast to the inconsistent national government policy on FP, the Catholic Church's position has been strong and unchanging. The Church's stand on FP is seen to have influenced the major national level policy changes in the late 1980s and first decade of the 2000s. These major national policy shifts and the Church's stance have affected high- and middle-level policymakers and program managers in the public health bureaucracy, including service providers in hospitals and public health facilities.

The current president, who took office in 2010, publicly announced his support for FP and stated that the DOH is responsible for providing FP services and commodities, especially for the poor and disadvantaged. In 2012, the DOH procured \$6 million in contraceptives. More recently, in 2012, the DOH issued an administrative order, the "National Strategy towards Reduction of Unmet Need for FP as a means to Achieve MDGs in Maternal Health."

In MCH, the stagnant MMR and slowing decline in child mortality places the country at the risk of missing its MDG targets in MCH. To ensure the reduction of maternal and child mortality, the DOH issued an administrative order in 2008 to implement a maternal, newborn, child health, and nutrition (MNCHN) strategy. According to the strategy, the DOH is responsible for providing technical assistance to the LGUs to help them adopt and implement the standards and guidelines. In addition, the DOH finances the implementation of the strategy in the form of centrally funded MNCHN grants. The main approach of the DOH toward improving maternal and newborn health is to promote FBDs.

## **OTHER DONORS' CONTRIBUTIONS TO FP AND MCH**

Since 2006, the European Union (EU) program in the Philippines has been focused on health sector reform. The EU program did not have any particular focus on FP and MCH; there was significant support given to health facility upgrading and procurement. In the program's second phase, 13 provinces in Mindanao were added to constitute the four-year Mindanao Health Sector Policy Support Program (MHSPSP). Among its sites are two USAID-supported provinces (Lanao del Sur and Davao del Sur).

The EU has recently started on a new project directed at improving MCH among indigenous populations of Mindanao, in collaboration with the National Commission for Indigenous Population, the DOH, and the United Nations Population Fund (UNFPA). UNFPA is expected to contribute in the area of FP and MCH. Since the project is still young, its initial activities consist of establishing baseline data and community/social preparation, in line with its participatory approach.

The United Nations Children's Fund (UNICEF) has recently signed a global memorandum of understanding detailing areas of collaboration with USAID/Washington. Its seventh Country Program for Children (CPC) aims to increase access to high impact preventive services for

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<sup>4</sup> USAID began gradually phasing out its donation of FP commodities in 2003.

pregnant women and members of the household, especially children. UNICEF works in the “most vulnerable” LGUs, focusing on 36 LGUs (30 municipalities and 6 cities) for pilot interventions on mother, newborn, and child initiatives, and implements behavior change communications in LGUs with high incidence of child mortality and HIV, and with low sanitation coverage. Other assistance provided by UNICEF includes technical assistance on PhilHealth-accredited birthing homes, support for training on BEmONC, and advocacy for the hiring and deployment of midwives and female functional literacy.

Under its seventh CPC, UNFPA covers the provinces of Benguet, Albay, Camarines Sur, Eastern Samar, Sultan Kudarat, Saranggani, and Compostela Valley. In these sites, UNFPA provides capacity-building activities such as training health care providers and volunteers and physically improving health facilities. It also assists the DOH in procuring contraceptives such as pills, injectable, IUDs, and implants. In addition, UNFPA prioritizes adolescent health and works with LGUs to provide information and counseling services especially in high schools. UNFPA is currently working with the EU to address the reproductive needs of the indigenous population in Mindanao.

The World Health Organization (WHO) strengthens health systems with special focus on the MDGs. It assists the DOH in the development of guidelines for essential intrapartum and newborn care (EINC). The WHO also helped develop a training manual for the practice of EINC, which includes a module on AMTSL. Presently, the manual is being piloted in Region 12.

The World Bank supported RH in the Philippines through the second phase of the Women’s Health and Safe Motherhood Programme (WHSMP), which commenced in 2005 and completed in June 2012. The project aimed at improving the access (in selected sites) of disadvantaged women (including indigenous people) of reproductive age to reproductive health services; and developing and implementing sustainable and replicable systems within the framework of the health sector reform agenda. The areas of coverage are in Luzon (Sorsogon Province) and Mindanao (Surigao del Sur).

World Bank is also supporting the KALAHÍ-CIDSS project (*Kapit-Bisig Laban sa Kahirapan*—community integrated delivery of services), which promotes community empowerment through participation in the planning and decision-making in *barangay* (local district) governance, and developing their capacity to design, implement, and manage development activities that reduce poverty.

From 2006–2010, the Japan International Cooperation Agency (JICA) supported the DOH in implementing the Maternal and Child Health Project in Biliran and Ifugao provinces to enhance BEmONC and strengthen management mechanisms for women health teams and midwives at the primary health care level. Beginning in 2010, JICA has been providing assistance to the DOH to scale up the project in other provinces in Leyte and Cordillera Administrative Region. The project’s end date is June 2014.

Table 4 classifies the different international donor agencies working on FP and MCH.

**Table 4: Other Donors' Assistance to the Philippines' Health Programs**

Agency	Project	Project Objective	Project Duration	Total Cost (in millions)	Geographic Focus	Project Components
EU	Health Sector Policy Support Program 2	Contribute to the improvement of the health status of the population and achieve health-related MDGs.	December 2010–December 2014	€ 36.00	16 provinces	HFEP MNCHN/CHT
UNFPA	7 <sup>th</sup> Country Program for Reproductive Health and Rights	Contribute to improving the reproductive health status of the Filipino people.	May 2012–December 2016	\$7.13 (for 2012)	14 provinces	MNCHN/CHT FP and Reproductive Health HIV/AIDS
UNICEF	7 <sup>th</sup> Country Program for Children	Increase access to high-impact preventive services for pregnant women and household behavior change interventions for vulnerable LGUs.	April 2012–December 2016	\$7.771 (2012–2014)	30 municipalities and 6 cities	MNCHN/CHT HIV/AIDS Nutrition Water, Sanitation & Hygiene
WHO	2012–2013 Biennium Program	Strengthen health systems with special focus on the MGDs and priority non-communicable diseases.	2012–2013	\$1.395	Nationwide	15 public health areas including MCH (does not include FP)
World Bank	II. Women's Health and Safe Motherhood Programme	Improve the access of disadvantaged women to reproductive health services.	2005–2012	Data not available	Two provinces in Luzon and Mindanao	Reproductive health, safe motherhood
JICA	Maternal and Child Health Project	Enhance Basic Emergency Obstetric and Newborn Care (BEmONC)	2006–2014	Data not available	Four provinces	Maternal health



## II. PURPOSE OF THE EVALUATION

The overall purpose of this performance evaluation was twofold:

- Measure the effectiveness and efficiency of the various USAID-assisted interventions in FP and MCH by investigating inputs, outputs, and outcomes in FP and MCH directly contributing to the achievement of FP and MCH performance indicators of the USAID/P health portfolio.
- Systematically document factors and conditions that contribute to or hinder improvements in FP and MCH outcomes and impact. A sampling of provinces that perform well and poorly, both assisted and non-assisted, measured in terms of the indicators, were investigated in-depth.

The evaluation was conducted in two phases. The purpose of the first phase was to review and analyze existing data and literature on the status of FP and MCH in the Philippines. Such literature included recent studies and surveys, as well as program and project reports, performance data, and similar documents. Specifically, Phase 1 generated provincial estimates of selected FP and MCH indicators from the 2006 FPS and the 2011 FHS. It also estimated the coverage and reach of major USAID-funded interventions, measured by key indicators by province.

The literature review identified areas for further investigation during Phase 2 of the evaluation in order to determine the key constraints on increasing the practice of modern FP and reducing maternal and neonatal deaths in the country. More importantly, the evaluation team used the findings of the literature review to propose an evaluation design for Phase 2, including the selection of sample sites, quantitative and qualitative methodologies, and the plan for data analysis.

The specific purposes of the second phase of the evaluation were to:

- Assess the impact of USAID-assisted interventions on (1) increasing access and provision of quality FP and MCH services in the public and private sectors; (2) strengthening information dissemination of FP and MCH messages and promotion of healthy behaviors in FP and MCH; and (3) improving the policy environment, relevant health systems, and financing for FP and MCH services.
- Conduct an in-depth analysis of the various factors and conditions, in both USAID-assisted and non-USAID-assisted provinces, that potentially contribute to or hinder the improvement of FP and MCH indicators.

Key evaluation questions are found in Annex D.

A team of eight consultants conducted the evaluation during an eight-week period between September 24 and November 16, 2012. The team comprised a team leader who also served as the FP expert, statistical analyst, an MCH technical expert, a communications expert, and four qualitative research specialists.

The evaluation results will be disseminated and discussed with the DOH, POPCOM , implementing partners, other development partners, LGUs, and other organizations/agencies involved in implementing FP and MCH programs and activities in the country. Findings and recommendations will be used to enhance the way specific approaches and interventions are currently designed and implemented at the LGU level, as well as to establish the support mechanisms required for an intervention to work optimally. Findings will be used to determine whether certain approaches and interventions currently being implemented under USAID-assisted activities should be continued and scaled up, modified, or terminated.

### **III. EVALUATION METHODOLOGY**

#### **ESTIMATES OF SELECTED FAMILY PLANNING AND MATERNAL AND CHILD HEALTH INDICATORS IN USAID-ASSISTED AND NON-USAID-ASSISTED PROVINCES**

The first part of the performance evaluation involved a quantitative analysis of key FP/MCH indicators for the individual assisted and non-assisted provinces from survey data representing the baseline and endline of USAID's five-year FP/MCH program. The team used data from the 2006 FPS and the 2011 FHS for most of this quantitative analysis.

The 2006 FPS was the last in a series of annual rider surveys conducted by the National Statistics Office (NSO) since 1995 in the years between the five-year rounds of the National Demographic and Health Survey (NDHS). These surveys were primarily funded by USAID to provide annual reproductive health indicators for monitoring and evaluation. A cost-effective approach was used for conducting these surveys as riders to the NSO's quarterly labor force survey (LFS). In the case of the 2006 FPS, the full LFS sample of about 45,000 households was used in order to provide more reliable estimates at the provincial level. This larger sample size also made it possible to include a maternal mortality module for producing estimates of the MMR. It should be noted that because some of the smaller provinces have relatively small sample sizes, it is necessary to take into account the number of observations in examining the provincial-level results from each survey.

The 2011 FHS was conducted by the NSO as a stand-alone survey that was based on the full master sample of primary sampling units (PSUs) at the first sampling stage. The total sample size was about 50,000 households, which also made it possible to obtain provincial-level estimates. The objectives of this survey were similar to those of the 2006 FPS. The FHS questionnaire was consistent with the FPS and NDHS methodology, thus ensuring that the estimates from the different surveys are comparable. In order to obtain quantitative performance measures for the assisted and non-assisted provinces, the following FP/MCH indicators were identified and tabulated at the provincial level:

- Total CPR
- Modern CPR
- Percent share of pills in modern contraceptive methods
- Percent share of BTL in modern contraceptive methods
- Percent share of private-sector FP services
- Percentage of deliveries assisted by SBAs
- Percentage of FBDs
- Percentage of under-5 children given vitamin A supplementation
- Percent of currently married women with unmet need for FP
- Percent of children under 3 years with exclusive breast-feeding for six months

The evaluation team later learned that the 2006 FPS did not include questions on exclusive breastfeeding. Thus, this indicator was dropped. For each of the remaining indicators, Stata software was used to calculate the standard errors and 95% confidence intervals for the estimates by province, taking into account the stratification and clustering in the sample design for each survey. These results were grouped separately for the 30 USAID-assisted provinces and the remaining provinces which did not receive assistance. The USAID-assisted provinces were further grouped into high- or low-input categories according to level of project interventions, as described below. The sampling errors for the estimates from the two surveys were used to conduct a hypothesis test to determine whether the differences were statistically significant at the 90% ( $\alpha=0.10$ ) or 95% ( $\alpha=0.05$ ) levels of confidence. In the case of estimates for provinces with less than 30 observations for either survey, the differences were identified as not significant.

The provincial-level results were then used to summarize the differences for selected key indicators that were significant at the 95% confidence level, in order to identify the provinces where the most progress was achieved for the various indicators, as well as provinces where the indicators significantly decreased. This was done separately for the assisted and non-assisted provinces. These tables were very useful during the Phase 2 in-depth qualitative analysis, when the team selected the best-performing provinces and those not showing much progress. For this exercise the team focused on a smaller subset of the indicators. The team used modern CPR rather than total CPR to focus more on the FP interventions of the USAID projects. The 2006 FPS and 2011 FHS results showed a decrease in the CPR for traditional methods over this five-year period, which resulted in a corresponding slight decrease in the total CPR. The traditional CPR has shown significant upward and downward swings in the FPS and NDHS series over the years, making it more difficult to interpret the total CPR indicator. Although unmet need for FP is considered an important indicator, it is also difficult to interpret. At the national level, the unmet need for FP increased significantly from 15.7% in 2006 to 19.3% in 2011. However, part of this increase may be related to increasing demand. There is also variability in the results for the unmet need for spacing and limiting. Therefore, the unmet need for FP indicator was not used for the final process of screening the provinces.

The evaluation team considers the baseline and endline survey data from the 2006 FPS and the 2011 FHS, respectively, to be of high quality. The NSO, which planned and conducted these surveys, has a reputation for very high technical and professional standards when conducting national household surveys. In addition, USAID funded technical assistance to ensure that the statistical methodology used in the sampling and estimation procedures was technically sound and effective, and this methodology was well documented. A strong effort was made to ensure consistency in the concepts and wording of questions used for the FPS, FHS, and NDHS in order to provide an effective evaluation of trends for major indicators. In addition, the statistical tools used for the quantitative analysis part of this evaluation, such as the tests of hypothesis, are based on international best practices. The confidence levels related to the sampling variability are clearly stated. The sample size for the two surveys is sufficient for a sound comparative analysis for most of the provinces. In the case of a few smaller provinces where the sample size was too small, it was not possible to determine statistically significant differences for the indicators, as stated in this report. In summary, the evaluation team is very confident of the conclusions presented in the quantitative analysis section of this report. The selection of the provinces for the Phase 2 in-depth qualitative analysis was based on the information on significant differences for key indicators, as well as logistical considerations and the level of project intervention determined from the literature review.

## ESTIMATES OF COVERAGE AND REACH OF USAID INTERVENTIONS

In order to measure the contribution of USAID-assisted projects to the country's performance with respect to the FP and MCH programs, the evaluation team identified provinces receiving high levels of inputs and assistance from the HealthGov, HealthPro, HPDP, PRISM, and SHIELD. After measuring coverage, the provinces receiving strong support from the five projects were assessed on how they performed using the results of the 2006 and 2011 national surveys. The assumption is that the provinces receiving significant inputs from the five projects were likely to show improvements in the output and outcome indicators. The process of identification of the provinces involved the following steps:

- **Step 1: Selection of project specific interventions and input indicators.** The team reviewed the reports and plans of the five projects and selected two to four interventions and input indicators that best represented the project's provision of assistance to the provinces, cities, municipalities, facilities, and health care providers. Factors for the selection of the interventions and indicators included: (1) strength of relationship between the indicator and the program outputs and outcomes; (2) quantifiable indicator, or—if qualitative—verifiable based on the reports; and (3) availability of the required data or information.
- **Step 2: Measurement and ranking of provinces based on provincial coverage of selected interventions and indicators.** The team, using data culled from the five projects, measured the level of coverage for each of the 30 USAID-assisted provinces. The provinces were then ranked based on their relative performance on the combined set of interventions and indicators.
- **Step 3: Determine level of consistency of high levels of coverage across the five projects.** For the 25 non-ARMM provinces, the team compared the top 10 high-input provinces from the Health Gov, Health Pro, HPDP, and PRISM projects for consistency in terms of level of support. The provinces that showed high levels of assistance from at least two of the four projects were then selected for further analysis. For ARMM provinces, the team measured the level of assistance using data and information primarily from the SHIELD project.

## METHODOLOGY AND DATA SOURCES FOR EVALUATION PHASE 2

The methodology and data sources for the second phase of the evaluation included reviewing background documentation, conducting key informant interviews, making site visits, and facilitating FGDs.

**Review of background documentation:** In addition to the literature review conducted during Phase I, the evaluation team reviewed other background documents provided by USAID and the projects as well as research studies, evaluation reports, DOH policy documents, and literature related to demand generation and provision of FP and MCH services (Annex B).

**Key informant interviews:** The team conducted structured interviews with a wide range of key informant both in Manila and in the field (Annex C). In Manila, key informants included USAID and implementation agencies' staff, as well as representatives from DOH, POPCOM, PhilHealth, and other donor agencies working on FP and MCH. In the field, the team interviewed governors, mayors, field staff of USAID projects, staff of Centers for Health Development (CHDs), provincial health officers (PHOs), city health officers (CHOs), municipal health officers (MHOs), nurses, midwives, trainers, outreach workers (barangay health workers,

CHATs, CHTs), and actual and potential clients. To ensure collection of standard data, structured interview guides were prepared and used to interview different types of key informants (Annex D). In total, 51 key informants, 44 service providers, and 45 clients were interviewed during the field trips. The types and numbers of respondents interviewed during field trips are found in Annex E.

**Site visits:** The team visited four provinces to gather qualitative data, gain an in-depth understanding of program achievements and challenges, and validate data gathered from project reports and other sources. The provinces visited were Lanao del Sur, Davao del Sur, Capiz, and Ilocos del Norte. The team visited a total of 15 LGUs, including 34 health facilities (from tertiary hospitals to the barangay health units) where FP and MCH services were provided.

The provinces were chosen based on the quantitative analysis conducted during Phase I. In order to identify interventions that contributed most significantly to increases in FP and MCH indicators, the team selected two provinces from the well- and poor-performing USAID-assisted provinces, as well as one well-performing non-assisted province. A fourth province was included to represent the ARMM.

- Lanao del Sur (Mindanao, ARMM): Received high levels of input from the SHIELD project, but indicators do not reflect significant improvements.
- Davao del Sur (Mindanao, non-ARMM): Received substantial assistance from the HealthGov, HealthPro, and HPDP projects and shows significant improvements in FP and MCH indicators.
- Capiz (Visayas): Received highest level of assistance from the HealthGov project and shows significantly improved modern CPR and percentage of FBDs.
- Ilocos Norte (Luzon): Received no USAID assistance but achieved significant improvements in CPR and FBDs.

Field trip reports to all four provinces are found in Annex F.

**Focus group discussions:** The team conducted four FGDs in each province to gain an in-depth understanding of key factors contributing to or hindering improvements in FP and MCH programs. These included:

- Community health teams (CHTs). Although use of CHTs is a fairly recent development, USAID projects provided significant assistance to the CHTs. The evaluation explored their potential use in future programs.
- Adolescents aged 15–19 who already have a child or children, and are either single, married, or in a consensual union.
- Reproductive-age women who are married or in a consensual union who want to limit or space childbearing but are not using a modern contraceptive method.
- Married men with children, both FP users and non-users.

In total, 128 individuals participated in FGDs. In addition, the team had in-depth interviews with several postpartum women who had recently delivered in a health facility, as well as other women and men who were satisfied users of modern contraceptives. Summaries of findings from the FGDs are found in Annex G.

## **IV. FINDINGS, CONCLUSIONS, AND RECOMMENDATIONS**

### **PROGRAM DESIGN, MANAGEMENT, AND COORDINATION**

The strategic objectives of USAID and the corresponding prescribed intermediate results guided program and project design. USAID selected the project provinces with the criterion of maximizing coverage based on population size, low health indicators, and the DOH recommendation to ensure that donors' assistance programs are not concentrated in the same sites. The selection assumed equal levels of capacity and readiness to provide services among provinces, thus leading to standardized templates of interventions.

The USAID projects implemented around 20 major interventions to improve the FP and MCH situation in program provinces. Although the standardized templates were applied in all selected provinces or municipalities, the level and extent of implementation of each varied depending on factors such as logistical project reach and acceptability to and political commitment of LGUs. The large number of municipalities (more than 700) in 30 program provinces also impeded the interventions' reach. For example, IPCC trainings were conducted in 10 municipalities per province, but the extent of coverage and level of intensity per municipality varied widely. Because of this, the USAID-supported interventions did not always achieve the desired optimal convergence at the LGU level.

Among the interventions were those designed to generate demand or increase supply for FP and MCH services. However, the projects were not always able to integrate the supply with the demand-generating interventions at the LGU level. For example, FP campaigns and IPCC trainings, which increase demand, often do not dovetail with the required level of existing or similarly generated FP commodity or service supply.

Provinces where all the projects implemented relatively uniformly high levels of interventions achieved significant improvements in the CPR and MCH indicators. However, achieving significant results in all selected provinces remains a challenge, given the limited resources and the magnitude and complexity of the problems.

USAID initially implemented all projects in the same provinces with the objective of maximizing the convergence and synergies of interventions. The aggregate site coverage of the projects, however, changed during implementation, as adjustments were made to respond to local realities. For example, PRISM2 originally covered 77 provinces and cities; however, during the third year, it focused on 36 sites. HealthPro implemented its Wave 1 and Wave 2 campaigns in 30 provinces (although DOH distributed the materials nationwide), but narrowed these down to 7 selected provinces for Wave 3. In the second half of the project period, the projects began to focus on those LGUs with greater levels of acceptance for program interventions and higher capacity to provide services.

A general finding regarding project design is that none of the five projects had conducted a baseline survey during the launch of interventions. Similarly, none of the projects planned or conducted an endline survey. The 2006 FPS data was used as the baseline for selected FP and MCH indicators like CPR and SBAs, while the 2011 FHS data served as the data source for assessing end-of-project performance. These high-level indicators are effective measures of

program impact, but a time period longer than 5 years is usually required to effect substantial changes at the national level. In the absence of secondary data, projects need to collect specific data tailored to measure the outcome of interventions (e.g., to measure access, demand, or quality of services). Lack of reliable outcome level-data hinders systematic monitoring of the projects by both USAID and the respective project management. It has also limited the team's efforts to evaluate project results against set targets.

USAID's management of the five projects intended to maximize integration of the projects' interventions through close coordination. USAID encouraged the projects to work and liaise with each other. At the central level, USAID established regular coordination meetings. These meetings, which were later expanded to include the DOH and other development partners, were mainly for purposes of information sharing. Technical working groups (TWGs) of cooperating agencies (CAs) were also formed in several areas, such as FP, and monitoring and evaluation. A FP TWG composed of USAID and CAs is in place and functional.

While the coordination mechanisms achieved information sharing, joint planning to integrate related interventions was not regarded as imperative because the projects have distinct deliverables (even though the overall portfolio objectives are shared). In addition, a lead group within USAID, such as a steering committee to provide collective oversight of the FP and MCH program, does not exist. Such a committee would have strengthened strategic management and coordination among the projects in the portfolio.

The different projects coordinate with the regional CHDs as part of the overall effort to transfer technology and enhance sustainability in the field. However, since the projects focus on their respective deliverables, field coordination among them is not as strong as it is at the central level. Moreover, the level of coordination is affected by the priorities and preferences of LGUs.

In general, the team found that all five projects have been highly responsive to the DOH at the central, regional, and provincial levels. Good rapport has been established with both CHDs and PHOs, though the commitment at the municipal level is mixed. The reach of the interventions to the municipal LGUs remains a challenge.

### **Recommendations for Program Design, Management, and Coordination**

The current portfolio is spread out nationwide and covers 30 provinces from 14 of 17 regions and all island groups. The team recommends that future projects be designed to focus on more municipalities and cities in fewer provinces clustered in fewer regions, to maximize synergies and logistical efficiencies and in turn lead to greater impact.

Province selection should also consider the absorptive capacity of the LGU to accept interventions, as well as its political commitment to improving FP and MCH services. While large provinces should also be given priority (in order to maximize population coverage), LGUs in the ARMM and other disadvantaged and hard-to-reach regions should be given special attention, with particular focus on women and the youth.

The current program design is focused on strengthening systems and providing technical assistance at the regional and provincial levels (municipal-level assistance started only in 2009, following the recommendation of the midterm health portfolio assessment). In the future, municipalities and chartered cities which exhibit political commitment and capacity apart from the provinces they belong to should be direct beneficiaries of the technical assistance.

Project designs should include baseline and endline data if alternative secondary data are not available, to enable systematic monitoring and evaluation. There should be operations research that tests the results of innovations and interventions and a strong M&E system to track progress and recommend refinements in strategies.

Coordination meetings among projects should be undertaken not only for information sharing but also for constructive joint planning in order to integrate similar interventions. The same recommendation is applicable for strengthening the TWGs, including the FP TWG. The functions of the TWGs should be broadened to include technical updates on global experiences and ways to integrate them into project interventions. In order to maximize the aggregate impact of the USAID portfolio of projects, USAID Contracting and Agreement Officers' Technical Representatives (C/AORs) should work as a team or within a steering committee to oversee not only the individual implementation but also the coordination and functional integration of the projects in the portfolio. At the field level, USAID should support strengthening coordination among the projects and the LGUs to ensure buy-in of LGUs into USAID assistance.

The team likewise recommends that USAID require joint annual workplanning among the projects, and that program designs include built-in mechanisms for coordination among the projects.

## **ASSESSMENT OF RESULTS OF USAID-ASSISTED INTERVENTIONS**

Following is a summary of findings on the results of the current USAID-assisted interventions:

### **I. Increasing access and provision of quality FP and MCH services in the public and private sectors**

Support for PhilHealth accreditation of health facilities and PhilHealth enrollment of beneficiaries in the public and private sectors: PhilHealth offers a package of public health benefits to subscribers and reimburses health care providers of accredited health facilities for the provision of FP and MCH services. Table 5 describes the services and reimbursements PhilHealth offers.

**Table 5: PhilHealth Services and Reimbursements**

<b>PhilHealth Services</b>	<b>Reimbursable Amount (PhP)</b>
Maternity care package (MCP) for normal deliveries	8,000
Newborn screening	1,750
IUD insertion	350
Bilateral tubal ligation	4,500
Non-scalpel vasectomy	3,000

To ensure that clients and providers are able to access these benefits, particularly the MCP package, the HealthGov and SHIELD projects assisted municipal LGUs in obtaining accreditation of their rural health units (RHUs) and birthing centers. HealthGov also assisted the municipalities in identifying poor households and advocated for the allocation of funds for their enrollment under the sponsored program.

Out of 531 RHUs and CHOs in HealthGov-assisted provinces, 202 were accredited for the MCP. Targeted enrollment of indigents to the PhilHealth exceeds 100%. Based on project reports, there are 1,515,160 conditional cash transfer (CCT) families, while 2,009,391 have been

enrolled in PhilHealth. In the private sector, the PRISM2-assisted private health facilities obtain MCP accreditation. Currently, there are 22 health facilities assisted by PRISM2 that are MCP-accredited. This process has led to the cities and municipalities being able to generate considerable resources, which were used to improve the delivery of FP and MCH services.

**Recommendations:** The team identifies this intervention as a best practice and recommends scaling it up. Specific recommendations to expand the intervention are provided in the next section on best practices. This technical assistance package is important to ensure sustainability of the FP/MCH programs and to improve the quality of services. In carrying out this intervention, there is a need to provide information about the benefits offered by PhilHealth to both clients and health care providers.

**Contraceptive self-reliance:** To respond to the need for contraceptive supplies given the phaseout of USAID-donated commodities, HealthGov provided assistance to the LGUs in implementing the national policy of contraceptive self-reliance (CSR). Under this policy, LGUs shall be responsible for the procurement of contraceptives especially for clients who are unable to pay for these essential commodities. Toward this end, HealthGov assisted municipalities in enacting local policies in support of CSR, estimating contraceptive requirements, and allocating funds and actually procuring contraceptives. As a result, out of 600 municipalities and cities, 186 procured FP commodities, 513 have MNCHN plans, and 180 have enacted FP and MNCHN policies. The SHIELD project also assisted the ARMM on contraceptive procurement, and PRISM2 assisted LGUs on contraceptive procurement.

**Recommendations:** It should be noted that a CSR plan by itself does not guarantee subsequent procurement. The most important factor is the availability of funds. A CSR plan helps to estimate contraceptive requirements. PhilHealth enrollment and accreditation, discussed above, ensures that funding for actual procurement is available. Therefore the team recommends USAID continue the intervention for estimation of contraceptive requirements. However, this activity needs to be integrated with other efforts to mobilize resources to actually procure contraceptives. A CRS plan alone will not work.

### **Facilitating the Use of DOH Grants to Procure Contraceptives and Improve Facilities**

In 2011, the DOH provided MNCHN and Health Facility Enhancement Package (HFEP) grants to regions, provinces, and municipalities to improve the delivery of FP and MCH services. The grants can be used to fund the purchase of contraceptive supplies, physical improvement of health facilities, and training for health care providers and volunteers. To facilitate the release of the grants and ensure their proper utilization, the HealthGov and SHIELD projects provided technical assistance to the DOH-CHD and the provinces. In the case of the ARMM, the SHIELD project helped prepare the documents required for the release of the grants from DOH to DOH/ARMM and then to the provinces. All the ARMM provinces were able to procure contraceptives and used part of the grants to engage the services of midwives to augment the health manpower, especially in hard-to-reach areas.

**Recommendations:** This intervention has been useful, particularly in the ARMM, for ensuring procurement of contraceptive commodities. However, the DOH should explore better ways of releasing and liquidating the grants to minimize the administrative burden of LGU beneficiaries. The team observed that in most cases, the funds have been used to upgrade birthing facilities, not for contraceptive procurement. Since a more stable and feasible option to procure

contraceptives and improve facilities exists through PhilHealth, the team recommends to discontinue the intervention.

**Strengthening service delivery networks by integrating the private sector:** PRISM2 focused efforts toward strengthening service delivery networks (SDNs), which is a public sector strategy, by engaging private health providers, private hospitals, and alternative delivery points (ADPs) at the central and regional levels to promote facility-based delivery of services. In some instances, PRISM used the DOH strategy of the Inter-Local Health Zone (ILHZ) as a mechanism for strengthening the service delivery network.

Where there are strong training institutions, PRISM2 identified private health facilities and providers as effective members of SDNs. Although the goal is to strengthen 36 SDNs, many are still in the preliminary stages, and no SDN to date could qualify as “fully strengthened.”

**Recommendations:** This is a relatively new intervention which has not yet shown results. Thus, the team was not able to fully assess the achievements of the initiative. USAID should request that the PRISM2 project conduct an assessment of the initiative by the end of the project’s life. Private sector participation—especially in expanding the market for commercial and branded contraceptives (pills, condoms, injectables)—is important and needs to be promoted. However, there seems to be no compelling evidence to support the belief that investing in training private sector providers has added value to the program. According to international experience, the private sector’s contribution to expanding access to long-acting or permanent methods of FP remains limited. Thus, as a general comment, the team recommends that USAID focus on the public sector to increase availability and access to long-acting or permanent methods during the next program cycle.

**Establishment of ADPs:** One of the concerns resulting from the phaseout of USAID-donated contraceptives is how to promote access to contraceptives in the commercial sector, since most pharmacies that carry contraceptive products are only available in densely populated areas and therefore may not be accessible. To address this problem, PRISM2 worked with pharmaceutical firms to set up ADPs in the absence of regular pharmacy outlets or where contraceptive commodities were lacking in public health facilities. PRISM2 reported that they have reached 591 ADPs for FP and MCH products, although the team observed that many of the outlets in Lanao del Sur were not functioning.

**Recommendations:** This is also a recent intervention and data are not available to fully assess the outcomes. PRISM2 should undertake an assessment to analyze the results.

**Organization of public health outreach services:** In the ARMM, the Philippine military regularly organizes medical outreach missions as part of its efforts to improve civilian and military relations. These consist of medical and dental consultations and the provision of free medicines. Taking advantage of this opportunity to provide public health services, the SHIELD project began offering immunization, antenatal care, and FP services during the medical outreach missions. More than 4,000 men, women, and children in the ARMM benefited from these interventions.

**Recommendations:** This intervention uses an existing mechanism to expand access to FP/MCH services in the ARMM, and it is a low-cost approach. USAID should request that the SHIELD project provide more detailed data on the achievements and continue the intervention if feasible.

**Training of public and private health care providers in FP and MCH:** The SHIELD and PRISM2 projects assisted the DOH in training private and public health providers in FP, postpartum IUD insertions, BTL, and AMTSL (only in the ARMM).<sup>5</sup> Training on postpartum IUD is a special training and not yet part of the regular curriculum. The projects mostly focused on training providers for level 1. The SHIELD project did support training on postpartum IUD and sterilization. Despite these efforts, the availability of trained providers is one of the major constraints affecting the FP program’s ability to reach and serve more clients.

Training data for the HealthPro, PRISM2, and SHIELD projects are presented in respective sections of this report. The HealthGov project has assisted the DOH in training providers in FP, but the data show that most of the training has been on basic FP that focuses on pills and temporary methods. Very little training on long-acting and permanent methods has been conducted. HealthGov reports that in 25 provinces, out of total 5,739 nurses and midwives, only 1,394 (24%) are trained in FP level 1 and 428 (7%) are trained in FP level 2. There are no reports on FP level 3 training. The SHIELD project has trained 49 providers in long-acting and permanent methods, including BTL, but the data on total numbers of providers are not available.

**Recommendations:** Training service providers as well as program managers is critical to improving availability of services. The team recommends that USAID provide further support for FP and MCH training. Specific and detailed recommendations for strengthening training are provided in the “Supply-related Considerations” section of this report. The most useful and relevant interventions for training are FP training courses for service providers that will equip them with the necessary knowledge and skills to provide FP information and services. To maximize benefits, this intervention needs to be complemented by the training of community volunteers. Training packages on AMTSL and EINC are also important. Health care providers who attend births need to be trained on AMTSL and EINC in order to reduce postpartum hemorrhages and maternal deaths. However, this training needs prior policy work to ensure that midwives are legally allowed to practice these clinical procedures.

## 2. Strengthening information dissemination

**FP campaigns: Waves 1, 2, and 3:** HealthPRO assisted the DOH in conducting three waves of its FP campaign. Wave 1 targeted the initiators (non-users); Wave 1’s theme aimed to get people to start FP: “*Planuhin ang pamilya, planuhin ang kinabukasan*” (“Plan your family, plan your future”). Wave 2 targeted young couples with messages promoting spacing of three to five years: “*3–5 taong agwat, dapat*” (“Three- to five-year spacing is just right”). Wave 3 was targeted at limiters, and was conducted in seven priority provinces. Its message was “*Ikaw at Ako ay Tayo*” (“You and I make us”). According to project reports, the FP campaign and materials reached more than 24.5 million people with key FP messages.

**Recommendations:** The team recommends that the FP campaigns continue. However, the messages must evolve from where they have been for many years—focused on the basic need to plan the family. These messages are generic and no longer compelling; people are now looking for new and useful information. The new messages should inform the public about specific methods and focus on dispelling the myths and misconceptions attached to them.

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<sup>5</sup> The FP training is divided into three levels. Level 1 covers the following methods: hormonal (pills, injectables, and implants); condoms; and modern natural family planning, including the standard days method and LAM. FP counseling is also included under level 1 or basic FP training. Level 2 involves IUD insertion using the interval technique. Level 3 training covers BTL and NSV.

Messages should be targeted to particular audiences and use various media, including those commonly used by different audience groups. Specific and detailed recommendations are included under the “Demand-related Considerations” section.

**Garantisadong Pambata campaign:** HealthPRO assisted the DOH with organizing a campaign, *Garantisadong Pambata (GP)*, to promote child health, especially regarding intake of vitamin A. Originally, GP focused on providing vitamin A to children under 5 years of age, but efforts evolved to cover other child health issues like immunization, breast-feeding, and deworming. The campaign also included messages promoting handwashing and proper use of toilets. HealthPro supported 160 GP health events and mobilized more than 56,500 people.

**Recommendations:** Considering that this program has already been institutionalized at the DOH and LGU levels, and is supported by other donor agencies, USAID should focus its resources on promoting less utilized programs like FP.

**Safe motherhood campaign:** HealthPRO provided technical assistance to the DOH in the campaign to reduce maternal morbidity and mortality by focusing on educating women to seek antenatal care and delivery in a health facility with an SBA. Included in the information disseminated are the six actions that a pregnant woman should take to ensure safe delivery. HealthPro supported more than 190 health events with over 59,500 people mobilized. Together with the GP, the safe motherhood campaign reached more than 11.4 million people.

**Recommendations:** USAID should discontinue supporting the intervention because it is being supported by other donors.

**CHATs and CHTs:** The SHIELD project utilized community involvement, when CHATs were organized in barangays and these teams were trained in a four-day course on caring for mothers and newborns in the community (CMNC). At the time of the evaluation, a total of 1,805 CHATs were trained. CHATs were envisioned as change agents that would provide the community with basic health information and help improve health behavior and attitudes. Community members in the CHATs are trained to identify women and children in need of services and to refer them to a facility or a service provider.

Community health teams (CHTs)—originally called “navigators”—were pilot tested in Compostela Valley by the HPDP in connection with the development of *The Family Health Book*. Poor households were identified by utilizing the Department of Social Welfare and Development (DSWD) National Household Targeting System for Poverty Reduction (NHTS-PR) and were assisted by trained CHTs in accessing priority health services. The project expanded the intervention to an additional five sites—four provinces (Batangas, Davao del Sur, Pangasinan, Leyte) and one city (Quezon City). Currently, *The Family Health Book* covers 10 public health practices; it may need to be refined to focus more on the priority FP and MCH concerns.<sup>6</sup> The DOH adopted the CHT model nationwide in 2011.

**Recommendations:** The team has identified the CHAT model as a best practice for community mobilization to increase access to and utilization of FP and MCH services. Upgrading community volunteers’ skills is essential to creating demand for services. The important features

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<sup>6</sup> It should be noted that a CHAT is a unique CHT model. The CHAT model provides FP/MCH-specific counseling, active case finding of individuals who need services, and referrals to specific facilities or providers. This is discussed in more detail in the “Best Practices” section.

of this intervention include: (1) identifying clients who need services, (2) organizing group counseling sessions, (3) referring potential clients to specific providers and facilities to access the type of services they need, and (4) utilizing satisfied FP clients to promote male involvement in FP. The model and specific recommendations to scale up the approach are discussed in detail in the “Best Practices” section of this report. The team recommends that USAID assist in modifying the CHT model to adopt successful elements of the CHATs.

**Lakbay Buhay Kalusugan (LBK):** LBK was established to support the effort to bring health information and services to geographically isolated and disadvantaged communities. With a bus donated by Victory Liner, Inc., and the services of the Probe Team, LBK made health “everyone’s business” through a private-public partnership which brought information and services to poor and inaccessible communities. Through LBK, HealthPro pilot tested models for promoting FP and MCH in remote areas. The project reports that LBK had 44,375 beneficiaries, which included 3,408 pregnant women and 10,973 children.

**Recommendations:** This intervention is a good model for private-public sector collaboration to bring health information and services closer to the disadvantaged communities. The team however, recommends USAID to discontinue support because 1) the intervention is not specific to FP and MCH 2) there is no data providing evidence that the approach has actually helped increasing the acceptance and utilization of FP and MCH services and 3) so far, the DOH and the private sector has provided more funding for the LBK than USAID’s assistance and they will likely continue their support in the absence of USAID’s assistance.

**Community theaters:** HealthPro organized community theaters as a way to embed FP. The approach included encouraging male involvement in family health. From April–July 2012, 126 plays in 7 provinces were staged, accessing almost 47,000 beneficiaries at the cost of PhP80 per person. Of these, 29,800 (63%) were actually reached in the health classes that immediately followed the play.

**Recommendations:** According to HealthPro’s reports, the intervention has reached large audiences. There is no evidence, however, that the approach has helped increase FP acceptance. Therefore, the team recommends that USAID discontinue support for the street theaters and focus its BCC assistance on particular audiences using various media, including those commonly used by different audience groups.

**IPCC trainings:** HealthPRO trained the health care providers in IPCC to improve their skills in assessing patients’ health concerns and providing accurate and timely health messages. The training curriculum is generic and covers other public health concerns, like the module on FP. The IPCC toolkit includes technical briefs, supportive supervision tools, job aids (flip charts, desk charts, cue cards, FP placemats), and client education materials (posters, flyers, interactive comics).

About 4,930 of 7,388 health care providers (67%) were trained in IPCC. Likewise, 35,631 of 76,871 volunteers (46%) were trained. According to project reports, the total number of people counseled on FP as a result of these efforts is 2,192,685.

**Recommendations:** According to data provided by HealthPro, IPCC trainings had good coverage. However, the team recommends that USAID discontinue the practice of stand-alone IPCC training. Among all other topics, the focus on FP specific counseling gets diluted. Despite high coverage of the intervention, the team’s analysis shows that that there is no correlation

between IPCC trainings and increases in CPR. IPCC training for FP is redundant, because FP counseling is already part of the basic FP training course. The team recommends improving and expanding FP counseling as part of FP skills trainings.

**Integration of FP into immunization services:** HealthGov conducted an operations research in Misamis Occidental to integrate FP messages into immunization and antenatal care. Health care providers and volunteers were trained to give FP information anchored on three messages during immunization activities. Women who came for immunization were given messages related to the practice of FP, and those women who expressed interest in practicing FP were given counseling and referred to a facility for services. The reported results showed that the intervention group had a significantly higher increase in the CPR (9.8%) compared to the control group.

**Recommendations:** While the results of the operations research are promising, the team observed during trips to the providences where the intervention is being scaled up that the providers were very busy on immunization days and were not always able to provide adequate counseling and advice on referral. The team does not recommend USAID discontinue support, but the approach needs to be refined for expansion.

**Capacity-building for demand generation at the national level:** HealthPro assisted the DOH National Center for Health Promotion (NCHP); the National Center for Disease Prevention and Control (NCDPC); POPCOM; and the FP/MNCHN taskforce in BCC planning, design, implementation, and monitoring and evaluation. This included development of key FP/MNCHN messages for national campaigns and providing BCC templates for duplication in 30 selected provinces.

**Recommendations:** USAID-funded projects should continue BCC assistance at the national level with a strategic approach to disseminating audience- and method-specific FP information using a variety of communication channels. The team's specific recommendations are found in the "Demand-related Considerations" section of this report.

### 3. Improving the policy environment and systems strengthening

**Improving quality of health data:** HealthGov assisted LGUs in improving data management for effective planning through Data Quality Check (DQC), and the indicators subjected to DQC were CPR, antenatal care, SBAs, FBDs, exclusive breast-feeding, and vitamin A coverage. As of September 2012, 333 of 598 trained LGUs were found to be continuing the implementation of the DQC. A monitoring tool and an assessment tool were developed for LGUs to check continued DQC practice.

**Recommendations:** The DQC intervention is a useful health systems strengthening approach to improving data quality. However, care should be exercised in using the data to report on outcome indicators. The team found no evidence that the intervention has helped to enhance FP and MCH indicators in project provinces, since its utilization focused on having data to report on performance rather than to improve services, and thus recommends discontinuing the intervention.

**Assistance in formulation of FP and MCH policies:** In addition to conducting studies covering a wide range of policy issues, HPDP helped the DOH formulate the MNCHN strategy and the administrative order on "Reduction of Unmet Need for FP." HPDP also assisted in formulating budget execution guidelines for the MNCHN grants facility and estimating FP

commodity requirements for provinces and cities. HPDP also assisted the DOH in refining guidelines for the formation of CHTs through pilot testing in Compostela Valley.

The PRISM2 project assisted PhilHealth in the development of policy guidelines on health facility accreditation of private facilities. PRISM was also involved in reviewing the policy on the practice of AMTSL in relation to the midwifery law.

## **BEST PRACTICES IN FAMILY PLANNING AND MATERNAL AND CHILD HEALTH**

Among the 20 interventions implemented by USAID-supported projects summarized above, the team identified the following 4 best practices that resulted in improvements in FP and MCH outcomes.

### **I. CHATs**

CHATs were envisioned as change agents that would provide the community with basic health information and help improve health behavior and attitudes. Community members in the CHATs are trained to identify women and children in need of services and then refer them to a facility or a service provider. The master list of all eligible clients in the community was conducted for active case-finding by the CHATs using a tool that focuses on a few basic and critical FP and MCH services. For those couples who are interested in FP services or for current users who want to switch methods, the CHATs organized group counseling sessions where both men and women were engaged in method-specific discussions. Depending on the topic, the CHATs invite satisfied users who shared their experiences in using a particular method. Community members who expressed interest in FP services were then referred to the appropriate facilities or service providers for further counseling and service provision.

The FGDs with CHAT members revealed the following information:

- All CHAT members received training on the community-based tool to identify men, women, and children who need FP/MCH services.
- The CHATs mentioned that their main jobs are to identify individuals who need FP/MCH and help those who are interested receive the services.
- The CHATs are supervised by the RHU and barangay health station staff and participate in monthly CHAT meetings.
- The CHATs do not receive any compensation but take a lot of pride in performing their work as health volunteers.

Interviews with health care providers and review of the RHU records showed that the efforts of the CHATs resulted in increased referrals for FP services and a significant increase in the number of women delivering in birthing clinics.

### **2. Allowing midwives to provide life-saving practices and drugs**

In the ARMM, the secretary of health issued a directive allowing midwives to perform life-saving practices and administer life-saving drugs. Midwives in the rest of the country do not have the benefit of such a clear policy. Under the Midwives for Every Community in ARMM (MECA) program, which was funded by DOH Central through the FP and MCHN grants, the SHIELD project prioritized the training of the midwives in the above skills.

AMTSL is a highly recommended<sup>7</sup> clinical practice that is designed to prevent postpartum hemorrhage and reduce the duration of the third stage of labor and its complications. It should be noted that postpartum hemorrhage is the leading cause of maternal mortality in the Philippines, and AMTSL is a low-cost, yet highly effective, intervention to prevent that complication.

During field trips outside of the ARMM, the team observed that providers who received BEmONC training learned how to practice AMTSL. However, there has been no standard training for service providers assisting normal deliveries. The DOH has recently introduced EINC training through a pilot activity in Region 12, which includes a module in AMTSL. The training is being piloted in Region 12 with technical assistance from the WHO.

The training of midwives in the ARMM and allowing them to administer oxytocin even without the supervision of a physician is undoubtedly a life-saving intervention. The practice of AMTSL involves the following steps:

- Administration of a uterotonic drug such as oxytocin within one minute of delivery of the baby and after ruling out the presence of another baby
- Controlled cord traction and countertraction to support the uterus
- Massaging the uterus after the delivery of the placenta

Lack of access to birthing facilities in the ARMM is not a critical issue as trained midwives practice AMTSL during home deliveries. The provincial health staff in one ARMM province claimed that as a result of the AMTSL policy, the maternal deaths in the province were further reduced in 2012.

### **3. Introduction of postpartum IUD**

FBDs are steadily increasing in the country and will continue to increase in the future due to the government's strong policy and implementation of MNCHN. The increasing numbers of women delivering in the facilities present a great opportunity for providing FP information and services. However, at present, the provision of FP counseling during antenatal care and the postpartum period is weak. Interviews with postpartum women indicate very low knowledge of specific FP methods and availability of services.

In facilities where large numbers of women deliver, the only postpartum method offered (if any) is BTL, usually during caesarean sections. In most hospitals, post-partum women are usually advised to go to the RHUs for FP. Some facilities in the ARMM region, where postpartum IUDs are available, are the exception. In the few facilities where postpartum FP services were offered, the team observed high levels of acceptance.

With assistance from the SHIELD project, health care providers in a few health facilities in Wao District in Lanao del Sur were trained to provide postpartum IUDs. The project reports that in a five-month period (May–September 2012) 22 providers were trained and have inserted a total of 168 postpartum IUDs.

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<sup>7</sup> The World Health Organization (WHO) estimates AMTSL can eliminate half of the postpartum hemorrhage cases and save many women's lives.

The team visited the birthing facility and district hospital in Wao, which offered this procedure. The facilities had a moderately high number of deliveries, with averages of 20–30 deliveries per month. The postpartum IUD acceptance rates for these facilities were high and ranged from 40–50% of women who delivered. The acceptance rates could have been higher if untrained midwives were more effective in motivating the women that they helped deliver. The interview of the midwives who were trained on the postpartum IUD insertion revealed the following:

- The three midwives who were trained in a high-volume training facility in Manila were very confident in their acquired skills and had no difficulty performing the procedure.
- The expulsion rates were quite low, which is indicative of the quality of the training.
- The midwives who were trained in a medical center in Region 10 were not as confident and claimed that they were not able to perform a single postpartum IUD insertion during the five-day training.
- None of the midwives who were interviewed were aware that IUD insertion is covered by Philhealth.

Women who accepted the procedure were satisfied with the method and claimed that they were willing to help convince other interested women. This intervention confirms that there is a market for long-term methods of contraception and in instances where these interventions are available, acceptance and satisfaction rates are high.

#### **4. Accreditation of facilities by PhilHealth for the maternity care package (MCP) and enrolment of PhilHealth beneficiaries in the public and private sector**

The benefit packages offered by PhilHealth is a sustainable way of funding FP and MCH services. The accredited birthing facilities with 20–30 deliveries per month generate an average of PhP 200,000 to 300,000 in additional income, which can be used by the RHU to carry out the following activities:

- Procurement of equipment, contraceptives, and other FP and MCH supplies
- Physical improvement of the health facilities
- Training and skills development of health care providers
- Meetings with health staff and volunteers

The team observed that health managers at the LGU level, especially in Lanao del Sur, took advantage of this financing opportunity to improve FP and MCH services and carried out the following steps:<sup>8</sup>

- Investing in facility improvement to meet accreditation requirements. Birthing facilities require minimal investments in terms of space and equipment. Many RHUs can be converted into birthing facilities while maintaining their other public health functions.

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<sup>8</sup> However, in other provinces the team visited, the majority of local managers were not aware of the financial opportunities provided by PhilHealth and did not use funding to improve FP and MCH services.

- Enrolling poor families in the sponsored program of PhilHealth. While the NTHS families enjoy automatic enrollment, other poor households need to be sponsored by the LGU to ensure adequate coverage.
- Encouraging pregnant women to deliver in the birthing facility. The CHTs can be trained and deployed to help in motivating pregnant women to undergo prenatal checkups and deliver in the birthing centers.
- Getting accredited for the outpatient benefit package and reimbursements for FP services.

### **Recommendations for Scaling up the Best Practices**

The team recommends that USAID assist in replicating and scaling up the cited best practices. Prior to replication, USAID-funded projects should conduct a more thorough review and evaluation of these best practices to explore ways of implementing them more effectively and efficiently. Interventions should also identify the elements and factors that need to be present for successful implementation and scaling up of the best practices. USAID-supported projects should take the technical leadership in applying these recommendations to scale up the best practices:

### **Enhancing Community Involvement through CHATS:**

- Focus on a few critical FP and MCH services. One of the reasons for the success of CHAT is the prioritization of services that the CHAT helps promote.
- Organize group counseling sessions to discuss specific methods for couples who are interested in FP services.
- Invite men to join and participate in the group counseling sessions. During the FGDs, men expressed a strong interest in participating in FP counseling activities.
- Ask satisfied users to share their experiences and help dispel method-specific myths and misconceptions.
- Facilitate service provision.
- Refer clients for FP services.

### **Allowing Midwives to Practice AMTSL:**

- Amend the midwifery law to allow midwives to practice AMTSL and administer oxytocin in line with WHO protocols and standards.
- Review ongoing pilot testing of EINC/AMTSL training package in Region 12 because it offers the advantage of reducing health risks and advancing health benefits to both the mother and the child.<sup>9</sup>

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<sup>9</sup> The AMTSL and EINC in the ARMM are being scaled up using the Quality Improvement Collaborative (QIC) mechanism. The team did not have an opportunity to observe the QIC and thus cannot comment on it. However, QIC is an effective approach used in over 15 countries to improve quality of care in many technical areas, including AMTSL.

- In areas where accredited birthing facilities are difficult to access and thus unrealistic to expect women to deliver in, USAID should ask the DOH to consider relaxing the policy of FBDs and allowing midwives to practice AMTSL in a domiciliary setting.
- Include AMTSL as part of the requirements for accreditation and reimbursement by PhilHealth. The benefit packages offered by PhilHealth is a powerful tool to influence the behavior of health care providers and clients.

**Postpartum FP:** The team recommends expanding the postpartum FP program, particularly in large hospitals and birthing facilities, to ensure that all women delivering at these facilities are provided with FP information and that a choice of methods are readily available at the sites. Priority should be given to long-term and permanent methods (BTL and IUDs), as couples reach the desired family size at relatively young ages. Expanding and replicating the postpartum IUD intervention will involve the following considerations:

- Prioritize staff at hospitals and birthing clinics that have a high volume of deliveries for receiving postpartum IUD and BTL training.
- Support the DOH in establishing more training sites for BTL and postpartum IUDs, particularly preceptor sites among those birthing clinics that have high caseloads and high acceptance rates for BTL and postpartum IUDs.
- Help the DOH monitor the quality of the training in BTL and postpartum IUDs. The projects should also assist the DOH in incorporating postpartum IUDs into level 2 training.

**Sustainable financing through PhilHealth accreditation and enrollment:** To maximize the benefits offered by PhilHealth to both clients and providers, USAID should consider the following:

- Improve the dissemination of information regarding the benefit packages to both clients and health care providers. Particular attention should be paid to the reimbursements for FP services. Subscribers need to be aware that FP services—especially BTL, non-scalpel vasectomy (NSV), and IUD—are covered. Health care providers also need to know that they can claim reimbursements for providing such services.
- Include the practice of EINC (including AMTSL) as part of the MCP and newborn screening packages. EINC (including AMTSL) is a cost-effective intervention that reduces health risks and provides added health benefits to the mother and the child.
- Simplify requirements of reimbursements for FP services, especially for NSV, BTL, and IUD. Presently, only accredited hospitals can claim reimbursements, even though those procedures are done on an outpatient basis and can easily be performed in health centers and clinics. While waiting for these guidelines, the projects can help RHUs to receive reimbursements by assisting them in establishing working arrangements with accredited hospitals.
- Improve further the turnaround time for claims processing.

## **FACTORS CONTRIBUTING TO THE IMPROVEMENT OF FAMILY PLANNING AND MATERNAL AND CHILD HEALTH INDICATORS**

In addition to the previously mentioned best practices implemented by USAID-funded projects, the team identified various factors and conditions both in USAID-assisted and non-USAID-assisted provinces that contributed to the improvements in FP and MCH outcomes.

**Appropriate integration of services:** “Integration of services” is understood here as bundling a package of services offered to clients. This comprehensive approach to service delivery is advantageous for clients since they do not have to go to different facilities or come to the same facility multiple times to get needed services. This is an important element of quality of care. This is also an opportunity to efficiently reach potential FP clients when they come for other services (e.g., prenatal and postnatal care). The team observed the following examples of integration:

- Integration of IUD insertion during the immediate postpartum period
- Integration of FP counseling during immunization services for children
- Integration of FP counseling during antenatal care

The team observed that in selected facilities where FP information and services were integrated with maternity services, acceptance of postpartum FP was high. It is important for health care providers to consider the proper timing for introducing the integrated package. For example, on immunization days, mothers may not be very receptive to FP messages; they are busy taking care of their children, and the health workers are also too busy taking care of other women and children.

**Sustainable financing for FP and MCH services through PhilHealth:** Accreditation of facilities by PhilHealth for the MCP and enrollment of PhilHealth beneficiaries as a sustainable financing mechanism is discussed in detail in the previous sections of this report. PhilHealth offers packages for outpatient care, maternity care, FP, newborn care, and Tuberculosis-Directly Observed Therapy. The outpatient package is paid to health care providers based on capitation arrangements. The other packages are reimbursements for services rendered by the health facility. These reimbursed funds can be used for procurement of contraceptive supplies, improvement of health facilities, and training of service providers and volunteers. The FP package reimburses sterilization and IUD insertion services in accredited hospitals.

Financing through PhilHealth present the following advantages:

- Clients do not have to pay for services anymore.
- Quality of care is enhanced because the resources are available to upgrade facilities, ensure availability of supplies, and upgrade health providers’ skills.
- This benefit is strongly supported by national policy, which makes for a stable and reliable source of financing.
- The PhilHealth reimbursements offer added motivation and incentives for health care workers to provide FP and MCH services.
- Enrollment in the program is high nationwide, because CCT families are automatically enrolled in PhilHealth.

**Presence of a local champion and a good manager and leader:** “Local champion” describes a person who is a strong, committed, and competent advocate for FP and MCH services within the community. Having a local champion is important because:

- Champions can motivate other stakeholders.
- Champions’ actions are credible and their opinions are respected. Hence, they can easily influence the adoption of desirable practices.
- Champions can facilitate the mobilization of national and local resources.
- Champions can offer opportunities for making meaningful changes happen.
- Champions can influence the adoption of supportive policies.

An outstanding example is a midwife in Basilan, who has attracted wide support for her work in FP and MCH. She was instrumental in issuance of the policy allowing midwives to practice AMTSL and administer oxytocin. She also empowered midwives by training them in AMTSL at her own birthing clinic and introducing the practice in Basilan. As another example, a municipal health officer in the ARMM was responsible for the establishment of the birthing facility that practices successful postpartum FP services.

**Political support (national and local):** At the national level, President Benigno Aquino III supports the provision of a wide range of FP services and has endorsed the passage of the Responsible Parenthood, Reproductive Health and Population and Development Bill (the “RH Bill”). The president’s support encouraged the DOH to allocate MNCHN funds to improve FP and MCH program implementation in the LGUs.<sup>10</sup>

At the local level, the LGU can issue a legal instrument (e.g., executive order, administrative order, city ordinance, or municipal ordinance) to support and fund the provision of FP and MCH services. Even though national support is important, the team observed that the LGU leadership ultimately carries more weight. In those LGUs where mayors were supportive of FP services, services were more available. This local political support offers the following advantages:

- Guides program managers in making priority decisions
- Removes barriers against proper program implementation
- Fosters smooth program implementation
- Serves as strong motivation to perform well
- Ensures financing for FP services and commodities

**Matching supply with demand:** The results of the FHS showed that there is a demand for FP, and the team confirmed this observation during the field visits. During the FGDs and interviews with clients, men and women expressed interest in using specific FP methods. In fact, many clients come to the clinic with a particular method in mind. Unfortunately, the choices at the clinic are usually quite limited; in most cases, the pill is the only method available. Access to long-term and permanent methods of contraception is scarce and difficult.

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<sup>10</sup> It should be noted, however, that there is only one person attending to the FP program within the DOH. This indicates that the high-level political support is not yet reflected in prioritization of FP.

Where LGUs have trained providers offering a wide range of FP methods and services, utilization of FP services is high and clients are better satisfied. It is important that there is a match between supply and demand of services. The following are key elements of strong supply and demand sides in FP:

- Availability of trained health care providers
- Availability of a wide range of FP options, including long-term and permanent methods
- Establishment of a functional referral system to ensure continuity of service provision
- Availability of method-specific counseling
- Target audience and method-specific messages, particularly to address misconceptions and myths about specific methods
- Use of satisfied users for promoting FP to share information and experiences on using specific methods
- Enhancement of provision of FP services in hospitals, especially those with high-volume maternity services

**Community involvement:** The provision of FP information and services is enhanced by the strong and active participation of community volunteers who serve in CHTs and CHATs as previously discussed in this report. These volunteers act as “navigators” who guide the people in accessing FP and MCH services. CHTs were particularly instrumental in referring pregnant women to deliver in health facilities. However, CHATs were successful in emphasizing referrals for FP services.

## **SUPPLY-RELATED CONSIDERATIONS**

In general, contraceptive use is high where facilities provide FP services, contraceptive commodities are available, and the population is correctly informed.

The availability of contraceptive supplies—such as pills, condoms, and injectables—is not uniform among LGUs. The sources of supply are often unreliable. Many LGUs are procuring contraceptives, but most have a limited quantity available. In such cases, LGUs prioritize poor clients or new users. Women who come for re-supply are usually told to procure contraceptives from the pharmacies or other private sector sources.

Providers tend to recommend the pill since it is the method that is most likely to be available in the facilities. Moreover, most providers are not trained in provision of long-term or permanent methods. However, providers claim that when clients come to the clinic for FP they generally already have a method in mind. FP counseling is weak in the health facilities.

Trained providers continue to be in short supply, especially providers of IUDs and sterilization services. The major program effort to train providers in FP happened in the 1990s; many providers have since been assigned to other positions or have retired. Basic training in FP is being offered on a sporadic basis, and only a selected few are given the opportunity to attend. Refresher training is rarely available.

In areas where postpartum IUDs are offered, acceptance is high among women who deliver in facilities. Among postpartum women who deliver in hospitals, ligation seems to be the only

method available for limiters. However, many hospitals visited by the team were not providing ligations. In others, ligation was provided based on the availability of operating rooms and gynecologists, as other obstetric and gynecological services were given the priority.

**Recommendations for improving supply:** The team recommends further support for training providers (facility-based and outreach workers) and program managers in FP and MCH. Trained providers and managers continue to be in short supply. Recommended areas for strengthening training are:

- Basic and comprehensive FP (FP levels 1, 2, and 3). In particular, level 2 and 3 training courses are important for increasing the number of providers able to deliver long-term and permanent methods of contraception. The team does not recommend integrating the three levels of training courses. Level 3 cannot be integrated with levels 1 and 2 because it is only for physicians learning BTL and vasectomy. It is possible to integrate levels 1 and 2, but then the course will be very long—perhaps as long as three weeks. This length of time will make the training unattractive to the providers and local chief executives.
- Postpartum IUD training: This is a special course and should be given priority among staff in facilities with a high volume of FBDs.
- Regular contraceptive technology updates: This is an essential follow-up activity to ensure that trained providers are updated regularly.
- FP trainings should include interpersonal communication skills and method-specific counseling skills.
- AMTSL for all health care providers assisting deliveries, in compliance with WHO protocols and standards. The intervention should facilitate the practice of AMTSL by all SBAs for all women.
- BEmONC training for RHU staff to ensure adequate numbers of providers are available to manage obstetric emergencies.
- Management, leadership, and supportive supervision training for middle managers of LGUs.
- Community volunteers should be trained on a system for identifying clients in the community that are in need of particular services, and use standard procedures for community mobilization and referral to appropriate facilities and providers.

It is important that training be tailored to functions performed by health providers and managers of FP and MCH programs. Hence, there is a need for separate training/module for mid-level local program managers in supportive supervision, monitoring and evaluation, and the proper use of program data for planning.

In addition to strengthening the services at the facilities, USAID should also promote alternative models to increase access to services. Given the inadequate access to long-term and permanent methods of contraception, the team recommends deployment of mobile teams to provide NSV, BTL, and IUDs in RHUs. This model was implemented in the Philippines during 1970s and 1980s and was particularly successful at increasing BTL acceptance. Another alternative is to support Marie Stopes mobile teams to increase access to long-term and permanent methods.

## DEMAND-RELATED CONSIDERATIONS

The USAID intermediate result 3 pertains to increasing appropriate and healthy behavior in the country. As the “lead health promotion and communication vehicle” of USAID, HealthPro carried out its demand-generation mandate by developing the “institutional capacity” of the DOH, LGUs, and other collaborating institutions on BCC.

Capacity-building for demand generation at the national level consisted of assisting DOH NCHP, NCDPC, POPCOM, and the FP/MNCHN taskforce in BCC planning, design, implementation, monitoring, and evaluation. This included development of key FP/MNCHN messages for national campaigns and providing BCC templates for duplication in 30 selected provinces as project sites. The project also pilot tested models for promoting FP and MCH to reach interior areas through the mobile Lakbay Buhay Kalusugan. Other key interventions of the project are described in previous sections of this report.

DOH appreciates HealthPro’s technical assistance to strengthen national information dissemination and materials development support. However, implementation from the regional to the provincial and municipal levels has become difficult to scale up because of competing regional priorities and inadequate funding.

In project provinces, BCC materials that were developed through HealthPro assistance are available, but these materials are inadequate in quantity (except when some LGUs provided budgets to reproduce selected materials). A key issue in the media and print campaigns is the lack of method- and target-audience-specific messages (e.g., youth, men, and those with unmet needs). Another aspect that was observed is the failure to address the prevailing FP misconceptions, myths, and side effects—all of which are key reasons people have resisted accepting or continuing specific methods.

The intervention on IPCC was received positively in the LGUs the team visited. However, the IPCC training provides counseling skills in a variety of public health topics. The curricula have several modules including FP, maternal health, neonatal health, child health, nutrition, and tuberculosis. FP-specific messages are getting diluted within the amount of information being given.<sup>11</sup> It was noted that FP counseling is weak in facilities, especially in the hospitals where there is a high volume of MCH clients and priority is given to MCH.

The HealthPro project reports that the national campaign and materials reached more than 24.5 million people. An independent study conducted in six provinces (Albay, Capiz, Compostela, Negros Occidental, South Cotabato, Tarlac) reported that 9 out of 10 recalled having heard of the campaign, and many respondents were motivated to take action after the campaign.

Roxas City and Pres. Roxas (LGUs in the Capiz province) are good examples of areas where positive results of the campaign were reported. However, other areas like Digos City did not share the same experience. In the FGD, only 1 out of 9 women recalled having seen/heard of FP campaigns on TV/ radio (“We do not have radios,” at least two women said, and “We do not watch the local TV”).

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<sup>11</sup> IPCC training was expected to contribute to the improvement of FP and MCH performance in target provinces. Provincial-level data on number of trained providers as of 2010 were correlated with the change in modern CPR between 2006 and 2011. None of the correlations were found to be significant.

The main sources of FP information for women are relatives (especially mothers), the health worker, or a neighbor. Of those who participated in the FGDs, the team observed high FP awareness, which corroborated with the observation made earlier that the potential demand for FP is high. Both women and men are interested in practicing FP, but they do not always know where services and commodities can be obtained.

Health concerns and fear of side effects are evident in responses to the question of why people are not using modern contraceptives. There are widespread perceptions that pills are hazardous to women (they cause hypertension, weight gain, dizziness, headaches, irregular spotting) and that vasectomies have negative effects on men's health (equivalent with castration, would make men weak, reduces sexual appetite, etc.). Women and men receive limited method-specific information.

The public has an inadequate understanding of the PhilHealth FP benefit package. Hence, there is room for improving communication and information on PhilHealth benefits, the location of accredited facilities, the need for facilities to apply for FP accreditation, and the use of PhilHealth packages to serve more FP clients through RHU facilities and not just hospitals.

Restrictive policies or practices discourage some clients from going to health facilities. Some women believe that providers will reprimand them if they return to the facility pregnant immediately after the last birth, or pregnant while they are single or underage. These fears seem to have been exacerbated after the MNCHN campaigns of CHTs. In Ilocos Norte, for example, the team observed that the governor had banned home deliveries, although some women still prefer to have them because of privacy and more personalized care. Lack of sensitivity by health providers and inadequate quality of services seem to discourage some women from going to the facilities.

**Recommendations for increasing demand:** USAID should assist with increasing FP method-specific information through all channels of communication, matched with availability of supply. While there is high awareness of generic FP services, knowledge of specific methods is still low. The messages in the national campaigns are too generic and may be likened to the natural expectation that all shampoos can clean hair. Such brand stories are no longer compelling since people are now looking for new and useful information. Thus, campaign messages should inform the public about specific methods and focus on dispelling the myths and misconceptions attached to them. Such messages should be targeted to particular audiences and use various media, including those commonly used by different audience groups. This same principle applies for interpersonal communications and BCC materials for FP and MCH.

It is a fact that the Philippines has a very young population, with almost half the inhabitants falling in the 10–29 age group. The country's young adult population subset (ages 15–25) is estimated at 26 million. New campaigns must therefore consider particular age groups and gender. The advent and rapid growth of social media offer a great opportunity to launch campaigns that are both target-audience and method specific. USAID should continue to assist the DOH with its mass media to make sure that FP remains relevant in people's lives. All demand-generation efforts should address the widespread misconceptions and misinformation regarding FP methods.

Finally, while the strongest and most compelling public health communication can facilitate health-related behavior and increase demand for products and services, it cannot compensate for poor products or inadequate supplies or distribution. The supply component (services and commodities) must therefore match the demand created by the program.

Consumption of TV and radio remain stable for national coverage, while print has declined. Billboards' creative innovations have attracted much attention because of the new digital format. Yet, only social media (i.e., the internet and mobile phone) have grown consistently overtime. Internet cafes have proliferated in the country such that users of the Internet cut across socioeconomic classes. Facebook and Twitter are most popular where subscribers may be directed to one's website, which may have messages designed specifically for the target audience. The Internet and mobile phones are powerful vehicles of communication for young people, because they feed into teens' natural tendency for privacy.

Community outreach workers must be given standard training to guide them in their mobilization work in the community. Knowledge of contraceptive technology and skills training in the area of information-sharing, as well as an understanding of the LGU service delivery system, should be included as key components of these trainings. Demand-generation interventions should focus on consistency and continuity of IPCC training of the service providers. IPCC training should be method specific.

Demand-generation interventions should promote male participation in FP. This includes inviting males to FP seminars and counseling sessions. Information on male FP methods should be widely disseminated to counter myths associated with methods such as vasectomies. Utilizing champions or satisfied users of vasectomy may be an approach to increasing men's involvement in FP.

## **FAMILY PLANNING SERVICES AND INFORMATION NEEDS OF THE YOUTH**

The 19.8 million Filipino adolescents (10–19 years) constitute 21.5% of the Philippine population in year 2010 according to NSO 2012 statistics.

According to the NDHS as well as the three rounds of the Young Adult Fertility and Sexuality Study (YAFS), the trends of early sexual initiation and premarital sexual experience are increasing among adolescents, exposing them to the risks of unplanned pregnancy and sexually transmitted diseases. While 18% of young adults (15–24 years) reported premarital sexual experiences in 1994 (YAFS2), 23% reported the same in 2002.

Sexual initiation is gender differentiated among young adults (15–24 years). Young adult males' median age for the onset of sexual intercourse is 17, while the median age for females is 18 (YAFS3). The majority of these first sex experiences occurred while the youth were still in high school, and the majority were unprotected from the possibility of pregnancy or sexually transmitted diseases.

Although postponement of sex until marriage is the social norm, premarital sexual experience is ever-increasing, with more young males engaging in premarital intercourse (from 26% in 1994 to 31% in 2002) than females (from 10% in 1994 to 16% in 2002). Premarital sexual intercourse among the teenagers (15–19 years) increased from 8.1% in 1994 (YAFS2) to 11.7% in 2002 (YAFS3).

These trends translate to increasing adolescent pregnancy, early childbearing and early motherhood. Data from the 2006 FPS and the 2011 FHS reveal that women ages 15–19 years who have begun childbearing increased from 6.3% to 9.5% during the five-year period. A further analysis of the survey data reveal that the percent of teenagers 15–17 years old who ever gave birth increased from 1.4% to 2.5% during the five-year period. The increase from 2006 to 2011 is statistically significant at the national level, and similar for both urban and rural areas. To address these, the DOH designed the Adolescent-Friendly Health Services, which includes a basic essential health package, adolescent pregnancy package, and sexually transmitted infections/HIV packages (DOH, 2010). Nevertheless, there are limited services or information that address the reproductive needs of young adults in schools, facilities, and communities in the provinces that the team visited. The team did not see the implementation of adolescent health packages during their field visits.

In addition, the fertility of Filipino women 20 years and older has decreased between 2006 to 2011, but teenage fertility has increased from 38 to 54 births per 1,000 women during the same period (NSO and USAID, 2012). One possible explanation for this is the 37% unmet need for FP of currently married teenagers compared to lower levels of unmet need for FP of women in older ages.

Teen mothers who participated in FGDs were of the view that their numbers are increasing. Notably, the majority of these teenage mothers had no prior information or knowledge of sexuality, pregnancy, and motherhood. Their sources of information on sexuality are mass and social media (fashion magazines, movies, telenovela, the Internet, SMS, Facebook, Twitter) and peers. Popular media is encouraging early sexual activity. Although parents are the preferred source of information, few parents talk with their children about sexuality.<sup>12</sup> In addition, sex education for adolescents is not taught uniformly and consistently in the schools. The youth were neither aware of facilities that offer services and information tailored to their needs nor were they likely to use facilities that serve adults. They indicated interest in getting more information on appropriate care for infants and mothers, as well as FP services for spacing or limiting births. One of the FGD participants was 15 years old with two children, while another 18-year-old mother was pregnant with her third child.

Service providers are aware of and concerned about the increasing teenage pregnancies the team observed in the provinces visited. However, providers are not prepared to address the issue. Some are hesitant to provide FP information and services to young unmarried mothers.

During the field trip to Capiz, the team observed a teen center, which provides teen-friendly services utilizing peer educators. The teen center concept started as a UNFPA pilot project in the town of Mambusao in the province of Capiz in 2003. It has now expanded to 52 out of 53 public high schools in the province, supported by the Provincial Population Office under the Office of the Governor, who provides technical support and training for teachers who in turn train students as peer group facilitators. The governor allocates the regular annual budget for maintaining the center and supporting the staff. The center is managed by the students with a set of officers, supervised by the assistant principal with direct access to the principal. One-hour peer group teaching/counseling sessions are conducted at all high-school levels. Depending on the need, one or several days a week may be allotted for such sessions. Subjects focus on

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<sup>12</sup> While teens would like to learn from their parents on sexuality, international experience shows that the best approach for reaching the teens is peer-to-peer communication.

adolescent and youth development for good citizenship. Regularly discussed topics include sex and values education. The team recommends an assessment of this initiative to determine if it contributes to the reduction of teenage pregnancies.

**Recommendations for FP service and information needs of the youth:** The team recommends USAID assist with the development of a campaign focusing on the risks of teen pregnancies, using mass media with particular support from social media. The alarming trends in early sexual initiation and premarital sexual experience among the young indicate the need to protect adolescents from pregnancy and early motherhood. The challenge is to develop a campaign story that (1) is relevant and meaningful to the teen’s present life, but avoids any misinterpretation of encouraging promiscuity—like one that focuses on the risks of teen pregnancies—and (2) does not provoke adverse reaction from the Catholic Church. All mass media materials, including public billboards, should encourage readers to seek further advice from health care providers and/or refer them to specific websites. Social media, the Internet, and mobile phones should be used for peer group communication to reach out to the youth.

About a third of the total population, or 29.7 million Filipinos, are Internet users. In addition, 88 million are mobile subscribers, 50% of whom are young. This indicates a great opportunity to more easily communicate with them. With the proliferation of Internet cafes in the country, users of the Internet cut across socioeconomic class. Facebook and Twitter are the most popular social media sites. These new media, the Internet, and mobile phones are powerful vehicles for peer group communication. Moreover, they feed into the teens’ natural desire for privacy.

USAID should assist in establishing a 24/7 hotline for FP and MCH information and counseling for adolescents. Recall that teens want to learn more about FP and MCH, but they are not getting such information or advice from their parents. At the same time, they do not want to learn such information from other adults.

Therefore, they are more likely to get bad advice from a friend. Together, these realities suggest an opportunity to set up phone counseling services which will cater to those in need. Teens may be directed via short message service (SMS), Facebook, or Twitter to call a hotline, which will have a trained peer counselor waiting to accommodate them.

USAID should assist with providing teen-friendly services utilizing peer educators. The teen centers the team observed in Capiz may be used as a model. The team recommends that USAID conduct an assessment of the effectiveness of the model in terms of providing information and services to the youth.

## **GENDER CONSIDERATIONS**

In the Philippines, men are traditionally tasked with earning income for the family, whereas women are expected to be in charge of housekeeping and childrearing. By extension, family health in general and fertility regulation in particular are seen as belonging to the Filipino woman’s domain, with men playing passive roles in FP.

National survey data on contraceptive use support the observation that Filipino women are primarily responsible for fertility regulation and the practice of FP. Based on the 2011 FHS, the four leading modern contraceptive methods in the Philippines are those used by women. In contrast, the prevalence of modern contraceptive methods used by men is very low at 1.2% for male condoms and only 0.1% for vasectomy. Although withdrawal, a male method of

contraception, ranks third overall in the Philippines (at 8.2%), it is a traditional method that the medical community considers less effective than modern FP methods.

Findings from the FGDs conducted across the four study provinces corroborate the view that women are primarily responsible for FP. When asked to cite the FP method they were using (if any), the top responses of the focus group participants were the pill, injectables, the calendar/rhythm method, and withdrawal. None of the male focus group participants had undergone a vasectomy, with many expressing the belief that vasectomy results in male castration (*kinakapon*) and loss of libido.

Although Filipino men are considerably less involved in FP compared to women, men are not averse to FP and may even favor it. When asked if men had a role in FP, the male focus group participants invariably said yes. They believe that it is necessary for them to cooperate in FP, at the very least by supporting their wife's preferred contraceptive method. A key motivation for their involvement in FP is the desire to have the number of children they can feed and put through school. The men also expressed a concern for the health and well-being of their wife, whose life could be imperiled by frequent and closely spaced pregnancies.

Male and female focus group participants alike value consultation and joint decision-making on FP—a finding that mirrors the results of the 2008 NDHS. Based on the 2008 NDHS, virtually all (99%) of the married women who were using contraception at the time of the survey reported that their husband was aware of their use of contraception.

FP programs in the Philippines focus almost exclusively on women. Barangay health workers, who are usually female (like midwives), more often than not seek out women to invite to FP seminars or counseling. Based on the FGDs, men rarely attend community assemblies on FP or seek FP information and services. And yet many Filipino men consider FP important and would like to obtain information and counseling on it. FP programs should therefore create more opportunities to target men as FP acceptors.

**Recommendations for increasing male involvement in FP:** The team recommends that USAID support interventions to increase male involvement in FP by utilizing champions or satisfied users of male methods. Implementation of a “satisfied vasectomy clients” approach to promote the method has been instrumental in increasing vasectomy prevalence in India and Bangladesh. The satisfied clients contribute to increasing the overall acceptability of vasectomy by communicating to others that they should not be afraid of the procedure.

## OTHER ESSENTIAL QUESTIONS

The SOW for the assignment included two broad questions related to the FP and MCH situation in the Philippines. These questions asked why the country's MMR has remained at the same level for the past 15 years, despite the significant increases in FBDs and in SBAs, and why the CPR has not increased more rapidly in the past 10 years.

### Why isn't the MMR Declining?

Global experience in maternal health identifies three most effective strategies to reduce MMR:

- SBA at all births is considered to be the single most critical intervention for reducing maternal deaths, because it hastens the timely delivery of emergency obstetric and newborn care when life-threatening complications arise.

- An emphasis on making emergency obstetric care available to all women who develop complications is also central to reducing maternal mortality. This is because all major causes of maternal mortality worldwide—hemorrhage, sepsis, hypertensive disorders, and obstructed labor—can be treated effectively if managed without delay.
- Access to FP information and services is a critical factor in curtailing maternal deaths. Unintended pregnancies, especially among the young and the poor, often lead to suboptimal pregnancy care and unsafe abortions, which contribute to high MMRs.

In the Philippines, the policy to reduce the MMR emphasizes increasing FBDs as the main strategy, not increasing SBAs. This approach assumes that skilled birth attendance and high quality services are available in all health facilities, which is not always the case. Data show that only about 50% of the RHUs are accredited for the MCP. Even for normal deliveries, large hospitals are usually the only option, which results in overcrowding and reduced quality of care. Promoting FBDs alone, without ensuring the presence of SBAs and high quality services, is not enough to reduce maternal mortality.

To improve access to emergency obstetric care, DOH is investing in training SBAs in BEmONC. Although the training modules are standard, quality and consistency of actual trainings may not be monitored. Also, large numbers of health care providers are not yet trained. In addition, AMTSL training for service providers who assist normal deliveries is not available. Even if they were trained, midwives are prohibited by law from practicing AMTSL without the supervision of a doctor.

FP is not fully recognized or positioned as a critical intervention to reduce the MMR. As a result, resources are skewed toward maternity services, not FP. The team observed that the DOH capitalizes primarily on building maternity facilities to increase FBDs—and training of service providers in BEmONC to a lesser degree—but FP services do not receive the same level of attention. In June 2012, the DOH issued an administrative order on “National Strategy towards Reduction of Unmet Need for FP as a Means to Achieve MDGs in Maternal Health.” This administrative order states that addressing the unmet need for FP is a critical strategy in improving maternal health. This is a very positive step forward. However, the administrative order was issued very recently and, during the field visits, the team did not observe any ramifications of the order.

As a result of inadequate access to FP, unwanted pregnancies are increasing, leading to unsafe abortions, which in turn contribute to high maternal mortality. Abortion is not legal in Philippines; however, studies have shown that unsafe abortion is widely practiced. According to a study conducted by the Guttmacher Institute in 2000, over 400,000 induced abortions took place in the Philippines. An analysis of DHS data indicates that the total abortion rate for Philippines is around 1.7. Although recent estimates are not available, the team’s observations indicate that abortion rates may be increasing, especially among the youth. In one tertiary hospital, the team examined the causes of six maternal deaths during the previous year; three of these maternal deaths (all within the 20–24 age group) were due to sepsis, a condition closely correlated with unsafe abortions.

**Recommendations for reducing the MMR:** The team recommends that USAID assist the DOH in implementing more effective strategies to reduce the MMR. The assistance areas should include:

- Advocacy and policy work to recognize presence of SBAs at all births as the most critical intervention for reducing maternal deaths
- Technical assistance to train more skilled providers
- Technical assistance in standardizing and expanding BEmONC training
- Policy guidance and advocacy for allowing midwives to practice AMTSL
- Technical assistance to expand training in AMTSL
- Policy guidance and advocacy work to implement the administrative order on “National Strategy towards Reduction of Unmet Need for FP as a Means to Achieve MDGs in Maternal Health”

### **Why isn't the Modern CPR Increasing?**

Use of modern contraceptives has stalled in the Philippines for many years due to several interrelated factors. These factors have been discussed in detail in previous sections of this report. Available evidence indicates the following new and old features of the Philippines FP program that contribute to the stagnating CPR in the country:

For at least two decades, government policies to support FP have been inconsistent. In particular, over the last decade the national policies supported the Catholic Church's doctrine on contraception. The policies promoted natural FP methods and lacked commitment to other modern methods of contraception. Over the years, the FP program has weakened as a result of declining commitment to FP services. The transfer of responsibility of FP implementation from POPCOM to DOH diluted the focus on FP. From a FP program under the POPCOM, FP was redefined as one of the health programs implemented under the DOH.

The FP program suffered another setback as the government devolved to the LGUs the responsibility of delivering various health services and managing health facilities. The policy shift led the LGUs free to choose their policy directions in provision of FP services; many of them were then unprepared for the change.

In the meantime, the unmet demand for FP services continued to increase, especially among the younger couples. This demand was not matched with quality FP services or an adequate and reliable supply of contraceptive commodities. Supply of contraceptives has been inconsistent since USAID phased out of contraceptive commodity donations. At present, method choice is mostly limited to the pills, injectables, and BTL, but the only contraceptive widely available is the pill. Access to long-term and permanent methods remains limited. Many providers are still not adequately trained and provider biases are quite common. This is reflected in inadequate method-specific information and widespread misconceptions.. Health concerns and fears of side effects persist.

Finally, the RH Bill, which seeks to establish a comprehensive and integrated national policy on reproductive health, has been in Philippine Congress for almost a decade and a half. Lack of a national policy, compounded by the Catholic Church's strong and unchanging stance on FP, continues to influence local policymakers, program managers, and services providers.

It should be noted, however, that the Church's stance on FP does not seem to affect individuals' attitude toward modern contraception. Religion does not appear to play a role in acceptance and use of contraception by couples.

**Recommendations to increase modern CPR:** USAID cannot address all of the cited factors that contribute to the stalling CPR in the country; however, the agency can provide substantial assistance. Specific recommendations for strengthening the FP program are documented in detail in previous sections of this report. In summary, the team recommends that USAID assist in:

- Expanding and scaling up postpartum FP
- Utilizing PhilHealth accreditation and enrollment as a sustainable financing mechanism to fund FP services and commodities
- Expanding and scaling up the CHAT model for community mobilization for FP
- Strengthening training capacity of the DOH to standardize and scale up quality FP training
- Strengthening the DOH capacity to manage the FP program more effectively
- Strengthening alternative service delivery models such as mobile teams to increase access to long-acting and permanent methods of FP
- Demand creation and method-specific information utilizing all communication channels, including social media
- Strengthening method-specific counseling skills of providers
- Developing a campaign to address FP service and information needs of the youth
- Increasing male involvement in FP utilizing satisfied users of male methods
- Policy guidance and advocacy work to implement the administrative order on “National Strategy towards Reduction of Unmet Need for FP as a Means to Achieve MDGs in Maternal Health”

# **ANNEX A: STATEMENT OF WORK**

## **GLOBAL HEALTH TECHNICAL ASSISTANCE BRIDGE II PROJECT**

**GH Tech Contract No. AID-OAA-C-12-00027**

### **SCOPE OF WORK**

**Performance Evaluation of the Family Planning and Maternal and Child Health Portfolio of USAID/Philippines (Final 9-14-12)**

#### **I. INTRODUCTION**

The U.S. Agency for International Development (USAID) in the Philippines seeks to conduct a final performance evaluation of its Family Planning (FP) and Maternal and Child Health (MCH) portfolio in meeting its overarching objectives: 1) LGU provision and management of health services strengthened, 2) provision of quality services by private and commercial providers expanded, 3) appropriate healthy behaviors and practices increased, and 4) policy environment and financing for provision of services improved. The evaluation will investigate each project in the FP and MCH portfolio to determine what contribution each made to achievement of the aforementioned overarching objectives.

USAID is seeking the services of a third-party evaluation team (with participation of an evaluation specialist) over a period of five (5) months to implement the requirements defined in this statement of work.

#### **II. BACKGROUND**

Family health indicators in the Philippines are very mixed, with some important areas of weakness. Generally, the country's pace of improvement has been below that of its immediate neighbors since the 1990s. The national policy approach to FP has been ambivalent for more than a decade and modern contraceptive prevalence (37%, 2011 FHS) has not grown in the last ten years. Unmet need, especially for limiting, remains relatively high. The maternal mortality ratio is believed to be in the region of 100–150, still at least double the Millennium Development Goal (MDG) target of 52 by 2015. A policy of facility-based births has been in place since 2008; in that year most births (56%) were still at home, although around a third of these were assisted by a skilled provider. The neonatal mortality rate has stabilized (14 per 1,000 births, 2011 FHS) but has shown little improvement over a decade. Deaths among under-5 children from acute respiratory infection and diarrhea remain high. Immunization coverage is good (85%, 2011 FHS), as is vitamin A provision (81%, 2011 FHS); other aspects of nutrition—e.g., exclusive breastfeeding (25%, 2011 FHS) and other feeding practices—remain weak.

Devolution of responsibility for health care to LGUs in 1991 continues to provide an all-consuming policy and service delivery challenge. Financing for primary care has become less predictable as roughly 1,700 LGUs now make decisions on directing local Internal Revenue Allotments to health and PhilHealth's coverage of family health remains sparse. The national DOH has been able to fill some of the gaps in the last two years by instituting a system of performance-based central grants. Other systems to support health at the LGU level—e.g., information for decision-making, logistics, and human resource management—remain weak.

Family health service delivery is primarily a municipal LGU responsibility. The supply side ranges widely, from good to poor in terms of availability and quality, while the demand side is generally weak. IPCC skills are patchy, there are few trained communication professionals at the municipal level, and the demand side lacks strong management and leadership. Addressing both the supply and demand challenges is complicated by the scale of the problem: there are 1,600 municipalities in the country and the current USAID program has had only limited success in penetrating this level.

The ARMM represents a special case of devolution and the health challenges there are exacerbated by high levels of poverty, a history of poor governance, and periodic open conflict. Some of the major health indicators there showed deterioration between 2003 and 2008. However, initial results from the 2011 FHS are showing positive trends in many of the key health indicators for FP and MCH.

### **Family Planning**

The FP indicators for the Philippines are unusually weak for a country at the Philippines' stage of economic and educational development: CPR is currently around 37% for modern methods (FHS 2011), having moved just 1.0 percentage point from the previous FPS in 2006. This means that the target for the current strategic objective agreement (2006–2013) is going to be missed.

Past DOH policy has favored natural FP, leaving LGUs free to choose a policy more favorable to modern methods, if they wish. However, the policy articulated by the current president and administration is clearly encouraging couples to assume greater freedom in choosing family size. Total fertility has declined from 6.0 in the 1970s to 3.1 (2011 FHS), and the mean ideal number of children across all women is at 2.8. Unmet need remains significant—11% for spacing and 9% for limiting in 2011 (both higher than in 2006)—reflecting the low contraceptive use and the fact that there are only two main modern methods in use today: pills and female sterilization.

Contraceptive use among poor women remains low (32% modern methods in 2011 against 39% among non-poor women). The national health insurance scheme (through the Philippines Health Insurance Corporation or “PhilHealth”) is the primary protection for the poor through premiums paid by LGUs on behalf of indigent families, but it barely covers routine FP.

### **Maternal and Child Health**

Initial data from the 2011 FHS suggest that the maternal mortality ratio (MMR) has remained at a constant level in the past five years (estimated at 221 per 100,000 live births in 2011 from an estimated 162 per 100,000 live births in 2006—although there are major measurement issues on MMR). This equates to around 2,500–3,000 deaths annually and places the Philippines in about the middle of the spectrum for Southeast Asia—below Cambodia and Indonesia, which are closer to 400, but above Vietnam (100), Malaysia, and Thailand (both below 50). The rate of improvement is far below DOH expectations, since the MDG target for 2015 is 52 and will almost certainly be missed by a wide margin.

DOH's response has included an administrative order mandating a shift to FBDs. The 2011 FHS shows that 55% of deliveries were facility based (up from 42% in 2006), and 72% were assisted by a skilled provider (up from 64% in 2006). Considerable effort is now needed to ensure basic and comprehensive emergency obstetric and neonatal care at appropriate quality, the associated referral protocols, community-level outreach to ensure birth preparedness for individual

mothers, and consistency between the new standards and the existing PhilHealth accreditation requirements.

Neonatal mortality is relatively low compared to some neighboring countries (14 per 1,000 births in 2011) but has not improved markedly over the last decade (17 per 1,000 births in 2003). Infant (25) and under-5 (34) mortality rates show a similar picture: slow improvement but, in most instances, the Philippines has not kept up with neighboring countries. In 1960, the infant mortality rate was better than those in Indonesia, Korea, Malaysia, Sri Lanka, and Thailand; now the Philippines ranks fifth out of the six countries (*World Development Index*, cited by the World Bank)

### **Health Portfolio Results Framework, 2006–2012**

The current USAID program is governed by a strategic objective agreement (SOAG) signed with the Government of the Philippines on 27 September 2006, with a strategic objective of “Desired Family Size and Improved Health Sustainably Achieved.” The SOAG has been amended several times to extend its term. The latest amendment was signed in 2012 to extend its term to September 2013. The current SOAG is based on a health strategic framework originally developed in 2002 and slightly amended for the 2006–2012 health assistance programs (see figure 1 on page 5).

To achieve the strategic objective, the strategy focuses on four intermediate results. These are:

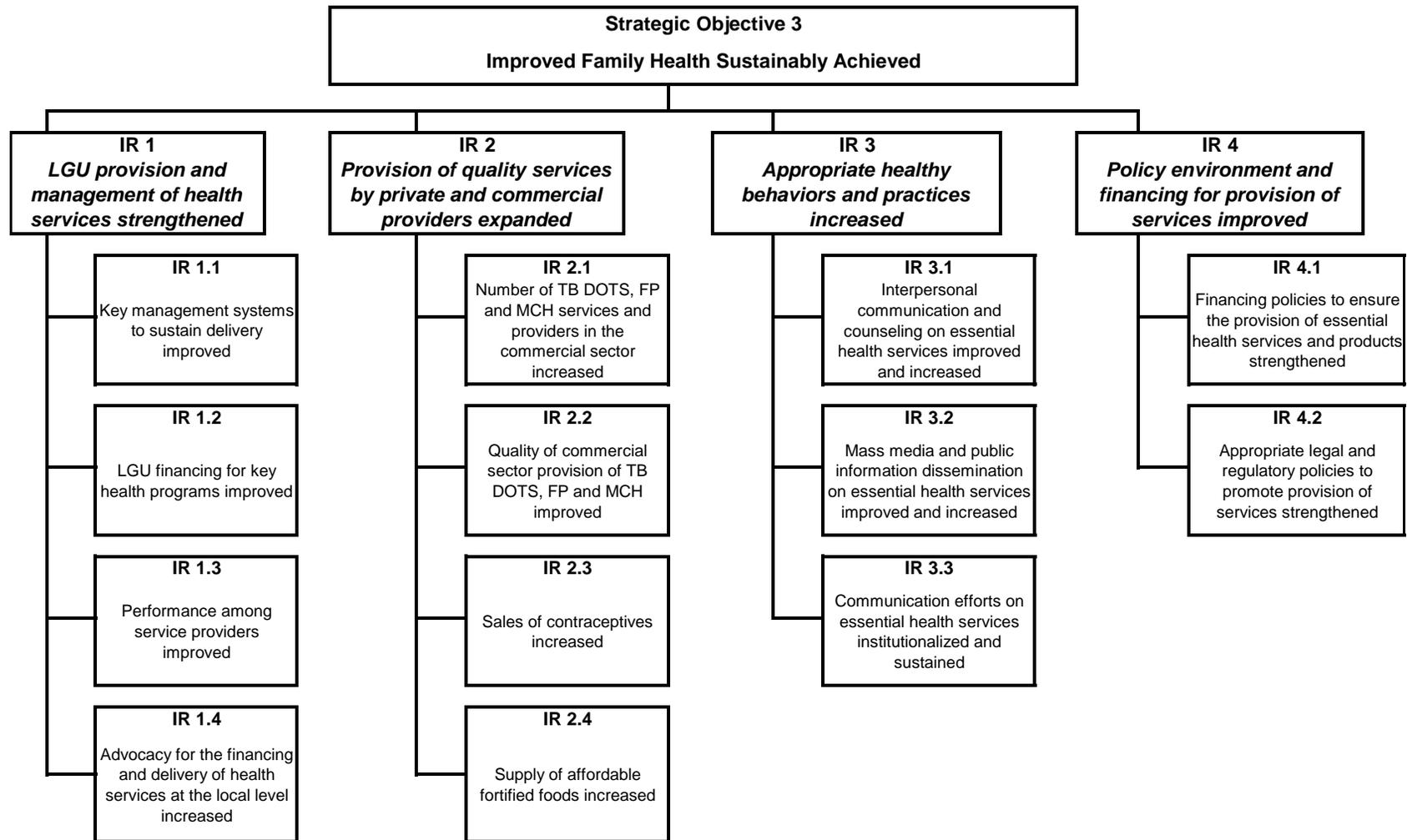
1. LGU provision and management of health services strengthened,
2. Provision of quality services by private and commercial providers expanded,
3. Appropriate healthy behaviors and practices increased, and
4. Policy environment and financing for provision of services improved.

The first two intermediate results are directed toward improving the efficient, effective, and sustainable delivery of health and FP services in the critical areas of local government and the private health sectors where most health services are delivered. The last two intermediate results focus on developing the engines of change for promoting access to services. They will take steps necessary to develop the positive and person-oriented approaches necessary to create an environment for change. Financing and regulatory policies at the national and local levels will be strengthened to ensure the appropriate atmosphere for public and private sector progress. These intermediate results have been developed to ensure complementarity and synergy across the strategic objective. Thus, efforts to increase the use of FP have concomitant benefits upon other health services such as maternal and child health or TB treatment. The strategic objective is designed to capitalize on integrated program implementation as much as possible; thus, each intermediate result should not be viewed as a separate program. Success in one intermediate result will not individually achieve the results set out for this strategy. Each intermediate result enables the others to be achieved and must be implemented in an integrated manner. *(For a quick view of the intermediate results and their respective sub-intermediate results, please refer to figure 1 again.)*

The SOAG defined “family health” to include four elements: FP, MNCHN, TB, and HIV/AIDS—and currently includes five projects (all starting October 2006 and ending December 2012 unless otherwise noted on pages 6–8 [Description of Programs and Activities]). A sixth project focusing on micronutrient (A2Z) ended in September 2011. The total annual budget averages

around \$22.5 million. Except for PRISM2 (which covers 76 provinces and cities), the various U.S.-assisted projects are operating in the same project sites (25 provinces for HealthGov, and 5 provinces and 1 city for SHIELD ARMM). The different projects are implementing various interventions designed to help increase modern CPR by one percentage point in every province per year. For MCH, the targets set by the DOH at the national level provide the standard for program performance at the provincial level.

**Figure 1: Strategic Framework Underlying the Current SO3 Program**



### III. DESCRIPTION OF THE PROGRAMS AND ACTIVITIES TO BE EVALUATED

USAID is the biggest donor-funder of the FP program in the Philippines. FP is one of four priority programs supported by the U.S. Government. In the current project cycle (2006–2012), USAID provides an average of \$ 10.8 million annually for FP for an estimated total of \$64.7 million over six years. USAID also supports the MCH program of the Government of the Philippines with an average annual funding of \$2.0 million, for an estimated total of \$12.2 million over the six-year period from 2006–2012. USAID’s FP and MCH portfolio currently supports five projects, as follows:

#### **Project Title:Strengthening Local Governance in Health (HealthGov)**

Award Number: 492-A-00-06-00037  
Award Dates: September 30, 2006— December 30, 2012  
Funding: Total LOP—\$ 28,521,227.00  
FP—19.1 million  
MCH— 3.2 million  
TB—3.0 million  
HIV—2.7 million  
Implementing Partner(s): Research Triangle Institute (RTI)  
AOR: Ma. Paz de Sagun  
Previous Evaluation(s): Midterm

Brief Description: HealthGov is primarily health governance and systems strengthening project that operates in 25 provinces nationwide. It aims to strengthen LGU’s commitment to health and enhance their capacity to sustainably provide, finance, and manage quality health services, particularly FP, MCH, TB and HIV/AIDS.

#### **Project Title:Sustainable Health Improvement and Empowerment through Local Development (SHIELD)**

Award Number: 492-A-00-06-00035  
Award Dates: September 30, 2006–December 30, 2012  
Funding: Total LOP—\$ 18,251,999.00  
FP—11.9 million  
MCH—3.7 million  
TB—2.4 million  
Implementing Partner(s): Helen Keller International (HKI)  
AOR: Consuelo Anonuevo  
Previous Evaluation(s): Midterm

Brief Description: SHIELD is the lead USG mechanism for providing technical assistance in FP, MCH and TB to the provinces in the Autonomous Region in Muslim Mindanao (ARMM). Aside from strengthening health governance and systems, it also focuses on enhancing service delivery and community mobilization for health.

**Project Title: Private Sector Mobilization for Family Health (PRISM2)**

Award Number: GHS-I-00-07-00004  
Award Dates: October 30, 2009–October 29, 2014  
Funding: Total LOP—\$ 28,852,261.00  
Obligated Amount as of Dec. 30, 2011—\$16,666,301.00  
FP—14.7 million  
MCH—1.9 million  
Implementing Partner(s): Chemonics International  
COR: Yolanda Oliveros  
Previous Evaluation(s): None

Brief Description: PRISM2 is the lead USG mechanism for providing technical assistance for expanding the provision of FP and MCH services in the private sector. PRISM operates in 76 provinces and cities nationwide including the ARMM. It aims to build public-private partnerships to assure availability and access to quality FP and MCH products and services. It provides support to the DOH, DOLE, local government units and other national and local partners in their provision of technical assistance to the private sector to strengthen its role in the delivery of FP/MCH products and services.

**Project Title: Health Promotion and Communication (HealthPRO)**

Award Number: GHS-I-00-07-00010  
Award Dates: June 25, 2007–September 24, 2012  
Funding: Total LOP—\$14,969,885.00  
FP—10.3 million  
MCH—1.8 million  
TB—2.4 million  
HIV— 370,000  
Implementing Partner(s): University Research Co. (URC)  
COR: Reynalda Perez  
Previous Evaluation(s): Midterm

Brief Description: HealthPRO is the lead U.S. mechanism for providing technical assistance to the DOH and LGUs along health promotion and BCC. It covers FP, MCH, TB, and HIV/AIDS, and operates in 30 provinces nationwide.

## **Project Title: Health Policy Development Project (HPDP)**

Award Number:	492-A-00-06-0003 I
Award Dates:	October 6, 200–December 30, 2012
Funding:	Total LOP—\$11,103,615.26 FP—8.7 million MCH—1.6 million TB—323,617 HIV— 444,000
Implementing Partner(s):	UP Econ Foundation
AOR:	Ma. Paz de Sagun
Previous Evaluation(s):	Midterm

Brief Description: HPDP is the lead U.S. mechanism for providing technical assistance to the DOH in the area of health policy. The project aims to establish a supportive policy and financing environment for priority health programs by encouraging policies and plans that increase and sustain access to quality health information, services and products, and to strengthen and institutionalize a health policy formulation process for improved health sector performance.

Annex A enumerates the major interventions under each of the above project activities and an illustrative list of project deliverables/indicators for each.

## **IV. THE PROGRAM HYPOTHESES**

In the course of the evaluation, the following hypotheses will be revisited:

- Hypotheses #1:
  - (a) The convergence of USAID-supported FP interventions to strengthen public and private sector service delivery; health promotion; and health governance, systems, and health policy in the same project sites will significantly contribute to increases in contraceptive prevalence rate (CPR).
  - (b) The converge of USAID-supported MCH interventions to strengthen public and private sector service delivery; health promotion; and health governance, systems, and health policy in the same project sites will significantly contribute to increases in the following selected MCH indicators: percentage of deliveries assisted by SBAs, percentage of FBDs, and percentage of under-5 children given vitamin A supplementation.
- Hypothesis #2:
  - Specific current interventions in FP and MCH are working, but these interventions need to be adequately scaled up to impact on FP and MCH indicators at national level.

## **V. PURPOSE/OBJECTIVES AND USE OF THE EVALUATION**

This performance evaluation and evaluation of impact of the FP and MCH portfolio of USAID/Philippines aim to:

1. Measure the effectiveness and efficiency of the various USAID-assisted interventions in FP and MCH, by investigating inputs, outputs, and outcomes in FP and MCH directly contributing to the achievement of FP and MCH performance indicators of the USAID/Philippines health portfolio. Findings will be used to determine whether certain program approaches and interventions that are being implemented under current USAID-assisted activities shall be continued and scaled up, modified, or terminated.
2. Systematically document factors and conditions that contribute to or hinder improvements in FP and MCH outcomes and impact. The findings of the 2011 FHS indicate that the national CPR for modern methods has not changed significantly in the past five years. However, the 2011 FHS data show that there are provinces that are showing considerably high (although not statistically significant) increases in modern CPR. There are also provinces that are showing significant increases in the use of certain FP methods like the pill, even if the overall modern CPR performance of these provinces does not show any statistically significant improvements. Similarly, some provinces are showing reductions in maternal deaths and improvements in MCH indicators even if no significant improvements are being noted at the national level. A sampling of provinces that perform well and poorly, from USAID-assisted and non-assisted provinces, measured in terms of the indicators mentioned in Hypotheses #1 above, shall be investigated in-depth. The generation of knowledge on the determinants and barriers to improved FP and MCH performance will be used to introduce modifications in the design of interventions in future projects as well as interventions for replication and scaling up.
3. Results of the evaluation will be disseminated and discussed with the DOH, POPCOM, implementing partners, other development partners, LGUs, and other organizations/agencies involved in implementing FP and MCH programs and activities in the country. Findings and recommendations will be used to enhance the way specific approaches and interventions are currently designed and implemented at the LGU level (e.g., mobilizing students in nursing and other relevant courses to conduct community-level health classes to increase reach of promotion activities, and deployment of CHTs to increase deliveries assisted by SBAs), as well as establish the support mechanisms required for an intervention to work optimally (e.g., orientation of community health volunteers on assisting couples with preparing and executing a birth plan, and setting up a communication system for responding to obstetric emergencies).

## **VI. EVALUATION APPROACH AND METHODS**

This evaluation, by design, is essentially a final performance evaluation. To a limited extent, it also hopes to measure the impact of USAID-assisted interventions between 2006–2011. This evaluation activity shall be carried out in two phases.

### **Phase I will include the following activities:**

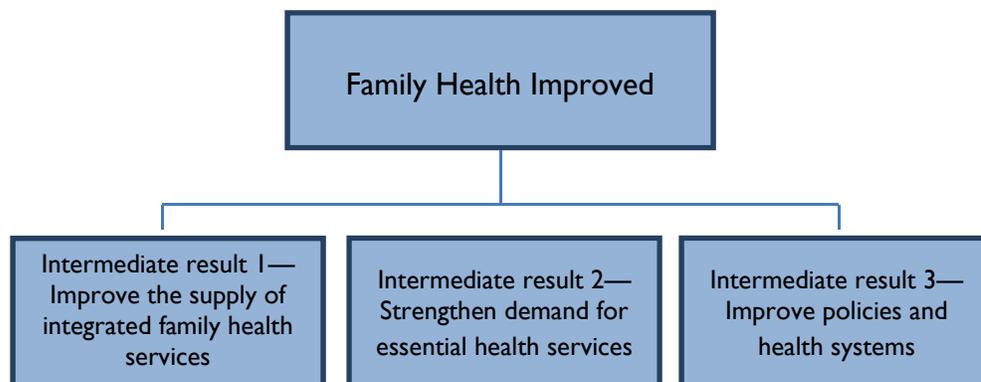
Review and analysis of existing data and literature on the status of FP and MCH in the Philippines from recent studies and surveys, as well as program and project reports, performance data, and similar documents. Specifically, it will generate provincial estimates of selected FP and MCH indicators from the 2006 FPS and 2011 FHS. The literature review shall identify areas for further investigation to determine the major determinants and key constraints for increasing practice of modern FP and reducing maternal and neonatal deaths in the country. Priority for review and evaluation are data, document, and literature on the following broad areas:

- Access and provision of quality FP and MCH services in the public and private sectors.

- Information dissemination of FP and MCH messages and promotion of practice of healthy behaviors in FP and MCH.
- Policy environment, relevant health systems, and financing for provision of FP and MCH services.

The three broad areas identified above correspond to the three intermediate result areas in the health strategy for 2012–2017. See figure 2 below.

**Figure 2: Proposed Results Framework for the FY 2012–2017 Health Strategy**



The three intermediate results focus respectively on:

- Improving supply of services, which includes the availability and quality of public sector services and selective expansion of the private sector as a primary care supplier.
- Strengthening demand for primary care services by encouraging adoption of appropriate healthy behaviors within families. This will be done through better interpersonal communication and counseling, and expanded use of mass media—aimed at both individual clients and potential clients—plus a re-energized approach to community mobilization and expanded advocacy efforts.
- Removing policy and systems barriers to improved supply of and demand for services, including financial barriers in particular.

This focus on supply, demand, policy, and systems represents a return to basics.

Suggested outputs of the literature review are:

1. A map of USAID and non-USAID projects and interventions in FP and MCH by province.
2. Estimated coverage and reach of various U.S. Government interventions and activities in terms of number of LGUs (municipalities), health facilities, and service providers covered, as well as number of women of reproductive age who have access to FP and MCH information and services as a result of U.S. Government efforts and interventions as determined from project reports.
3. A descriptive analysis of findings from the literature/secondary documents review.

4. More importantly: Using findings of the literature review, the evaluation team will propose an evaluation design that will include, among others, suggested sample sites, quantitative and qualitative methodologies, and a plan for data analysis. Said design will be implemented under Phase 2.

**Phase 2 will include the following:**

1. Undertaking an in-depth quantitative analysis of FHS data which will include, among others, a determination of the following:
  - Statistically significant increases across time (between 2006–2011) of selected FP and MCH indicators. Specifically, the performance in assisted provinces and non-assisted provinces using data from the 2006 FPS (as baseline) and the 2011 FHS will be determined using the following indicators: i) CPR, ii) percentage of deliveries assisted by SBAs, iii) percentage of FBDs, and iv) percentage of under-5 children given vitamin A supplementation. The team of evaluators shall assess the list of indicators above and recommend the final list of FP and MCH indicators to be included in Phase 2 of the evaluation.
  - Provinces performing well and poorly, both USAID supported and non-USAID supported, based on the indicators enumerated in the foregoing paragraph. Using data from the 2006 FPS and 2011 FHS, provincial estimates for selected FP and MCH indicators will be done including estimates of sampling errors and confidence intervals at .05 and .10 levels.
2. Assessment of impact of USAID-assisted interventions along the following:
  - Increasing access and provision of quality FP and MCH services in the public and private sector.
  - Strengthening information dissemination of FP and MCH messages and promotion of practice of healthy behaviors in FP and MCH.
  - Improving policy environment, relevant health systems, and financing for provision of FP and MCH services.
3. In-depth analysis and documentation of the various factors and conditions both in USAID-assisted and non-USAID-assisted provinces that are believed to potentially contribute or hinder the achievement of FP and MCH indicators.

Based on current literature on successful FP programming, these factors and conditions may include:

- Leadership and good management
- Supportive policies
- Evidence-based programming
- Communication strategies
- Contraceptive security
- High-performing staff
- Client-centered care
- Easy access to services
- Affordable services
- Appropriate integration of services

4. Identification of interventions and activities that contributed most significantly to increases in FP and MCH indicators in provinces that are performing well or poorly, both assisted and non-assisted. .

Appropriate inventory sheets, checklists, and questionnaires will be developed and utilized to generate data on project reach/coverage, as well as data from project reports. Key informant interviews, group interviews, FGDs, and field visits will also be undertaken to gather qualitative data as well as validate project reports and data gathered from inventories, checklists, and questionnaires from health facilities and service providers. Key informant interviews, group interviews, FGDs, and field visits shall be organized early enough and prior to field deployment of the team. Field visits shall be undertaken to validate project reports and data gathered from inventories. Thus, field staffs need to clearly understand the purpose of field visits and have required documents/materials readily available to ensure that visits are effective.

Appropriate statistical tests of relationships will be utilized to determine the project-level output indicators that are significantly related to CPR, SBA, FBD, and vitamin A coverage levels in assisted and non-assisted provinces. Appropriate regression analysis to determine which factors have the greatest impact on CPR and MCH indicators shall be undertaken, if possible.

Based on evidence gathered and results of analysis made, the evaluation team will recommend a package of FP and MCH interventions and activities for replication and/or scaling up in the next project cycle aimed at increasing performance and achieving targets in FP and MCH for the period 2012–2017. Interventions and activities for replication and scaling up will include a description of the key features that should be considered and support requirements that need to be put in place for optimum impact (e.g., it is not enough to increase the number of midwives deployed—they should be trained on life-saving skills like AMTSL or administration of oxytocin to have impact on MMR; make postpartum FP services available in facilities where mothers deliver). The application of an appropriate tool for determining cost-effectiveness of project interventions is being recommended.

At the start of Phase I, the team shall be given time to undertake remote consultation to organize the work for the literature review and agree on assignments, format for deliverables, and deadlines. Work for the final week of Phase I shall be done in-country. At the start of Phase 2, it is important for the team to establish a well-defined evaluation strategy and workplan. The initial week of Phase 2 shall be allocated for developing a detailed evaluation plan, methodology, data collection tools, data analysis plan, and timeline for the evaluation, among others.

## **VII. THE EVALUATION QUESTIONS**

The list of illustrative evaluation questions below will be reviewed and revised (if needed) by the evaluation team to inform a reasonable data collection tool:

### **Effectiveness**

1. Are there statistically significant improvements in key FP and MCH indicators between 2006 and 2011?
  - What is the increase in the national CPR and selected MCH indicators between 2006 and 2011?
  - What is the performance in CPR and selected MCH indicators for the same time period in assisted provinces and in non-assisted provinces?

- (Estimates for each province and collectively among all assisted provinces and non-assisted provinces shall be generated.)
  - What are the changes in trends in method mix at national and provincial
  - Levels observed between 2006 and 2011?
2. What factors and conditions significantly contribute to or hinder the achievement of key FP and MCH indicators both in USAID-assisted and non-USAID-assisted provinces? (Note: The evaluation team needs to recommend indicators to measure the presence and/or absence of the various factors/conditions indicated below and define the standards when an indicator can be considered a significant contributor or hindrance. Please see “Elements of Success in Family Planning Programming,” *Population Reports*, series J, No. 57, September 2008.)

**Sample Table 1**

Factors/Conditions	(Check all that apply)					
	USAID-assisted			Non-USAID-assisted		
	Province 1	Province 2	Province 3	Province 1	Province 2	Province 3
Leadership and good management						
Supportive policies						
Evidence-based programming						
Communication strategies						
Contraceptive security						
High-performing staff						
Client-centered care						
Easy access to services						
Affordable services						
Appropriate integration of services						

3. What USAID-assisted interventions contributed directly or indirectly to the achievement of key FP and MCH indicators in USAID-assisted provinces?
- Up to what extent were target beneficiaries (municipalities, health facilities, health providers, populations) of various FP and MCH interventions covered by the following USG-assisted projects?
  - What more could have been done by USAID-assisted interventions to achieve key FP and MCH indicators?

**Sample Table 2**

Project	Percentage of Target Beneficiaries Covered				
	Municipalities	Health facilities	Health providers	Women of reproductive age	Others
Health Governance (HealthGOV)					
SHIELD ARMM Project					
Private Sector Mobilization for Health 2					
Health Promotion and Communication					
Health Policy Development					

4. Were activities designed and implemented to reflect different gender roles in project sites? Were benefits equitably shared in accordance with the respective gender action plans of projects?

**Efficiency**

1. How could USAID-assisted interventions be more efficiently implemented?
2. How efficiently did USAID manage the various FP and MCH activities in its portfolio? What management mechanisms were put in place to ensure effective coordination and synergies with DOH, CHDs, LGUs, cooperating agencies, development partners, and other key groups and organizations (e.g., POPCOM, PhilHealth)? Has the interaction of DOH and other partners been effective in achieving goals and objectives? How can these interactions be improved in the next project cycle?
3. What are the gaps in programming of USAID assistance for FP and MCH in the Philippines?

**Other Essentials**

**Good Practice**

1. What are the three (3) most cost-effective packages of FP and MCH interventions which may be recommended for scaling up in 2012–2016?

**Project Design**

1. Was the original project design well-conceived? Were there any aspects of the project for which preparation was insufficient?
2. Why has the contraceptive prevalence rate (CPR) in the Philippines not increased more rapidly in the past 10 years? What are the key barriers in increasing acceptance of family planning in the country? Why has the country’s maternal mortality ratio (MMR) remained at the same level in the past 15 years? Why is MMR not declining despite increases in deliveries assisted by skilled birth attendants and facility-based deliveries?

## VIII. DATA SOURCES

The following are high-quality data sources which will be reviewed by the team in the course of conducting the evaluation:

- Research studies, surveys, evaluation reports, and similar documents and literature related to i) demand generation; ii) provision of FP and MCH services; and iii) policy, systems, and financing support to FP and MCH.
- Current contracts and cooperative agreements with USAID cooperating agencies including modification documents.
- Project strategy papers, concept paper of project approaches, project implementation plans, workplan, and other similar and/or related project documents.
- Performance management plans (PMPs), project monitoring and evaluation plans.
- Project progress reports (annual, quarterly) which contain information especially on indicators tracked (baselines, targets, progress toward targets).
- Evaluation reports and other relevant reports.
- Data on coverage of project interventions/activities generated from customized inventory sheets/checklists/brief questionnaires developed to gather data on project coverage/reach.
- Data from field observations, key informant interviews, focus group discussions, and group interviews.
- 2006 FPS and 2011 FHS reports.
- Complete data sets from the 2006 FPS and 2011 FHS.

USAID/Office of Health shall ensure that all of the survey results, project reports, and summaries of the relevant service statistics and project performance data are available prior to the field deployment of the evaluation team.

## IX. COMPOSITION OF THE EVALUATION TEAM

**Evaluation specialist (team leader) and international technical program expert – FP/MCH:** Recognized international expert in the field of evaluation of health programs. S/he should have an excellent understanding and knowledge on the practical application of various types of evaluation designs, methodologies, and tools. S/he should have a minimum of at least 12–15 years of experience in evaluating big health programs (at least \$10 million), both as team leader (at least 5–8 years) and team member (7–10 years). S/he should have a very good grasp of the issues in FP and MCH, especially in the context of the Philippines and other Southeast Asian countries. S/he should have actually led at least a couple of evaluation activities on FP and/or MCH in the past five years and should be able to provide the appropriate website links where final reports of the aforementioned evaluation activities can be accessed. Excellent writing, analytical, basic computer operation, and team management skills are required. (Expatriate)

**Statistical analyst/specialist:** Must have a degree in basic and advance statistics. Understanding of basic demography required. S/he must possess exceptional knowledge on the

theory of and application of various analytical/statistical methodologies and tools used in health evaluation designs including meta-analysis. Familiarity with sampling designs and methodologies used in demographic and health surveys, including analysis and interpretation of survey data. S/he should have excellent understanding of basic health indicators particularly indicators for FP and MCH. S/he must be familiar with health data quality-related issues in the Philippines and/or other developing countries. S/he must have prior documented experience (10–15 years) in applied health statistics, estimation procedures of survey data, as well as procedures for data quality analysis. Operation of basic statistical software is a must. (Expatriate)

**Technical program expert—FP:** A recognized international expert in FP and reproductive health. A background in demography and public health is required. S/he must have prior documented experience (10–15 years) in FP program implementation and advising countries and government in the area of family planning and reproductive health. Familiarity with FP program implementation issues in developing countries and Asian cultures, as well as public health systems in these countries, is a must. S/he should be able to provide appropriate website links where final reports of the published works in family planning assessment and evaluation in the past five years can be accessed. (Expatriate). The team leader will act as the FP expert on this evaluation.

**Technical program expert—FP/MCH:** A recognized international expert in FP/MCH. A background in public health is required. S/he must have prior documented experience (10–15 years) in FP and MCH program implementation and advising countries and governments in the area of FP and MCH. Familiarity with FP and MCH program implementation issues in developing countries and Asian cultures, as well as public health systems in these countries, is a must. S/he should be able to provide appropriate website links where final reports of the published works in FP and MCH program assessment and evaluation in the past five years can be accessed. (Local)

**Four (4) sociologist/qualitative research specialists:** Formal training in the area of sociology, psychology, or any of the social sciences with advanced training in social science research. They should be recognized local experts in the use/application of qualitative research methodologies. Considerable gender background and familiarity with Philippine health systems and FP and MCH programs required. At least 10–15 years documented experience in conducting social research studies including health research with known research works using qualitative research methodologies. They should be able to provide appropriate website links where final reports of the published works in health research in the past five years can be accessed. Excellent observation, writing, and analytical skills—including skills in basic computer operations—are required. (Locals)

**Private sector communication/marketing/demand-generation specialist:** Formal training in business marketing and any communication-related degree. At least 10–15 years documented experience in marketing and promotion of social programs, products, concepts, and messages, preferably in health. Solid experience in designing, implementation, and evaluation of communications campaigns, preferably including health-related communication campaigns is essential. S/he should be able to provide appropriate website links where final reports of the published works in social and health communication in the past five years can be accessed. Deep understanding of consumers' cultures and behaviors in Asia and the Philippines is required. Experience in public-private partnerships and institutionalizing development cooperation interventions is preferred. Excellent written and oral communication skills are required. (Local)

**Logistics Assistant/Coordinator:** S/he shall provide administrative, logistical, and documentation support to the evaluation team (i.e., developing and coordinating the schedule of the team; arranging meetings, appointments, field visits, and similar activities; providing logistical support in arranging travel requirements for the team such as hotel and airline bookings; preparation of PowerPoint presentations; drafting of communications; data-gathering tools and instruments; and preparation of draft and final reports and presentations). As needed, s/he shall provide process documentation assistance to the team members in their consultations. Familiarity with partners and contact persons in the health sector is required. Relevant experience is a must. Recommendation letters from past three similar assignments should be submitted. (Local)

A DOH staff from the National Center for Disease Prevention and Control (NCDPC), where the FP and MCH programs are lodged, shall be invited to participate in this evaluation activity. Likewise, USAID Mission staff from the Program Office and the Office of Health shall provide guidance to the evaluation team throughout the various phases of the evaluation.

## X. PERIOD OF PERFORMANCE

Phase 1 work is to be carried out by the evaluation team over a period of three weeks (two weeks virtual and one week in-country). Phase 2 will be carried out for five weeks in-country. Finalization of report will be carried out for 10 days within four weeks following departure in-country. Team members will be provided 5 days each, and the team leader and statistical analyst will be given a total of 13 days for report writing.

ACTIVITIES/TASK	Level of Effort
Team consultation for Phase 1 to organize the team, discuss assignments, and agree on deliverables and deadlines.	2 days
Literature review and analysis of past FP/MCH/NDHS and other health surveys including the 2011 FHS (virtual).	10 days
Travel days (to and from Manila).	4 days
Consolidate findings and finalize report from the literature review and analysis of statistics from surveys.	6 days
Development of detailed evaluation plan, methodology, and timeline for the evaluation. This will include, but will not be limited to: initial schedule of interviews, interview guides, site visit, and list of critical documents to be reviewed. Desk review of relevant materials development of data/information collection instruments and methods for analysis.	5 days
In-country/field visits, interviews, information collection, focus group discussion.	18 days (including travel time)
De-briefing activity with USAID and relevant FP and MCH stakeholders.	2 days
Draft report writing.	10 days
Consultant team incorporates USAID feedback into report.	2 days
Consultant team incorporates additional feedback and submits report to GH Tech Bridge II for formal editing and formatting.	1
<b>Total:</b>	<b>61 days</b>

## **XI. DELIVERABLES**

The detailed deliverables and deliverables schedule for this evaluation activity are indicated below. The contractor shall deliver the following items to the appropriate USAID activity manager:

1. **Minutes/summary from all team planning meetings and calls.** Due within three days from conduct of meeting/call.
2. **Detailed workplan and report outline for Phase I.** Due within the first seven days from project award date. The workplan shall include any suggestions for revisions in the statement of work. The workplan and outline of the literature review report shall be approved by the activity manager within five days of reception.
3. **Report on the literature review and analysis of DHS/FPS/FHS Data.** Due not later than day 5 upon arrival of the team in the Philippines.
4. **Detailed workplan (including evaluation design and tools) and final report outline for Phase 2.** Due within first seven days of the team's in-country deployment. The workplan shall include any suggestions for revisions in the statement of work for Phase 2 and the evaluation strategy describing the design and methodologies, including data-gathering tools and guide questions developed, number and selection of respondents, and plans for analysis of qualitative data gathered. The workplan shall reflect the evaluation team's schedule for interview, data collection, field visits, report writing, and periodic interim briefings for USAID. The offeror will also submit an outline of the evaluation report during this time. The outline of the final evaluation report and workplan, including data-gathering plans and tools developed, shall be approved by the activity manager within five days of reception.
5. **Interview and site visit summary** for all site visits and interviews conducted under Phase 2. To be submitted together with the draft report prior to departure of the team leader from the Philippines.
6. **Draft and final evaluation reports.** The draft report shall be submitted by the team leader to the activity manager prior to departure from the Philippines following in-country work under Phase 2. The final report shall be submitted by the team leader to the activity manager on or before December 18, 2012. The draft and final reports shall follow the format and content areas detailed in Annex B of this SOW. Comments on the first and second draft reports will be provided by the activity manager within one week of reception.
7. **Presentation of Phase I results and interim presentation of progress on Phase 2 to USAID.** Proposed schedule is early part of the week of October 29.
8. **Final presentation (debriefings) of evaluation results to USAID and partners.** Prior to the submission of the first draft of the evaluation report, the evaluation team shall present the results of the evaluation to USAID, DOH, and relevant stakeholders (e.g., POPCOM, development partners, and LGU representatives). These sessions shall be used to solicit comments and clarify issues. The offeror will coordinate with the activity manager to schedule these sessions toward the end of the in-country work.

**Final Report.** The final evaluation report shall be submitted to USAID by the team leader no later than 10 working days after final comments are received from USAID. The final report must meet the standards provided in the “Checklist for Assessing USAID Evaluation Reports” in Annex B. The evaluation report should be no more than 30 pages in length, not including annexes and three to four pages for an Executive Summary. Ten copies of the printed final report shall be submitted to USAID together with a CD containing an electronic version of the report and all annexes and raw data used in its preparation.

## **XII. FUNDING**

Office of Health/Philippines is allocating funds estimated at around \$496,139.00 from its program evaluation budget for this activity.

# ANNEX B: DOCUMENTS REVIEWED

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# **ANNEX C: PERSONS CONTACTED**

## **USAID/PHILIPPINES**

Gloria Steele, Mission Director, USAID

Reed Aeschliman, Deputy Director, USAID

Ann Hirschey, Chief, Office of Health

Judy Chen, Deputy Chief, Office of Health

John Callanta, M&E Specialist, Office of Program Resource and Management

Maria Paz de Sagun, Program Management Specialist

Reynalda Perez, Program Management Specialist

Yolanda Oliveros, Program Management Specialist

David Derek Golla, Program Management Specialist

Helen Hipolito, Project Development Specialist

Ma. Teresa Carpio, Project Development Specialist

Consuelo Anonuevo, Project Development Specialist

Ma. Victoria Dagohoy, Project Management Assistant

## **SHIELD PROJECT**

Dr. Leonardo A. Alcantara, Jr., Chief of Party

Raymundo Gonzaga, Deputy Chief of Party

Dr. Edward B. Tandingan, Quality Assurance Advisor

Emerita G. Barquilla, M&E Manager

## **HPDP PROJECT**

Orville C. Solon, Chief of Party

## **HEALTHGOV PROJECT**

Alejandro N. Herrin, Chief of Party

Rosario Benabaye, Central Technical Team Leader for Service Delivery

Noemi Bautista, Central Technical Team Leader for Systems

## **HEALTHPRO PROJECT**

Inna Sacci, Chief of Party

Carmina Aquino, Deputy Chief of Party

Cecilia Manuel, Field Operations Director

Nilo Yacat, Mass Media & Communications Advisor

## **PRISM2 PROJECT**

Michelle Gardner, Chief of Party

Lemuel Marasigan, Deputy Chief of Party

Grace Viola, RTRU Advisor

## **EU**

Ms. Anja Bauer, Task Manager for Health

Ms. Rita Bustamante, Programme Officer

## **UNICEF**

Dr. Mariela Castillo, Health Specialist

## **UNFPA**

Dr. Mike Singh, Program Officer

## **WHO**

### **PhilHealth**

Dr. Liezel Linsangan, Senior Manager

Dr. Ann Remonte, Medical Specialist III

## **POPCOM**

Ms. Rosemarie Mendoza, Deputy Executive Director

## **DOH**

Ms. Mylene M. Beltran, Director, Bureau of Health for International Cooperation

Dr. Sally Paje, National Center for Disease Prevention and Control

Dr. Juanita Basilio, Medical Officer V, National Center for Disease Prevention & Control

Dr. Diego Danila, National Center for Disease Prevention & Control

Mr. Tony Roda, Health Promotions & Communications

Ms. Rose Aguirre, Health Promotions & Communications

## **DAVAO DEL SUR**

Dr. Abdullah Dumama, Regional Director, Center for Health Development II

Ms. Ellen Plenos, HealthGov Coordinator

Dr. Azucena Dayanghirang, Provincial Health Officer

## **LANAO DEL SUR**

Dr. Alinader Minalang, Provincial Health Officer II, Lanao del Sur

Dr. Pinky Rakiin, Provincial Health Officer I, Lanao del Sur

Dr. Noemi Requilme, District Health Officer and Chief of Hospital of Wao

Mayor Elvino Balicao Jr., Municipal Mayor of Wao

Ms. Helen Tago, Nurse of Wao District Hospital  
Ms. Charito Jamayon, Nurse of Wao District Hospital  
Ms. Winona Nacional, Chief Nurse, Wao District Hospital  
Ms. Luzviminda Empiro, Nurse of Wao District Hospital  
Ms. Natividad Capistrano, Nurse of Wao District Hospital  
Dr. Emelyn Alvarez, Municipal Health Officer of Wao  
Ms. Amea Angeles, Nurse  
Ms. Natividad Capistrano, Midwife III  
Ms. Lily Oreta, Service Provider

### **ILOCOS NORTE**

Atty. Windell Chua, Provincial Administrator  
Dr. Juanito Chua, CEO, Ilocos Norte Hospital Management Council  
Dr. Llewellyn Santos, Chief of Ilocos Norte Provincial Hospital  
Ms. Godelina Balanay, FP/MCH Coordinator, Provincial Health Office  
Mrs. Adelina Josue, DOH Representative

### **Laoag City, Ilocos Norte**

Michael V. Fariñas, City Mayor  
Dr. Manolito Dacuycuy, Sangguniang Panglungsod Member  
Dr. Renato Mateo, City Health Officer  
Dr. Robert Luzod, Chief, Laoag City General Hospital  
Ms. Marilyn Manuad, FP Coordinator  
Ophelia Rodillas, Public Health Nurse II  
Marilyn Mamliad, Public Health Nurse I  
Sylvia Alcaraz, Public Health Nurse I

### **Bacarra, Ilocos Norte**

Mayor Nicomedes dela Cruz, Municipal Mayor  
Dr. Manuel Andres, Municipal Health Officer of Bacarra

### **Paoay, Ilocos Norte**

Bonifacio Clemente Jr., Mayor  
Dr. Alfredo Domingo, Municipal Health Officer  
Ms. Edita Gascon Lacambra, Population Program Worker II

**Batac City**

Dr. Julito Catubay, Chief of Clinics, Mariano Marcos Memorial Medical & Training Center

Dr. Marte Rose Gapuzan-Corpuz, Medical Specialist III, Mariano Marcos Memorial Medical & Training Center

Ms. Katrina Mae Corpuz, Nurse I, Mariano Marcos Memorial Medical & Training Center

Ms. Almeida Invencion, Nurse Supervisor, Mariano Marcos Memorial Medical & Training Center

Mr. Dennis Rubio, Administrative Assistant II, Mariano Marcos Memorial Medical & Training Center,

Ms. Gisele Gonzales, Medical Officer III, Mariano Marcos Memorial Medical & Training Center

**CAPIZ**

Mr. Francisco Dariagan, Provincial Administrative Officer

# ANNEX D: DATA COLLECTION TOOLS

## INTERVIEW GUIDE FOR USAID PROJECT CONTRACTING OFFICER'S TECHNICAL REPRESENTATIVES AND CHIEFS OF PARTY

1. Which of the project's interventions significantly contributed (directly or indirectly) to the improvement of FP and MCH performance in target provinces?
2. What more could have been done by this project to improve FP/MCH performance? How could the interventions be more efficiently implemented?
3. What are the management and coordination mechanisms in place for coordinating with all stakeholders including DOH, CHDs, cooperating agencies, other donors, and other key groups such as POPCOM and PhilHealth?
4. What are the mechanisms for coordinating among the five projects?
5. What is the one best practice among FP and MCH interventions of this project that has actually produced successful results?
6. Was the original project design (in terms of project strategies and approaches) well-conceived? Were there any weaknesses?
7. Why has the CPR in the Philippines not increased more rapidly in the past 10 years?
8. What are the key barriers in increasing acceptance of FP in the country? Please identify three key barriers.
9. Why has the MMR remained at the same level in the past 15 years?
10. Why is MMR not declining despite increase in deliveries assisted by SBAs and in FBDs?

## INTERVIEW GUIDE FOR OTHER INTERNATIONAL AGENCIES AND DONORS (UNFPA, UNICEF, EU, WHO)

1. What are the agency's major interventions in FP and MCH?
2. What are the successful/effective interventions in FP and MCH that have been implemented under the projects that you are assisting?
3. What is the geographic (provincial) focus of the assistance provided for improving FP/MCH programs? (Do they work in the selected four provinces; if yes, who is the contact at the province?)
4. What is the agency's approximate annual (or five-year) assistance budget for FP/MCH interventions?
5. How does the agency coordinate with USAID and USAID-funded FP/MCH projects?
6. What are the successful USAID interventions contributing to the improvement of the FP and MCH programs?
7. What are the weaknesses of USAID-supported projects and interventions in FP/MCH?
8. Why do you think the CPR is not increasing?
9. Why do you think the country's MMR remained on the same level in the past 15 years?

## **INTERVIEW GUIDE FOR DOH, POPCOM, PHILHEALTH, REGIONAL DOH**

1. How effective are the five projects of USAID in terms of achieving key FP/MCH objectives? What is the basis of the response and why?
2. What more could have been done by USAID interventions to achieve key FP/MCH results?
3. Were the original project designs well-conceived?
4. How could USAID FP/MCH interventions be more effectively implemented?
5. What management mechanism is put in place to ensure effective coordination and synergy with the partners?
6. How can the interactions between the development partners (specify) be improved?
7. What are the gaps in programming USAID assistance?
8. Why is the CPR not increasing? (probe to get to the root of the constraints)
9. What are the key barriers to increasing acceptance of FP? (probe to get into the root of the issues)
10. Why has the country's MMR remained on the same level in the past 15 years?
11. Why is MMR not declining despite increases in SBAs and FBDs?
12. If the facility is DOH/PHIC accredited for FBD, are they automatically allowed to provide the whole range of FP services, including sterilizations?
13. (For PHIC) Is there a plan to develop an FP benefit package? What is the level of utilization of the current FP benefit package? What is causing the low level of utilization?
14. (For DOH) Can the MNCHN grant cover for the establishment of a sterilization services (fixed or mobile)? If yes, what could be the possible barriers for pursuing this?
15. (For POPCOM) What kinds of support do you get from USAID?

## **INTERVIEW GUIDE FOR SERVICE PROVIDERS AT FACILITIES (DOCTORS, NURSES, AND MIDWIVES)**

1. What type of FP/MCH services are you providing? If not all, why not?
2. Which FP methods are you providing and what are the caseloads in the past month/week? (Investigate records and documentation)
3. Where do you refer the clients who are interested in sterilization (female or male) or other methods not available in the facility? How do you ensure that the client actually accesses the service in the facility where they were referred to? Is there a functional referral system?
4. How do you promote FP and recruit clients?
5. Which FP method(s) do you think are best options for women and men in this area? Why?
6. How and when did you receive training to perform your job?
7. Did you receive any support/training from USAID-funded projects to perform your job? How helpful was the assistance you received? (e.g., info materials, job aids, CSR, etc.)
8. Did you receive any follow-up after you were trained? What was expected from you following the training? Were you able to deliver on these expectations? Why?

9. Who supervises your work? What is the supervision mechanism? How often? Is the supervision helpful? Would you say that your performance improved because of it?
10. What are your needs to improve your job performance?
11. Are you an FP acceptor? What method? Why is it your method of choice?

## **INTERVIEW GUIDE FOR POSTPARTUM WOMEN WHO DELIVERED AT A FACILITY**

1. How old were you at your last birthday?
2. Are you currently single, married, widowed, divorced/separated, or in a common-law/live-in arrangement?
3. How many pregnancies have you ever had?
4. How many sons and daughters do you have?
5. How did your last pregnancy end?
6. When did you deliver?
7. What is the most important reason for deciding to deliver your baby in this health facility?
8. At the time you became pregnant, did you want to become pregnant then, did you want to wait until later, or did you not want to have any (more) children at all?
9. Immediately prior to this pregnancy, were you using any method to delay or avoid getting pregnant?
10. Why did you not use any FP method at that time?
11. Did you see anyone for prenatal care during your last pregnancy?
12. Whom did you see?
13. Did you get counseling during prenatal visits?
14. What FP information did you receive?
15. After giving birth, did you receive any information or service on FP methods for delaying or avoiding a pregnancy from anyone in this health facility or birthing clinic?
16. Describe the type of information, commodities, or services that you received at this health facility/birthing clinic?
17. After giving birth recently, do you want to become pregnant soon, do you want to wait until later, or do you not want to have any (more) children?
18. Would you be interested in using any method to delay or avoid getting pregnant?
19. Why did you not want to use any FP method?
20. What FP services do you think are available in this health facility?
21. During your delivery, was your husband with you?
22. If you wish to use an FP method to space or limit fertility in the future, would you consult with your husband about this?

## GUIDE FOR FOCUS GROUP DISCUSSION WITH MEN

*(Expected FGD participants: Eight married males ages 25–44)*

Province:	Date of FGD:
Municipality:	Facilitator:
Barangay:	Documentor (if any):
No. of Male FGD participants:	Time Started:          Time Ended:

1. How important are males in deciding when and how many children to have?
2. When a husband and a wife use an FP method to space or limit their number of children, do they discuss what FP method they will use?
3. When does a husband consider using an FP method rather than the wife?
4. What factors lead men to accept/agree to use condoms or non-surgical vasectomy (NSV) to delay or limit fertility?
5. What factors prevent/hold back men from using condoms or NSV to delay or limit fertility?
6. What are the advantages and disadvantages of condoms and NSV?
7. What do think are the characteristics of men who would be interested to receive information on NSV?
8. How could men's interest and access to information on NSV be improved?
9. How and where do men get NSV services?
10. Where do men get information on other FP methods?
11. Where do men prefer to get information on FP methods?

## GUIDE FOR FOCUS GROUP DISCUSSION WITH WOMEN WITH UNMET NEED FOR CONTRACEPTION

Date of focus group:	Venue of focus group:
Province:	Municipality:
Time start: _____ Time end: _____ Duration: _____	Barangay:
Facilitator/ Moderator:	Documentor (if any):
Topic of focus group: women's unmet need for contraception	
<b>Selection criteria for participants:</b> Eight women who: (1) are ages 25–44, (2) are either married or in a consensual union, (3) have at least one child, (4) want to either limit or space their pregnancies but are <u>currently not using a family planning method</u>	
No. of female focus group participants in attendance:	

1. Would you like to have another child, or would you prefer not to have any more children?
  - a. For those who mentioned that they would like to have another child but wish to delay their next pregnancy, ask: *How long would you like to wait from now until your next pregnancy?*
  - b. For those who mentioned that they would not like to have another child, ask: *Why do you no longer want to have children?*
2. Why are you *currently* not using a family planning method to prevent pregnancy?
 

(Note: If the focus group participants had been chosen/screened properly, they should all *not* be using a family planning method at present, even though they want to either space or limit pregnancy).
3. Have you ever used a family planning method in the past?
 

If yes (had used a family planning method in the past), ask:

  - a. *What family planning method did you last use?*
  - b. *How did you learn about/obtain information on the family planning method that you last used?*
  - c. *From whom/where/how did you obtain the family planning services that you last used?*
4. For those who discontinued using a family planning method: What are your reasons for discontinuing the use of the family planning method you last used?
5. For all: Would you like to be able to use a family planning method *now*?
 

(Note: If the focus group participants had been chosen/screened properly, they should all answer “yes” [they want to have access to a family planning method].)
6. For all: What family planning method would you like to be able to use, and why?

7. *For all:* Do you think your spouse agrees with your desire to space or limit pregnancy? Would he support you or cooperate with you in the family planning method that you would like to use?
8. *For all:* Do you know of a place where you can obtain family planning services? If yes, what place is this? In the last year (12 months), did you visit this place to obtain family planning information and services?
9. *For all:* In the last year (12 months), were you visited by a health worker who talked to you about family planning? If yes, what did you learn from that visit?
10. *For all:* What would help you to access information and services on your desired family planning method?

## **GUIDE FOR FOCUS GROUP DISCUSSION WITH COMMUNITY HEALTH TEAMS**

1. What type of training have they received? Were they trained in FP?
2. What are the main responsibilities of the CHTs/CHATSSs? Who supervises their work?
3. How often do they go out in the community to make home visits?
4. Do they have a system for identifying people in need of FP/MCH Services? What protocol or guides are they using?
5. Describe the system of referrals of clients they encounter in their community visits
6. What constitutes the bulk of their community work?
7. How is their performance assessed? What kinds of incentives do they get from the clinics?

## GUIDE FOR FOCUS GROUP DISCUSSION WITH TEEN MOTHERS

Date of focus group:	Venue of focus group:
Province:	Municipality:
Time start: _____ Time end: _____ Duration: _____	Barangay:
Facilitator/ Moderator:	Documentor (if any):
Topic of focus group: family planning/RH information and services for adolescents (esp. teen mothers)	
<b>Selection criteria for participants:</b> Eight female adolescents who (1) are ages 15–19, (2) have at least one child, and (3) are either married or in a consensual union or unmarried	
No. of female focus group participants in attendance:	

**SELF-INTRODUCTION BY PARTICIPANTS:** Please tell us briefly about yourself. What is your name? How old are you? With whom do you live? And what are you doing apart from bringing up your child/ren?

1. Based on your observations, are there a lot of girls in your community who get pregnant? Do you think the reality of teenage pregnancies is a serious concern in your community? Why do you say so?
2. What are usual circumstances behind teen pregnancies in your community? (Is the pregnancy usually planned or unplanned?)
3. What is the typical reaction of parents when they find out that their teenage daughter is pregnant?
4. What is the usual reaction of the male who had gotten a teenage girl pregnant? Does he provide support (financial, emotional) for the child and for the mother of his child?
5. Where do teenagers in your community usually obtain information and education about sex? (From parents? School? Peers? The Media? Personal experience?)
6. Do you think adolescents in your community need to be formally/systematically provided information/education about sex and family planning? Why do you say so?
7. Do you think adolescents in your community ought to be provided family planning services, if they should so want them? Why do you say so?
8. Are family planning counseling and services (e.g., natural family planning, condoms, oral contraceptives, injectables, among others) made available for adolescents in your community? If yes, from where/whom can adolescents obtain such counseling and services?
9. Do you currently want to either limit or space your pregnancies? If yes, have you sought family planning counseling and services in the last year (12 months)? What has been your experience (whether positive or negative) in that regard?
10. Do you think your community is doing enough to provide family planning and reproductive health information and services to adolescents? If not, what more can your community do in this regard?

## INVENTORY OF FACILITIES, STAFF, AND SERVICES AVAILABLE AT THE SDP VISITED

### Observation Checklist

Areas of Observation	Responses	Comments
<b>A. Description of Facility</b>		
A1. Type of facility	<input type="checkbox"/> Hospital (public) <input type="checkbox"/> Hospital (private) <input type="checkbox"/> RHU <input type="checkbox"/> BHS <input type="checkbox"/> Birthing clinic (private)	
A2. Is this facility PHIC accredited?	<input type="checkbox"/> YES <input type="checkbox"/> NO	Ask PHO/MHO If not, indicate if it has started the process for accreditation
A3. Is there a visible sign announcing the services available?	<input type="checkbox"/> YES <input type="checkbox"/> NO	Observation
A4. Are FP services offered in the facility?	_____ No of days/week	Ask MHO
A5. Are MCH services offered?	_____ No of days/week	Ask MHO
<b>B. Staffing</b>		
B1. No of staff working in MCH/FP	<input type="checkbox"/> Doctor (s) <input type="checkbox"/> Nurse <input type="checkbox"/> Midwife <input type="checkbox"/> Others (specify)	Ask MHO Indicate number
B2. Are these providers Accredited by PHIC?	<input type="checkbox"/> YES <input type="checkbox"/> NO	Ask MHO Specify the number of HPs accredited
B2. Are there CHATs organized under the SDP?	<input type="checkbox"/> YES <input type="checkbox"/> NO	Indicate the number of CHATs
<b>C. Waiting Room Facilities</b>		
B3. Is there a waiting area for clients?	<input type="checkbox"/> YES <input type="checkbox"/> NO	Describe
B3. Is there seating for all clients?	<input type="checkbox"/> YES <input type="checkbox"/> NO	Describe
B4. Are toilets available?		Describe

Areas of Observation	Responses	Comments	
<b>D. IEC Materials and Job Aids</b>			
D1. Which FP or MCH IEC materials are available	<input type="checkbox"/> FP flip chart <input type="checkbox"/> MCH flip chart <input type="checkbox"/> FP brochure and pamphlet <input type="checkbox"/> MCH brochure and pamphlet <input type="checkbox"/> Other (specify)	Tick if available	
D2. Are these translated in the local language?			
<b>E. Medical Examination Facilities</b>			
E1. Is there a separate room for examination?	<input type="checkbox"/> YES <input type="checkbox"/> NO		
E3. Is there adequate light in the examination area	<input type="checkbox"/> YES <input type="checkbox"/> NO		
E4. Is there an adequate amount of water available in the examination area?	<input type="checkbox"/> YES <input type="checkbox"/> NO		
<b>F. Equipment and Contraceptive Commodities</b>			
F1. How many of each of the following are available for FP and MCH Services:	Number in Working Order	Comments TICK where appropriate if present.	
1. Sterilizers			
2. Uterine sounds			
3. Specula			
4. Scissors			
5. Instrument containers			
6. Examination table			
7. Minilap kits			
8. Operation theater			
9. Recovery Room			
<b>G. FP Methods Available: (Record Below whether the SDP provides each of the following methods and if yes, PHYSICALLY CHECK AND COUNT the total number of contraceptives in both the clinic and the store room</b>			
Type of Contraceptives	Provided	Quantity Available	
Pills (no of cycles/packets)			Count the cycle of pills available
2. Condoms	<input type="checkbox"/> NO <input type="checkbox"/> YES		Number of single pieces
3. IUD	<input type="checkbox"/> NO <input type="checkbox"/> YES		

Areas of Observation	Responses		Comments
4. Injectables (no of Vials)	<input type="checkbox"/> NO <input type="checkbox"/> YES		
6. Female sterilization	<input type="checkbox"/> NO <input type="checkbox"/> YES		
7. Vasectomy	<input type="checkbox"/> NO <input type="checkbox"/> YES		
8. Natural Family Planning Billings SDM	<input type="checkbox"/> NO <input type="checkbox"/> YES		State who provides the service.
<b>H. Procurement, Storage, and Stockouts</b>			
H1. Source of FP Commodities	<input type="checkbox"/> Donated by UNFPA <input type="checkbox"/> Provided by CHD <input type="checkbox"/> Procured by the Province <input type="checkbox"/> Procured by the Municipality		Describe.
H2. Is there an inventory of FP commodities?	<input type="checkbox"/> NO <input type="checkbox"/> YES		
H3. Are FP commodities stored according to expiration date?	<input type="checkbox"/> NO <input type="checkbox"/> YES		
H4. Are storage facilities for contraceptives adequate?	<input type="checkbox"/> NO <input type="checkbox"/> YES		“Adequate” means no exposure to rain or sun, protected from rats and pests.
H5. Do you have a system for ordering supplies?	<input type="checkbox"/> NO <input type="checkbox"/> YES	Describe: <input type="checkbox"/> As needed <input type="checkbox"/> Regularly (quarterly monthly) <input type="checkbox"/> Other	Ask MHO
H6. For which contraceptives have you had a stockout in the last 6 months?	<input type="checkbox"/> Combined Pills <input type="checkbox"/> Progesterone-only pills <input type="checkbox"/> Condoms <input type="checkbox"/> IUDs <input type="checkbox"/> Injectables <input type="checkbox"/> Beads for SDM		
<b>I. Record-keeping and Reporting (Obtain and attach an example of client record form and other reporting forms used.)</b>			
II. Is there a separate client record for each FP client?	<input type="checkbox"/> NO <input type="checkbox"/> YES		Observe and examine

Areas of Observation	Responses	Comments	
12. Are client addresses recorded in sufficient detail on the card to allow for follow-up?	_____ NO _____ YES	Observe and examine	
13. In what condition is the record-card system?	_____ Well ordered _____ Partially ordered _____ Disordered, not usable	Observe and examine	
14. How are the records filed?	_____ No filing system _____ Alphabetically by surname _____ By patient number _____ By year of first visit to the SDP _____ Other	Observe and examine	
15. Are reports sent about FP services provided?	_____ NO _____ YES	Determine where are reports sent.	
16. If yes, when was the last report sent?	Month and date		
17. If yes, is feedback received on reports	_____ NO _____ YES		
<b>J. Management and Supervision</b>			
J1. Are there copies of written job descriptions outlining staff responsibilities?		Ask MHO: If there are, ask to see the job description.	
J2. Does a supervisor come to this facility?	_____ YES _____ NO	Ask MHO: If the nurse is the supervisor, is there a system she/he follows to supervise the staff? Describe.	
J3. What does the supervisor do? (Do not prompt)	Observe service delivery Inquire about service problems Make suggestions for improvements Examine the records Offer praise for good work Other	Ask Midwife (in RHU.)  TICK answers.	
J4. How many times in the last 6 months has the supervisor performed these tasks?	_____ No of times	Ask Midwife	
<b>K. Service Statistics</b>			
K1. Abstract and record the following FP Statistics for the last complete month:			
<u>FP Services Provided</u>	<u>New Acceptors</u>	<u>Revisits</u>	<u>Contraceptives Issued</u>
TOTAL			
Pill			
Condom			
IUD			

Areas of Observation	Responses		Comments
Injectable			
Female sterilization			
Vasectomy			
LAM			
NFP			
Referrals to other SDP			
K2. Abstract and record the following MCH service statistics for the LAST COMPLETE MONTH	<u>MCH Services</u>	<u>Number of Clients</u>	<u>Examine Record</u>
a. Antenatal care			
b. Deliveries			
c. Immunization			
d. Vitamin A supplementation			
e. Postnatal care			
f. Oral dehydration therapy			
K3. How many clients received FP and MCH Services in 2011?	<u>Total New FP Acceptors</u>	<u>Total FP Revisits</u>	<u>Total MCH Visits</u>

**Comments on any items or issue:**

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## ANNEX E: TYPES AND NUMBERS OF RESPONDENTS INTERVIEWED DURING FIELD TRIPS

Provinces Visited	# of governors, mayors, other managers interviewed	# of service providers interviewed	# of other KI interviewed (project staff, other donors, etc.)	# of FGD participants	# of sites visited, including health facilities	#of clients interviewed
Davao del Sur 2 cities 1 village	8	10	5	35	7	12
Lanao del Sur 1 town 4 villages	3	11	2	30	8	11
Capiz 2 cities 1 town	17	8	1	31	7	10
Ilocos Norte 2 cities 2 towns	15	15	-	32	12	12
Total 15 LGUs	43	44	8	128	34	45



# ANNEX F: SUMMARIES OF FIELD TRIPS

## LANAO DEL SUR FIELD TRIP SUMMARY

**Dates:** Oct. 28–31, 2012

### **Team members:**

- Jose R. Rodriguez
- Marita Concepcion Castro Guevara

### **Sites visited:**

- Wao District Hospital
- Wao Birthing Clinic
- Wao Rural Health Unit
- Wao District Hospital Training Center (venue of all four focus group discussions)
- Barangay Extension-Bliss (residence of a postpartum woman)
- Barangay Banga (residence of a postpartum woman)
- Residence of a female new acceptor of FP
- Residence of a female new acceptor of FP

### **Persons Interviewed:**

- Dr. Shalimar “Pinky” Rakiin, MD, MDM, CESE, Provincial Health Officer (PHO) I, Lanao del Sur
- Ms Alliah A. Matuan, FP-MNCHN Coordinator of LDS
- Ms Marilyn Santos, MCH Coordinator
- Dr. Emelyn L. Lizada-Alvarez, Municipal Health Officer/RHP, Wao, Lanao del Sur
- Dr. Noeme Calvo Requilme, District Health Officer and Chief of Hospital, Wao District
- Nurse Winona Nacional, Chief Nurse, Wao District Hospital
- Nurse Helen Tago, Wao District Hospital
- Nurse Luzviminda Empiro, Wao District Hospital
- Nurse Amea Angeles, Wao District Hospital
- Midwife III Natividad Capistrano, Wao Birthing Clinic
- Lily Ureta, Midwife III, Wao RHU
- Other midwives at the Wao Birthing Clinic

- Ms Adelfa Manabilang, SHIELD Coordinator for LDS
- Ms Noraina Macatoon, SHIELD point person for Wao, Lanao del Sur
- Nine postpartum women (of whom three delivered at the Wao District Hospital, and six delivered at the Wao Birthing Clinic)
- Two female new acceptors of FP

#### **Focus Group Discussions Conducted:**

- Community Health Action Team (CHAT) members (Oct. 29, 2012; 11 participants)
- Married and unmarried men with children (Oct. 30, 2012; 7 participants)
- Women with unmet need for FP (Oct. 30, 2012; 7 participants)
- Married and unmarried teen mothers with at least one child (Oct. 30, 2012; 5 participants)

#### **Findings Of Key Informant Interviews During the Field Visit To Lanao del Sur:**

- I. Interview with the provincial health officials and staff (assistant PHO, FP coordinator, and MCH coordinator)

##### *a. Program environment: policy and financing*

- Support from UNFPA: FP equipment, contraceptive supplies, training.
- Support from SHIELD: training and technical assistance.
- Budget support from DOH-ARMM mainly for salaries of staff.
- Policy support from the DOH-ARMM in AMTSL and oxytocin administration.
- FP-MNCHN grants from the DOH: used mainly to buy contraceptive supplies.
- Very little support from local governments.
- Muslim religious leaders are supportive of FP.
- High levels of enrollment in PHIC.
- Presently very few facilities are MCP accredited but this year there are at least 12 that have applied for accreditation.
- The PHO conducts annual program implementation reviews.

##### *b. Supply*

- There are 34 rural health units with fully functional facilities. Five RHUs are housed in a temporary facility.
- There are no barangay health stations except in Wao. Midwives are based in the RHU and visit barangays using temporary shelters.
- All RHUs have at least one staff trained in basic FP. But only 6 out of the 39 are doing IUD insertion on a regular basis.

- Only Wao is trained on postpartum IUD insertion.
- Three district hospitals have some capacity to perform sterilization services but only one is doing it on a regular basis (2–3 cases per month).
- Contraceptive supplies are not enough and inconsistent. The major source of funding is from the FP-MNCHN grants and it is good only for one quarter.
- Popshops are not working.
- Access to private sector FP outlets is limited.

## 2. Demand

- All municipalities have trained CHATs.
- Provincial health officials are wary of creating more demand given the lack of contraceptive supplies.

## 3. Interview with Wao district hospital staff

- Hospital is an accredited (level I) facility.
- Hospital staffs are trained on basic obstetric emergency and neonatal care, including newborn screening.
- One nurse is trained on postpartum IUD insertion.
- The hospital gets referrals from the birthing clinic for high-risk deliveries.
- Average number of deliveries is 10–15 per month.
- Approximately 50% of women who deliver in the hospital undergo postpartum IUD insertion (4–8 per month).
- Delivery room and equipment are complete and in good condition. Hospital supplies for delivery and FP are available.
- FP room is fully equipped, including postpartum IUD equipment and supplies.
- Client records are complete and updated.
- FP nurse has been trained on comprehensive FP and postpartum IUD insertion.
- Hospital officials and staff are not aware that PHIC reimbursement for IUD insertion is available.
- There are no trained staff for sterilization services (BTL and NSV).

## 4. Interview with Wao Rural Health Unit staff

- RHU has an accredited and licensed birthing center.
- Birthing facility has one delivery room open 7/24 and manned by seven midwives who have been trained on AMTSL and oxytocin injection.

- Birthing facility and FP room are fully equipped and supplied. Record-keeping is excellent.
- The staff handle 20–30 deliveries per month in the birthing center.
- Five midwives were trained on postpartum IUD insertion, and two of them perform a combined five to six IUD insertions per month. The other three are newly trained and do not yet have the confidence.
- One village that was visited (population: 60 households) had 29 current acceptors of IUD.
- Supplies of contraceptives are not a problem, as the municipality uses part of the PHIC capitation fund and the proceeds from the maternity care package to buy contraceptive supplies.
- A pharmacy outlet in the town’s poblacion carries contraceptive supplies.
- The RHU earns an average of 150,000 pesos per month from the birthing clinic, while the municipality is able to generate 4 million pesos from the PHIC capitation fund.
- The municipal health officer was trained on BTL but lacks the confidence to perform the procedure in the absence of the trainer.
- In 2004–2006 a surgeon performed NSV on a regular basis.

#### **Summary of Findings and Observations:**

- The province of Lanao del Sur receives some support from a variety of sources but is unable to provide enough contraceptive supplies to clients. Contraceptive self-reliance is not working.
- The provincial health office is not devolved to the provincial government and receives very little support from the LGUs.
- Enrollment in PHIC is high, but very few facilities are PHIC accredited. The high levels of enrollment in PHIC presents a great opportunity for the health facilities in the province to mobilize resources for FP and MCH services.
- There are not enough facilities to provide FP services, and trained staff are only available in the main health centers.
- Most health centers offer only pills, DMPA, and condoms. IUD services are only performed in a few facilities. Only one town is offering postpartum IUD insertion. The IUD acceptance rate in this town is very high mainly because of the availability of this method in the hospital and in the birthing facility. Postpartum IUD training is highly recommended for staff of high volume birthing facilities.
- Only one district hospital is offering sterilization services on a regular basis (once a month) and the volume of acceptors is low (2–3/month).

- Very few facilities (6/39) are MCP accredited. One town with an accredited health facility averages between 20–30 deliveries per month and generates 150,000 pesos per month from PHIC reimbursements. The town also uses its capitation fund to buy contraceptive supplies and is able to meet its contraceptive requirements.
- The province considers PHIC as the best option for funding its contraceptive requirements.
- The province is reluctant to conduct an aggressive demand generation campaign as there are not enough contraceptive supplies available and trained providers are not easy to access.
- Most health care providers, especially midwives, are trained on AMTSL and are administering oxytocin.
- The town of Wao has an excellent FP/MCH program that can serve as a good model for replication and scaling up.

## **DAVAO DEL SUR FIELD TRIP SUMMARY**

**Dates: Oct. 28–31, 2012**

### **Team Members:**

Pinar Senlet

Marilou Costello

Jose Hernandez

Nimfa Ogena

### **Sites Visited:**

- Center for Health Development (CHD), Davao City
- PRISM Office, Davao City
- Provincial Health Office (PHO), Digos City
- City Health Office (CHO), Digos City
- Davao del Sur Provincial Hospital
- Gonzales-Maranan Medical Center
- Barangay San Miguel Health Center

### **Persons Interviewed:**

- CHD Assistant Regional Director, Region II
- EU Project Team Leader, Davao City
- HPDP Consultant, Davao City
- PRISM Project Staff, Davao City
- Midwife from Basilan working with SHIELD Project (met with the Team at Davao City)
- HealthGov Regional Coordinator, Davao City
- HealthPro Regional Coordinator, Davao City
- Davao del Sur Provincial Health Officer, Digos City
- Davao del Sur Provincial Health Education Officer, Digos City
- Two city health officers, one nurse, and four midwives, CHO, Digos City
- Delivery room nurse in-charge, delivery room midwife, doctor and midwife at FP-outpatient department, and Procurement Officer, Davao del Sur Provincial Hospital, Digos City
- Midwife at San Miguel Barangay Health Center, Davao del Sur
- Owner and Medical Director of the private hospital, Gonzales-Maranan Medical Center, Digos City

- Ten postpartum women who delivered at Davao del Sur Provincial Hospital, Digos City

#### **Focus Group Discussions Conducted:**

- Community health team members
- Married and unmarried teen mothers with at least one child
- Married men with children
- Women with unmet need for FP

#### **Summary of Findings from Key Informant Interviews in Davao del Sur**

Interviews with the staff of CHD and PHO, and CHO (Digos):

- In general, CHD, PHO, and CHO are aware of USAID projects and are satisfied with the assistance they receive from USAID-funded projects, particularly from HealthGov and HealthPro. They have close relationships with the CAs, and the CAs are highly responsive to their needs. The regular meetings called by the regional director and participated in by the USAID CAs manifest this relationship. *“USAID has been helpful in our endeavor” to improve the health situation of the region-* (Dr. Ma. Socorro de Gracia, OIC Director III, Region II).
- The CHO cited specific project initiatives: DQC, SIMS inventory, and integration of FP in EPI as initiatives of HealthGov. *“It’s a good start,”* but CHO has not really pursued this to its full implementation because of competing priorities. But she sees SIMS as helpful in the enhancement of their pharmacy which now receives support from PhilHealth (4Ps). As for DQC, she says she appreciates accurate data, but this effort served to bring down their performance because of the new stricter definitions. The FP integration in EPI is a *“theoretically a good approach”*—but CHO doubts the midwives’ consistency in implementing FP counseling/services during this time because, in reality, midwives are too busy during immunization day (long lines of clients and crying babies) and everyone wants to go home.
- On IPC training of HealthPro: since there are limits on the number to be trained, they prioritize new and younger providers. They put the older and *“retirable”* providers low in priority selection for training. (But these are the real front liners in the clinic, because they are more trusted by the clients!)
- *“USAID TA is good but useless to us in the city if we can’t have support for logistics and supplies.”* It is a fact that the LGUs have limited budgets.
- The IEC materials being provided are limited in quantity. The messages need to be more personalized rather than general in presentation. Furthermore, there must be enough supply to put in other strategic places like bus terminals.
- Communications materials are inadequate and sometimes not appropriate for the audience. Use of simple terms and in the vernacular is recommended. *“We have some Barangays that are peopled by IPs who are not well educated or illiterates and will get very little from the IEC materials.”*
- Despite the beliefs of many that religion does not matter in the acceptance of FP, religion is a factor in the low CPR because the enthusiasm of providers to give advice on

contraception is stymied for fear of reprisals from their local priests, and also by the inconsistent messages from the government.

- Commodity procurement is a problem. According to the Dr. de Gracia (of CHD), LGUs have the funding but they don't know how to procure contraceptives. Provinces and HealthGov are helping the LGUs to procure contraceptives. This year, CHD procured contraceptives and distributed them to the LGUs.
- However, this is not the case in Digos city. The CHO said, "It all boils down to finances." "We do not purchase our FP commodities" because we have no funding for this. We wait for DOH (CHD) to provide us with commodities, but the quantity is limited. We cannot provide re-supply of contraceptive, so they prioritize new users (or recruits) and tell them to get the next supply elsewhere (pharmacies).
- MMR is not increasing because there are still many deliveries not attended by skilled birth attendance due to preference of TBAs who give more personal care. They also cannot afford the hospitals.
- MNCHN is managed by the PHO. Does not seem to see this as trickling down to the city.
- CHD cited the work of HealthGov, particularly in "helping to propel the KP" to help local LGU to avail of resources from the central office (MNCHN) because they are known for "slow utilization" of funds.
- The PHO is frustrated because they have not been able to make progress in CPR. The PHO "commissioned" the provincial hospital to assign a day to provide TL earlier this month. More than 50 women received TL on that day.
- The HPDP fellows have been useful to the regional director, particularly for coordination work. The fellows serve for six months and appear to provide a good training ground for young and smart people who want to establish a career in public health.

Interviews with staff of USAID-funded projects and EU. The EU has just launched a comprehensive IP MNCHN project in Mindanao. The project is in its inception phase and will be conducting baselines this year.

- The EU project in Davao is focusing on the FP/MCHN needs of indigenous populations, (in Compostela, Bukidnon, and North Cotabato) implemented by with the National Commission of Indigenous People, in collaboration with UNFPA and DOH. The project has taken care to establish baseline information and studies at the start in order to understand the constraints of IP's low access to health services, (poverty, living in remote and hard-to-reach upland areas, communication and transportation challenges, including their general suspicion of Western medicine) and plan to design culturally appropriate interventions during the second stage. Seems the project is starting on the right track.
- USAID projects are informed of each other's activities, although there isn't an inter-CA coordination mechanism in place.
- The CHD calls for meetings with the CAs and other partners. The purpose of these meetings is to inform partners of CHD requests, not necessarily to coordinate the activities of international agencies.

- PRISM and HealthPro coordinate closely because PRISM uses materials produced by HealthPro for the private sector.

Interviews with the staff of CHO, provincial hospital, Barangay Health Office and the private hospital:

- In general, service providers are not showing an interest (enthusiasm) in FP services.
- Similarly, there isn't much appreciation of the assistance they received from USAID-funded projects. Some think that they have already been doing the interventions. Others think new activities increased their paperwork. The data quality improvement intervention decreased their accomplishments, especially with ANC coverage and # of new FP acceptors as they began reporting more accurately.
- Some of the providers received FP and IPCC training, but others have not. The usefulness of these trainings was difficult to assess. The FP staff of the hospital had received FP training some decades ago.
- Supply methods (pills, condoms, injectables) were present in all sites but in limited amounts. The commodities were provided by the CHD only recently and might last up to three months. Priority is given to new acceptors. Continuous users are supposed to purchase from the pharmacies.
- At the CHO, TL is provided by mobile teams of Marie Stopes Davao City staff every three months. Caseloads have been declining. Reasons unknown.
- FP materials developed by HealthPro are available in the CHO and the Barangay HO, not in the hospital.
- One of the MOs in CHO is trained in vasectomy. He performed three vasectomies in nine years. He thinks that vasectomy will not be accepted by Filipino men and TL is a better option.
- Service providers think that the pills are the best method for women in these communities. They are easy to use, available, not many side effects, etc. Women don't want to use other methods because of health concerns.
- Doctors supervise nurses and nurses supervise midwives, but none of them are trained in supervision. There is a checklist but it's not clear if the results are used to improve performance. The providers' performance is assessed based on their contribution to FP and MCH indicators (CPR, FBD, etc.).
- The Barangay midwife has high cases of MCH clients, but not much FP. Refers few IUD and sterilization clients to Digos city. Difficult to assess the results, perhaps half of the women access the services. The center has vaccines and limited amount of contraceptives but no supplies for maternal health (gloves, oxytocin, syringes, etc.).
- The hospital does not provide FP information and services to postpartum women. The staff thinks FP information is being provided during antenatal care. Antenatal care providers do not provide FP counseling. They believe FP information should be provided after delivery.

- None of the postpartum women interviewed (10) had received FP counseling during the antenatal or postpartum periods.
- HPDP project assisted in producing a list of the eligible poor women who could access the private hospital for delivery and the costs would be covered by PhilHealth. The medical director of the private hospital appreciated the efforts. But only two women out of hundreds of eligible pregnant women listed from LGUs delivered at the hospital so far. Needs further investigation.

### **Overall Considerations:**

- “The convergence of various USAID-funded interventions” is weak among several interventions taking place in Davao del Sur. Perhaps too many activities/interventions taking place spread all over the province. Also, some of the interventions are still too early in the pilot/inception phase to show results.
- There is an overall willingness and awareness (especially among women) to use FP (potential demand), but there are widespread health concerns. Demand-creation activities do not address this main impediment to modern contraception—misinformation, myths, and misconceptions among women and men. Instead, the messages are designed to raise awareness which is already there. At the same time, services are weak, both in terms of accessibility and quality. The FP services are inadequate even to meet the existing demand.
- The increasing need for FP information and services among the teenagers, especially among the unmarried, is alarming. Although many respondents brought up the issue, there doesn't seem to be any action taken to address the issue.
- FP services are lower in the priority of services for providers, as there is stronger focus on maternal and child services. FP is practically absent in provincial hospital maternal services (evidenced by postpartum women interviews). There is definitely no integration there, as providers perceive FP to be provided in the primary health care services (RHUs and BHS).
- Hospitals have not been provided with sufficient FP strengthening efforts. Hence a BIG missed opportunity, because majority of women who are ready for information and counseling are there! No need to look for them in the community, unless you want to reach those who never access the health services.

## **CAPIZ FIELD TRIP SUMMARY**

**Dates: November 4–7, 2012**

### **Team members:**

Jose R. Rodriguez

Jose Rafael S. Hernandez

Marita Concepcion Castro Guevara

### **Sites visited:**

#### ***Iloilo***

- Center for Health Development-Western Visayas (CHD-WV)

#### ***Capiz***

- Residence of the Governor of Capiz (Victor A. Tanco)
- Office of the Provincial Administrative Officer of Capiz (Francisco D. Dariagan)
- Office of the Provincial Health Officer of Capiz (Dr. Samuel Delfin)
- Roxas Memorial Provincial Hospital, Roxas City
- Rural Health Unit, Municipality of President Roxas (with birthing facility and pop shop)
- A Teen Center based in the National High School at Barangay Cabugcabug, Municipality of President Roxas

### **Persons Interviewed:**

- Dr. Emilia P. Monicimpo, Officer-in-charge and Assistant Regional Director, Center for Health Development-Western Visayas (CHD-WV)
- Dr. Ma. Salvacion de la Cruz, MS IV, Cluster Head, FHN
- Dr. Maila Bernabe, M.D. III, Regional FP/BEmONC Coordinator, CHD-WV
- Helen Riviera, Health Education and Promotion Officer III, CHD-WV
- Victor A. Tanco, Governor of Capiz
- Francisco D. Dariagan, Provincial Administrative Officer of Capiz
- June D. Regalado, Public Health Nurse
- Dr. Elmer E. Bucayan, Provincial Health Team Leader (PHTL), Capiz
- Dr. Samuel Delfin, Provincial Health Officer (PHO) of Capiz
- Cecile G. Tuazon, FP/MNCHN Coordinator of Capiz
- Evelyn Bolido, Chief of Technical Staff, Provincial Health Office, Capiz
- Dr. Rosemarie Delfin, CHD-WV –DOH representative

- Ma. Joni Dichosa, Regional Technical Advisor (RTA) for Western Visayas (Region 6), RTI-HealthGov
- Joeffrey Espiritu, Health Education and Promotion Officer II
- Lionel Esmeralda, Provincial Population Officer, Office of the Governor of Capiz
- Dr. Celline Bauson, Chief of Hospital, Roxas Memorial Provincial Hospital
- Nurse Grace Usison, Supervising Nurse and former FP Coordinator, Roxas Memorial Provincial Hospital
- Ceres A. Orosco, Midwife II, Roxas Memorial Provincial Hospital
- Dr. Pilar A. Posadas, Municipal Health Officer, Municipality of President Roxas
- Concepcion De la Cruz, Principal of the National High School at Barangay Cabugcabug, Municipality of President Roxas
- Jonel V. Tipon, Head Teacher III in-charge of the Teen Center at the National High School in Barangay Cabugcabug, Municipality of President Roxas
- Pamela Bataican, Teacher and Teen Center Coordinator at the National High School in Barangay Cabugcabug, Municipality of President Roxas
- Krystal Migo Contreras, President, Peer Facilitators Association (PFA), Teen Center at the National High School in Barangay Cabugcabug (Silungan ng Kabataan), Municipality of President Roxas
- Mary Knoll Penalosa, Supreme Student Government President, National High School in Barangay Cabugcabug, Municipality of President Roxas
- Sheena Marie Lamazan, President, KPSEP Division Level
- Ten postpartum women (interviewed at the Roxas Memorial Provincial Hospital)
- One female new acceptor of FP (interviewed at the RHU of the municipality of President Roxas)

#### **Focus Group Discussions Conducted:**

- Community Health Team (CHT) members (T, Nov. 6, 2012, a.m.; 8 participants)
- Teen mothers and pregnant teenagers, ages 15–19 (T, Nov. 6, 2012; 8 participants)
- Women currently not practicing FP (T, Nov. 6, 2012; 7 participants)
- Married and unmarried men with children (T, Nov. 6, 2012; 8 participants)

#### **Results of Key Informant Interviews and Visits to Health Facilities in Capiz**

- I. Interview with the governor and Provincial Health Office staff:
  - The governor considers health a high priority for the province.
  - The province received a grant for facility improvement from the DOH and used the money to improve RHUs. As a result, all the 17 RHUS are accredited for MCP.

- The province also received a share of the FP-MNCHN grants and used the money to buy FP-MCH supplies and train CHTs. The CHT training has just been completed and in many municipalities are yet to be deployed.
  - The provincial health office has one staff trained on NSV. The trained staff claims that some municipalities regularly requests for his services. Generally however, access to sterilization services is poor. BTL is done as part of C/S operations in the provincial hospital and the doctors are not trained on minilap using local anesthesia.
  - The PHO staff reported that both the HealthGov and HealthPro projects had been very helpful in improving the provision of FP-MCH services.
  - With assistance from UNFPA, the province established teen centers that provide counseling services to high-school students throughout the province.
  - The province does not have a trained provider on postpartum FP.
2. Interview with the Provincial Capiz Provincial Hospital staff and observation of hospital facilities:
- Hospital averages 150–200 deliveries per month.
  - Hospital does not have a postpartum FP program.
  - Women who deliver are asked to come back for an FP visit one month after delivery, but few come back for FP services.
  - The hospital has trained IUD and BTL providers, but caseloads for these methods are low (2–3/month).
  - The hospital has a team trained on BEmONC. AMTSL is practiced by the hospital staff.
  - The hospital has level-2 accreditation from the DOH.
  - Delivery room has three delivery tables.
  - OB ward has 12 beds and full of postpartum clients. Average length of stay for normal deliveries is 24 hours.
3. Interview with RHU staff of President Roxas town and observation of the birthing clinic and FP room:
- The RHU is staffed with one MHO, three nurses, and seven midwives. The RHU staff is augmented by an additional physician and three midwives who help man the birthing center 24/7.
  - The birthing center is accredited by PHIC and averages 20–30 deliveries per month. The RHU earns between 200,000–300,000 per month from the MCP and newborn screening.
  - The RHU is well-stocked with FP commodities earmarked for the poor. For those able to pay, the RHU has commodities for sale in its pop shop.
  - The RHU does not have a postpartum program and staff advises postpartum clients to come back for FP services one month after discharge.

- Two midwives in the RHU have undergone comprehensive FP training and perform interval IUD insertion. Caseload is 1–2 per month.
- Staff are unaware that IUD services are reimbursable by PHIC.
- Birthing center is well equipped, although the space is quite limited
- FP room has adequate space and is well equipped. IEC materials for clients are available
- The RHU has a team trained on BEmONC and practices AMTSL.

In summary, the team gathered the following information:

1. Capiz received considerable assistance from the DOH and used the money to improve public health facilities, in the procurement of FP-MCH supplies, and in the training of health volunteers.
2. All the RHUs have been accredited for the maternity care package and significant increases in facility-based deliveries have been reported.
3. The province does not have a facility that offers postpartum FP services. The provincial hospital and the RHU of the town of President Roxas attend many women who deliver, but generally women do not receive FP counseling prior to discharge.
4. Access to sterilization services is poor. There is a trained NSV surgeon, but his services are underutilized.
5. The province has functional teen centers offering counseling services and information to high school students. The teen centers utilize trained peer counselors on reproductive health.

## **ILOCOS NORTE TRIP SUMMARY**

**Date: November 4–7, 2012**

### **Team Members:**

Pinar Senlet

Marilou Costello

Victor Agbayani

Nimfa Ogena

### **Sites Visited:**

#### ***Laoag City***

- Provincial Health Office
- Office of the Governor
- Ilocos Norte Provincial Hospital
- Office of the Mayor
- City Health Office

#### ***Bacarra Town***

- Mayor's Office
- Bacarra Municipal Health Office
- Sangil Barangay Health Station

#### ***Paoay Town***

- Office of the Mayor
- Paoay Municipal Health Office

#### ***Batac City***

- Mariano Marcos Memorial Hospital and Medical Center

### **Persons Interviewed:**

- Provincial Health Officer
- Provincial Family Planning Coordinator (Nurse in charge)
- Provincial Administrator
- Chief of Provincial Hospital
- CEO, Ilocos Norte Hospital Council
- OB-Gyn Outpatient Clinic Doctor
- OB-Gyn Outpatient Clinic Nurse

- 9 postpartum women who delivered at the provincial hospital
- 3 new acceptors who initiated use of modern contraception at the provincial hospital
- Private Pharmacy Clerk (across the hospital)
- Mayor of Laoag City
- City Health Officer, Laoag City
- FP Coordinator Nurse, Laoag City
- Chief of Laoag City General Hospital
- Administrator of Laoag City General Hospital
- Nurse of the delivery room, Laoag City General Hospital
- Mayor of Bacarra
- Bacarra Municipal Health Officer
- Bacarra Public Health Nurse
- Sangil Barangay Health Station Nurse, Midwife, and 2 Barangay Health Workers
- Mayor of Paoay
- Paoay Municipal Health Officer
- Paoay Public Health Nurse
- Paoay POPCOM Population Worker
- Batac City Mariano Marcos Memorial Hospital (MMMH) Chief of Clinics
- MMMH Gynecologist and Nurse in charge of delivery room
- MMMH Nurse Trainer providing BEmONC training
- Gynecology resident providing BTL

#### **Focus Group Discussions Conducted:**

- CHTs (Bacarra)
- Married men with children (Paoay)
- Women with unmet need (Paoay)
- Teen mothers (Paoay)

#### **General Observations in Ilocos Norte**

- A system for monitoring/supervision and evaluation exists (A provincial technical staff is housed in a separate office). Likewise in the City Health Office. A well-informed and strategic thinking staff: The PHO was seconded from the CHD-DOH—this tempered the fragmentations caused by devolution in health as experienced in other parts of the country.

Hence, the DOH system and program priorities continued to be followed without interruptions.

- The province benefited from TA from DOH providing them with key information to avail of potential grants and benefits that can be accessed at the central level (e.g., Dr. Romualdez—the secretary of health himself—advised then-governor Bongbong Marcos).
- The current governor (Imee Marcos) is very concerned about maternal deaths and wants to bring this down. Informed constituents in government of her determination to achieve the MDG targets by 2015. Her priority is maternal health and child health. There is an ordinance that prohibits delivery at home. This was voiced by the vice governor, the PHO, and other local officials in the LGU and in the health sector. FP is among the MDGs but it is not a priority.
- The Laoag City health officer informed the team that there is an MOU signed between the municipality and the Church to promote only natural methods of FP but not “artificial” contraception. The mayor was not aware of such an MOU—it was probably signed before his term. The city health officer later informed the team that in spite of the MOU, they follow the directions of the DOH, but he also admitted that “they are caught in between.” Team, is this correct?
- Approximately 70% of LGUs procure contraceptives.
- The CHD provides training in FP, counseling, and BEmONC funded by the MNCHN grant.
- Several health providers interviewed had undergone this training but some were trained in the 1990s and did not receive refresher training since then. BEmONC training uses 2003 WHO-recommended curriculum. BEmONC curricula include steps of AMTSL practice, but AMSTL training alone for normal deliveries is not available.
- EU and Asian Development Bank grants used for MCHN facility upgrading.
- FP is not a priority for most LGUs. But when there is commitment from the LGU executives for FP, FP is carried out more vigorously.
- Pills are the most preferred method followed by BTL and injectables.
- Pills and injectables are available in many sites, but continuous supply is unpredictable. Some facilities receive contraceptives from the DOH, others from LGU’s procurement.
- BTL is available in the provincial hospital but only when the operation rooms are available. If there are other surgeries, then BTL is not a priority.
- BTL is more available in MMMH because the facility is a BTL training site for OB/GYN residents.
- There are unwritten policies that limit access to BTL services—women under the age of 30 or those with less than three children are generally not referred for BTL services. It is the doctor’s decision to make exceptions to the rule.
- The team did not observe any facility providing IUDs.

- One LGU (Paoay) is accredited for PhilHealth outpatient package, maternity care package and TB –DOTS benefit packages. They used the funds to procure an ambulance, upgrade the facility, and procure equipment for the birthing facility. The MHO is aware of the PhilHealth FP package but did not apply for accreditation. Many other facilities are accredited for the maternity care package but are not aware that they can procure contraceptives with PhilHealth funding.
- Postpartum PhilHealth patients may experience delays in getting PhilHealth coverage for ligation and are asked to pay for this service (P600) before they can be discharged from the hospital.
- There is delineation between FP services and maternal care services. Maternal care providers do not think it is their responsibility to provide FP counseling. Postpartum patients report that they are not provided FP counseling or advice while they are in the hospital postpartum.
- Emphasis on maternal health MDGs, spearheaded by the governor, has helped to cause increases in FBDs. Home deliveries are banned, and women are sometimes “forced” to deliver at facilities. Some women may be reluctant to deliver at facilities (because of crowded delivery wards, attitudes of the service providers, etc.). One health worker noted that pregnant women are “hiding from them.”
- Pill use is increasing in Ilocos Norte because it is promoted by the service providers through the public sector facilities and private pharmacies because it is available.
- Prevalence of TL did not decline significantly because TL is available, although access is limited in some facilities.
- There are no FP and MCH info dissemination for teenagers. Even teen mothers do not receive infant and maternal care info.

# ANNEX G. SUMMARIES OF FINDINGS FROM FOCUS GROUP DISCUSSIONS

## HIGHLIGHTS OF THE FOCUS GROUP DISCUSSIONS WITH TEEN MOTHERS

### Profile of FGD participants:

City/Municipality, Province	Date of focus group	No. of participants	Age range	Civil status	No. of children
Digos City, Davao del Sur	29 Oct. 2012	11	14–19	10 in consensual union; 1 married	Ranging from 1 to 3 children (10 teens, with 2 currently pregnant); pregnant for the first time (1 teen)
Wao, Lanao del Sur	29 Oct. 2012	5	17–18	4 in consensual union; 1 married	All 5 teen mothers had 1 child (ages 1 mo. to 3 yrs.)
President Roxas, Capiz	6 Nov. 2012	8	16–19	All 8 in consensual union	1 child (4 teens); pregnant (4 teens)
Paoay, Ilocos Norte	7 Nov. 2012	5	16–19	3 in consensual union; 2 married	2 teens with 2 children; 3 teens with 1 child

### FGD Highlights:

1. Based on your observations, are there many girls in your community who get pregnant? Do you think the reality of teenage pregnancies is a serious concern in your community? Why do you say so?
  - Most of the FGD participants were of the opinion that there are many adolescents pregnant in the community and that they are increasing.
  - This trend is considered by many to be a problem as many of these adolescent mothers have no resources yet to support their family for food and housing; some husbands have no work.
2. What are usual circumstances behind teen pregnancies in your community? (Is the pregnancy usually planned or unplanned?)
  - The majority of teen mothers said that their pregnancy just happened or was not planned, while some said their first pregnancy was planned but the next pregnancies were not planned.

- All the teen mothers who participated in the FGDs were no longer in school as a result of their early pregnancy and ensuing childbirth.
  - Circumstances mentioned behind the teen pregnancies are:
    - Strict parental upbringing
    - Received limited attention from working parents
    - Mother was far away
    - Required to support family of orientation
  - The majority of the teen mothers were in consensual union, while some are still living with parents.
3. What is the typical reaction of parents when they find out that their teenage daughter is pregnant?
- Most parents were happy but advised their daughter not to have a second child yet.
  - Many of their mothers said that they were still young to get pregnant.
  - Many of their parents said they will be provided support during pregnancy until the delivery of the child.
  - Some parents said nothing upon learning of the pregnancy.
4. What is the usual reaction of the male who had gotten a teenage girl pregnant? Does he provide support (financial, emotional) for the child and for the mother of his child?
- Most FGD participants said that their male partners were happy, excited, and supportive.
  - Some teen mothers said that the male partner was initially happy for the duration of the pregnancy but was overwhelmed with the financial responsibility after delivery so he did not want her to get pregnant again but unfortunately had another one soon afterwards.
5. Where do teenagers in your community usually obtain information and education about sex? (From parents? School? Peers? The media? Personal experience?)
- The majority of the teen mothers did not receive sexuality education in school.
  - Information about sex is often from “scandals” reported on the Internet and cellphone messages, TV drama or telenovela, movies, DVD, and Tagalog romance novels.
  - Many said that they had no information on sex before becoming pregnant but learned about sex from the Internet after having children.
  - Some teen mothers admitted that they got pregnant the first time without realizing that one’s first sexual encounter could result in pregnancy.
  - None of the teen mothers received sex education from their parents. Some were admonished by their parents to “be careful” or given the message, “Do not get pregnant.”

- Teen mothers expressed preference to learn about sex and sexuality from their parents.
  - Some teen mothers wanted sexuality education taught in school so that teenagers would learn about the consequences and risks of premarital sex and early pregnancy.
6. Do you think adolescents in your community need to be formally/systematically provided information/education about sex and family planning? Why do you say so?
- Many were of the view that information on sex and family planning are important to space or limit children, prevent illnesses, and so as not to lose their figure (“*hindi malosyang*”).
  - Some mentioned that information on sex and family planning is important to prevent an unplanned pregnancy. This was especially true for those who need to help earn a living because their husband squanders money on alcohol.
7. Do you think adolescents in your community ought to be provided family planning services, if they should so want them? Why do you say so?
- Most teen mothers stated that FP services should be provided to adolescents especially for adolescent mothers to enable them to space their pregnancies so they can take care of the child and provide for the child’s education.
  - Many teen mothers are not actively seeking FP services but some who received FP counseling from a midwife have either started using the pills or injectables, or are planning to have IUD insertion (Lanao del Sur).
8. Is family planning counseling, and family planning services (e.g., Natural Family Planning, condoms, oral contraceptives, injectables, among others) made available for adolescents in your community? If yes, from where/whom can adolescents obtain such counseling and services?
- Most mentioned that pills are available in the health center and the local drugstore (*botika*) but they do not avail of or buy them.
  - Some who do not want pills prefer Depo-Provera.
  - They mentioned that information on family planning is provided by Population Commission (POPCOM) seminars and barangay health workers (BHWs).
  - They also noted that there were no available condoms in stores (Davao del Sur).
9. Do you currently want to either limit or space your pregnancies? If yes, have you sought family planning counseling and services in the last year (12 months)? What has been your experience (whether positive or negative) in that regard?
- Many of the teen mothers said that they prefer to limit but they have neither discussed it with their spouses nor sought FP counseling.
  - One teen mother said that she uses the calendar method, but after probing, it was discovered that she was actually using NFP (Davao del Sur).
  - Some of the teen mothers would prefer pills or Depo-Provera after delivery as they are generally accessible from the health center.

10. Do you think your community is doing enough to provide family planning and reproductive health information and services to adolescents? If not, what more can your community do in this regard?

- Many teen mothers stated that they have never attended a training on FP/RH for adolescents.
- They said that the BHWs should conduct the training.
- While the midwife suggests use of FP methods, the commodities are not made available for adolescents so they get them secretly (“*pagtalikod lang*”).
- They want more FP/RH information in schools and at madrasa.
- Some expressed satisfaction with prenatal services of the health center.
- Other needed services for or assistance to teen mothers mentioned were:
  - Free vaccination against cervical cancer (addressed to the LGU).
  - More in-depth information on the various family planning methods (addressed to the LGU).
  - Livelihood and income-generating projects for teen mothers (addressed to the LGU).
  - Greater supervision by parents—“*dapat bantayan ang mga bata*” (addressed to the family).

11. Did you hear messages from the radio, TV about family planning and/or maternal health? If yes, what message(s) do you recall?

- Teen mothers rarely listen to the radio or watch TV; therefore, they get limited messages from the media on family planning, maternal, neonatal, and child health and nutrition. Some of them said that they had seen the television commercials of Trust which advertise condoms and pills. They have also seen advertisements of milk companies (like Enfakid) on television which have the message at the end saying “breast milk is still best for your kid.” A few of them were able to see the television episode of Kris TV (hosted by Kris Aquino) where newborn screening was featured. On BomboRadyo (a local radio station), the Capiz focus group participants have heard programs advising pregnant women to go for prenatal checkups, telling them to exercise, or discussing the food that pregnant women should eat (e.g., vitamins, fruits) or not eat.

12. If you were to give a message to teenagers like yourself, what message would you say about sex, pregnancy, child bearing, and family planning?

When focus group discussion participants from Capiz were asked about the message that they would like to convey to other adolescents, they mentioned the following:

- “Avoid the world of sex [for now].” “Do not engage in sex just yet.” “Do not be in a hurry [to have sex].”
- “Avoid having an early pregnancy because it is not easy to take care of a child.”
- “We hope you can see what happened to us.” “Do not follow our example, because our situation is really difficult.”

## HIGHLIGHTS OF THE FOCUS GROUP DISCUSSIONS WITH MARRIED MEN

### Profile of FGD Participants:

City/Municipality, Province	Date of focus group	No. of participants	Age range	Civil status	No. of children
Digos City, Davao del Sur	30 Oct. 2012	10	27–41	7 married; 3 in consensual union	1 to 8 children (Mean: 4.2)
Wao, Lanao del Sur	30 Oct. 2012	7	23–45	4 married; 3 in consensual union	1 to 2 children (Mean: 1.1)
President Roxas, Capiz	6 Nov. 2012	8	25–42	4 married; 4 in consensual union	1 to 3 children (Mean: 1.8)
Paoay, Ilocos Norte	6 Nov. 2012	6	24–33	4 married; 2 in consensual union	0 to 3 children (Mean: 1)

### FGD Highlights:

1. How important are males in deciding when and how many children to have?
  - Most of the men agreed that husband and wife should both be involved in deciding when and how many children to have.
  - Some husbands feel that the decision as to when and how many children to have should rest on the breadwinner or the one who generates income for the family.
  - In general, the men agreed that having many children would put a burden on them because they are more often than not the main breadwinner of the family. As some of them said, “*Mahirap ang maraming anak*” [It is difficult to have many children].
2. When a husband and a wife use an FP method to space or limit their number of children, do they discuss what FP method they will use?
  - Husbands discuss the various FP methods with their respective wives.
  - Men are interested to be involved in the decision-making process for FP.
  - The majority of the men expressed that husband and wife should discuss which FP method to use, especially if they have a preferred number of children (e.g., about 2–3 children) and when the wife is perceived to have a problem with the use of any specific method.
  - According to one male participant from Lanao del Sur, another reason why husband and wife need to discuss and agree on the FP method to use is so that they can avoid fights (“*kailangan talagang pag-usapan para hindi mag-away*”).
  - Most of the men mentioned pills as the preferred FP method of their wife. A few of the men reported, however, that their wife experiences side effects (headaches) from using the pill.
  - Male cooperation in FP is especially crucial for FP methods such as the calendar method, lactational amenorrhea, withdrawal, and the condom, which some of the male focus

- group participants identified as the FP method that they and their respective wives are using. One of the male focus group participants from Lanao del Sur disclosed that he is adept with the calendar method, and that he himself marks his wife's fertile and infertile periods on a calendar.
- Other than the condom, only withdrawal was mentioned as an acceptable method for men.
3. When does a husband consider using an FP method rather than the wife?
    - Most of the men prefer to delegate to the wife both the use and choice of a family planning method and also the responsibility of availing counseling for FP.
      - Some husbands will consider using an FP method like condom, vasectomy, or natural family planning (NFP) when they know that their wife has difficulty using an FP method.
      - Many husbands feel awkward in using a condom with their wife as the use of condom is associated with "cheap women." A male focus group participant from Capiz revealed that whenever he buys a condom from the pop shop, he has to ask for it from the sales clerk in a whisper or hushed tone, seemingly embarrassed.
  4. What factors lead men to accept/agree to use condom or non-surgical vasectomy (NSV) to delay or limit fertility?
    - Condoms are perceived to be affordable and pleasurable in general. A few men mentioned, however, that using a condom was sometimes an encumbrance (*sagabal*).
    - In general, the condom is viewed as a protection from sexually transmitted diseases rather than as an FP method.
  5. What factors prevent/hold back men from using condoms or NSV to delay or limit fertility?
    - When the wife already uses an FP method, there is no need for the husband to use any FP method.
    - Discomfort, inconvenience, and cost hold back most men from using the condom.
    - Vasectomy is believed to have side effects (e.g., deafness and low endurance in sex).
    - Some men have no information about vasectomy and condoms.
    - Vasectomy is considered "*kapon*" or castration:
      - *Kapon* and vasectomy both entail undergoing an operation that would result in the loss of sperm cells
      - *Kapon* and vasectomy will both cut the path of the sperm cell.
      - In vasectomy, the penis will still be erect but in *kapon* the penis will no longer get erect.
      - Vasectomy will do something to the vein (*ugat*) while *kapon* will extract the egg.

- In the case of NSV, the factors mentioned were the perception that NSV can reduce masculinity and the lack of promotion of NSV (in contrast to the 1970s and 1980s levels of promotion).
6. What are the advantages and disadvantages of condoms and NSV?
- Advantages of condoms and NSV:
    - Condom is affordable, accessible, safe, and easy to use and dispose.
    - “When I want to make love of my wife I can purchase a condom right away in a *botika* (drugstore). Condom is not something that needs to be taken orally.”
    - Condom is available for free at the City Health Office (Digos City, Davao del Sur).
    - In comparison with NSV, condom use does not entail a change in body part.
  - Disadvantages of condoms and NSV, most of which are misconceptions:
    - Vasectomy has a long-term negative effect on a man’s sense of masculinity (*pagkalalaki*).
    - Vasectomy will reduce sexual prowess—erection of the penis and the release of sperm cells will take longer.
    - Vasectomy involves an operation and cannot be undone.
7. What do you think are the characteristics of men who would be interested to receive information on NSV?
- Concern for the wife. If the wife is no longer comfortable with the present FP method used, men might consider receiving information on NSV. In Lanao del Sur and Capiz, when one of the evaluation team members explained how significantly more complicated and painful tubal ligation is for a woman than NSV is for a man, a few male FGD participants said that they would be willing to consider undergoing NSV so as to spare their wife from the difficulties of ligation.
  - Prioritization of needs given the number of children. If a couple has many children already, they might not be able to afford to buy pills or DMPA (Depo-Provera) anymore and could thus consider receiving information on NSV.
    - In Ilocos Norte, all FGD participants in ages 24–33 years expressed that they had reached two or three children, their desired maximum number of children.
    - In the focus group discussion in Lanao del Sur, where six of the seven men have only one child (the other male participant had two children), five of the men said that they wanted to have one or two more children in order to have a maximum of two or three children. Two of the men, however, mentioned that they did not want to have any more children.
    - In Capiz, where the eight male FGD participants had one to three children, seven of them mentioned wanting to have one or two more children (for a total of two to four children). Only one FGD participant said that he and his wife have achieved their desired number of children, which is two.

8. How could men's interest and access to information on NSV be improved?
- If the government FP program involves the husbands, they are willing to participate in meetings.
  - Integration of livelihood topics with FP meetings to get the interest of males.
  - When health professionals in health centers relate or explain the advantages or disadvantages on the use of the various FP methods.
  - The FGD participants said that they have seen some celebrities making an endorsement of pills and condoms. However, they expressed that they would believe the advertisement if the celebrities endorsing the FP product/s have actually used the FP method they are endorsing.
  - A testimonial from another male/s who has undergone NSV.
9. How and where do men get NSV services?
- The majority of the husbands are aware that NSV can be accessed in the health center, but they do not know how to access the service.
  - Some men were aware that the health center will refer an interested NSV user to the city health/main RHU, which may be too far away and too late in the year as there is no regular schedule for NSV service; they either have to wait for other potential NSV users or have to wait for the availability of a skilled health provider to perform NSV.
10. Where do men get information on other FP methods?
- Most men learn about FP methods through radio programs, word-of-mouth, and TV.
  - Some wives discuss or relate what FP methods they use to their husbands.
  - A few of the men reported getting advice on FP from their friends and relatives (like their grandfather).
  - Many husbands do not remember finding or reading posters in the health centers, drug store (*botika*) and hospitals.
  - Most married males acknowledge difficulty reading FP materials in English and Filipino/Tagalog.
  - In Capiz, where HealthPro produces and disseminates FP print materials (in English, Tagalog, and Hiligaynon), most of the male FGD participants mentioned seeing FP pamphlets at home (given by the midwife, or brought home by the wife from the barangay health center or rural health unit). However, none of the men has read the FP materials, claiming that they are "too busy" earning a living for the family to have the time to read these materials.
  - FP reading materials are not allowed by the Catholic Church, although the latter promotes Natural Family Planning and the calendar method.

11. Where do men prefer to get information on family planning methods?
- With very limited info on FP methods, especially NSV, all the men prefer to get information from the health facility.
  - Some revealed that they do not go to the health facility because there are too many people availing the services of the health center.
  - Others stated that they were not invited to the health center and that service providers discuss health concerns with the wives only.
  - While most accepted the laws of the Church on the use of Natural Family Planning, they still agree with what the health center teaches on the use of FP methods.
12. Did you hear messages from the radio, TV about family planning and/or maternal health? If yes, what message(s) do you recall?
- The FGD participants said that they have not witnessed the promotion of FP methods through theater, movies, mobile bus, drama, or any video presentation.
  - Except for the condom TV commercials (such as Trust advertisements), they could barely recall messages on FP and/or maternal and child health from various media sources.
13. When was the last time you visited the health center? If you visited a health center, did you receive counseling on FP? What messages/information do you recall?
- The husbands know about other FP methods through their wives who have been going to the health center to learn about FP methods. Most of them brought their wives to the health center and wait outside since they were not invited to come into the center. If invited, they said that they were willing to come in to discuss FP methods (Davao del Sur).
  - One male FGD participant from Lanao del Sur and two from Capiz mentioned that they had attended an FP seminar and received counseling at the RHU along with their wives.

## HIGHLIGHTS OF THE FOCUS GROUP DISCUSSIONS WITH WOMEN WITH AN UNMET NEED FOR CONTRACEPTION

### Profile of the FGD Participants:

Women of reproductive age 20 to 42 years old, with at least one child, and most of whom had an unmet need for FP, participated in the FGD conducted in Ilocos Norte, Capiz, Davao del Sur, and Lanao del Sur. Women with an “unmet need for family planning” would refer to married or cohabiting women of reproductive age who are currently not using any FP method but do not want any more children, or prefer to space births. The summary of these women’s profile appears in the table below:

City/Municipality, Province	Date of focus group	No. of participants	Age range	Civil status	No. of children
Digos City, Davao del Sur	30 Oct. 2012	6	20–37	2 married; 4 in consensual union	1 to 4 children (Mean: 1.8)
Wao, Lanao del Sur	30 Oct. 2012	7	21–40	4 married; 3 in consensual union	1 to 9 children (Mean: 3.3)
President Roxas, Capiz	6 Nov. 2012	8	24–42	6 married; 2 in consensual union	1 to 4 children (Mean: 2)
Paoay, Ilocos Norte	6 Nov. 2012	12			

### Highlights:

#### I. Fertility preferences

Would you like to have another child, or would you prefer not to have any more children? For those who *would like to have another child but wish to delay their pregnancy*: How long would you like to wait from now until your next pregnancy? For those who *would not like to have another child*: Why do you no longer want to have children?)

- When female group discussion participants were asked whether they want to have another child now, or delay their next pregnancy, or limit subsequent pregnancies, *most of them indicated a preference for either delaying or limiting childbearing.*
- In Wao, Lanao del Sur, the seven mothers mentioned that they either did not want to have a child just yet (four cases), or do not want to have another child any more (three cases). In Digos City, Davao del Sur, two women said they want to space their next pregnancy, whereas four do not want to have any more children. In the FGD in President Roxas, Capiz, the picture was more mixed: two mothers said that they want to get pregnant already because they each want to have two more children; three said that they would have wanted one or two more children, but for some reason are not likely to get pregnant ever again or in the near future; one woman said she wants to have another child but wishes to delay her next pregnancy; and two mothers mentioned that they no longer want to have another child.

- Across the four provinces where the FGDs were conducted, the women who expressed a desire to *space future pregnancies* said that they would like to get pregnant in five, seven, or nine years. The reason they gave for the interval between their most recent pregnancy and the next one is the difficulty of taking care of young children (“*mahirap mag-alaga ng bata*”). They said that they want their youngest child to be in school already before becoming pregnant again.
- Those who want to *limit childbearing* cited the following reasons for not desiring any more children:
  - Already having the desired number of children, if not more than enough children that they could care for properly (mentioned by those with four or more children. As they said, “It is enough to have 4/5/9 children” [*tama na ang 4/5/9 na anak*]).
  - Economic constraints (meager incomes) that would make it difficult to feed and educate more children. As mentioned by some of them, “It’s not easy to raise children” (*hindi madaling magpalaki ng anak*).
  - Physical difficulty associated with another childbirth because of the mother’s age (“I am old already” [*tigulang na ako*]).
  - Desire to be relieved of childbearing and child-minding in order to help the husband in farming and income earning.
  - Uncertainty in the status of the woman’s relationship with her spouse (mentioned by one woman whose live-in partner was legally married to another woman).

## 2. Current practice of FP

- Only a few of the women who participated in the FGDs are *currently* using a contraceptive method. One woman from Wao, Lanao del Sur, age 40 and with nine children already, no longer wants to have a child and so is currently using pills (brand: Trust). Another woman from Wao is currently using a traditional method of contraception—withdrawal—after shifting to it from the pill which she claims used to give her heart palpitations; occasionally, her husband uses a condom. One woman from Capiz who infrequently sees her husband (because he works in Manila) says they use the condom when he is in town for a visit.
- Five of the women are currently breast-feeding (three Lanao, one Davao, one Capiz), although perhaps only two of them can be said to be effectively using lactational amenorrhea because their infants are less than six months old (at the time of the FGD). The babies of the three other women are all over six months old and are nearly a year old.

## 3. Reasons for not *currently* using an FP method

(Why are you currently not using an FP method to prevent pregnancy?)

Most of the mothers who participated in the FGDs are currently not using any FP method, even though many of them want either to space or to limit childbearing. *The reasons they cited for not using any FP method at present are mostly either fertility related or method related:*

- Fertility related

- Desire to have an additional child already. (two cases)
  - Infrequent sex or no sex because the husband is away (working abroad; serving a prison term). (one case)
  - Currently breast-feeding, and menses have not yet returned. (two cases).
  - Husband is sterile (*baog*). (one case)
  - Woman is menopausal (in her 40s). (one mention, although four women are in their 40s)
  - Very recent experience of spontaneous abortion and Dilation and Curettage (*raspa*) (Woman had been pregnant and therefore had no need for contraception—but then had a miscarriage). (one case)
- Opposition to use by the husband/spouse
- There were two cases where the *husband/spouse* expressed opposition to the wife’s use of a particular FP method. One woman was forbidden by her husband from trying to use the pill (Capiz), and so she never did. In another case (Digos City, Davao del Sur), the husband advised his wife to stop using the pill because she was complaining of side effects she associated with pill use: severe headaches, bodily pains, fatigue, and crankiness; thus, she got off the pill and is not currently using contraception.
- Method related
- Health concerns. For example, a woman from Wao, Lanao del Sur, shared that she has goiter and was advised by the midwife not to take pills. Although she would not like to have another child yet, she is at a loss as to which FP method to use. She said that she cannot take pills, does not want to use injectables or a condom, and is interested in the IUD except that she has heard that one cannot lift heavy things (even her own 8-month-old baby) if she has an IUD.
  - Fear of side effects (mostly myths), or fear of the pain associated with a particular method
    - Pills: Will stay in the intestines and will not melt (one mention, Davao del Sur); pills are bad for the body. (one mention, Davao del Sur)
    - IUDs: Will cause fatigue; women who have an IUD should not lift heavy loads. (three mentions, Lanao del Sur; two mentions, Davao del Sur)
    - Injectables: Fear of the needle – “I might faint.” (two mentions, Lanao del Sur)
    - Lack of information on which FP method would be best suited (“*hiyang*”) to the woman’s body, or given her health concerns. (two cases, Lanao del Sur)
    - Lack of time to visit the health center for FP counseling; no one will be left at home to take care of the children. (three cases, Davao del Sur).

#### 4. Previous use of an FP method and reasons for discontinuation

(Have you ever used an FP method in the past? If yes, what FP did you last use; how did you learn about/obtain information on the FP method that you last used; and from whom/where/how did you obtain the FP services that you last used? What are your reasons for discontinuing the use of the FP method you last used?)

- Some of the female focus group participants who are currently not using a family planning method and desired to do so, had actually used a family planning method in the past.
- The method most commonly used by the women who had used contraception in the past, is the pill. Their reasons for discontinuing use of the pill are as follows:
  - Desire to have another child
  - Side effects reportedly experienced from using the pill in the past: severe headaches, bodily pains, high blood pressure, heart palpitations and feeling of nervousness (*nerbiyos*), and crankiness
  - The belief that the pill will stay in the intestines and will not melt
  - Not likely to get pregnant anyway because of infrequent or no sex (husband is either in prison or abroad)
- One woman from Capiz previously used *injectables* but stopped because she reportedly experienced side effects, such as weight gain, headaches, and loss of libido (*walang gana*). Another woman (from Davao del Sur) who was on injectables stopped using it when she and her husband decided to have another baby.
- All the women from Capiz who used contraception in the past had received family counseling from the midwife. They usually bought their pills or injectables from the pop shop or local pharmacy (*botica*), although one of them said that she used to get the Excluton pill for free from the President Roxas Rural Health Center (she stopped using the pill when her husband went to work abroad). In Digos City, Davao del Sur, one focus group participant said that she was not advised by any health service provider to use either the pill or injectables and that she chose the method by herself (*ako lang*); another woman from Digos City said that she used the pill upon consulting her sister-in-law who is a midwife. In Lanao del Sur, the four women who previously used the pill said that they had received family planning counseling from (as well as attended FP seminars at) the barangay health center, as well as received their supply of pills from the center.

#### 5. Need for contraception and preferred family planning method

(Would you like to be able to use a family planning method *now*? If yes, what family planning method would you like to be able to use, and why?)

- All the female focus group discussion participants from Lanao del Sur and from Davao del Sur would like to use a family planning method either to space or to limit their pregnancies. In Capiz, however, two women said that they are not seeking a family planning method because they want to have two more children. Furthermore, three women in Capiz mentioned that they did not think there was a need for them to use a

- family planning method because they are not likely to get pregnant ever again (menopausal) or in the near future (husband is either abroad or in prison).
- When the female focus group participants were asked about the family planning method they would like to use, no one mentioned that she desired a permanent method, whether for herself (tubal ligation) or her husband (vasectomy).
    - The most frequent response was the desire to use the *pill* (five mentions; three in Davao del Sur, two in Lanao del Sur), which the women mentioned as being available at the health center, and also because they know someone (like a sister or sister-in-law) for whom the pill worked well in spacing pregnancies.
    - Despite some myths surrounding the *intrauterine device* (that it makes a woman weak and unable to lift heavy loads), three women from Digos City, Davao del Sur said that they would like to use the IUD so that they would not have to keep buying a family planning commodity.
    - One woman from Capiz, who had a 2-week-old infant, said that she wanted to use an injectable upon being advised by a midwife that this method does not cause interaction effects with a mother’s breast milk.
    - Two women from Lanao del Sur wanted to either limit or space their pregnancy. However, not having received family planning counseling, they are at a loss as to which method to use, especially because one of them has a health condition (goiter).
6. Spousal agreement for spacing or limiting pregnancy including preferred family planning method
- (Do you think your spouse agrees with your desire to space or limit pregnancy? Would he support you or cooperate with you in the family planning method that you would like to use?)
- All the women who participated in the focus group discussions revealed that they and their respective husbands or partners discuss (*nag-uusap kami*) and seek to arrive at an agreement on the matter of spacing and limiting the number of their children. Husbands/male partners themselves recognize that birth spacing is important to be able to provide adequately for the needs of children.
  - According to a few of the women, their husband himself is the one suggesting that the wife undergo an IUD insertion (one mention) or tubal ligation (one mention).
  - In two cases, a male family planning method is currently being used (withdrawal backed up occasionally by condom use [one]; and condom use whenever the husband is in town for a visit [one]).
  - When asked if their husband would be willing to undergo a vasectomy, none of the women in the various FGDs answered in the affirmative.
  - Some of the women said that their husband is not open to condom use because he does not like it (four mentions).

- Across the FGDs conducted, there were only two reported cases of the husband expressing opposition to a particular family planning method. The husband of one of the women from Digos City, Davao dissuaded his wife from using the pill because of the side effects she experienced from its use, such as severe headaches, bodily pains, fatigue, and crankiness; she no longer uses the pill. One woman from Capiz wants to use the pill but says that her husband does not want her to do so; she is currently not using any family planning method.

## 7. Sources of family planning information and services

(Do you know of a place where you can obtain family planning information and services? If yes, what place is this? In the last year (12 months), did you visit this place to obtain family planning information and services?)

Were you visited by a health worker who talked to you about family planning? If yes, what did you learn from that visit?)

- The following were cited as sources of family planning information:
  - The barangay health center (for one-on-one counseling [Davao del Sur, Lanao del Sur, Capiz; for family planning seminars [Capiz, Lanao del Sur]; for information materials like pamphlets and leaflets [Capiz])
  - The midwife or barangay health worker, especially when she does house-to-house visits (Davao del Sur, Lanao del Sur, Capiz)
  - Mass media (e.g., radio or TV advertisements of condoms/pills/injectables; the TV program *Salamat Doc* [Thank you, Doctor])
  - Relatives (e.g., a sister or sister-in-law who has also used the pill)
- The following were cited as sources of family planning commodities services:
  - The barangay health center (for free commodities like the pill, especially for beneficiaries of the CCT Program)
  - The rural health unit (for free commodities like the pill, injectables (e.g., Excluton), and IUD insertion)
  - The public hospital
  - The pop shop, neighborhood pharmacy (*botica*) (to purchase condoms, pills, injectables)
  - The barangay midwife
- When asked about whether or not they have ever received family planning counseling:
  - All eight focus group participants from Capiz said that, yes, they have received family planning counseling from the midwife whether at home, or at a health facility (barangay health center, or President Roxas Rural Health Unit).
  - In Digos City, Davao del Sur, 5 of the 6 women who joined the focus group discussion said that they had been visited at home by a barangay health worker, who

mainly discussed neonatal and child health topics with them such as child immunization and vitamin A supplementation. The health worker would also inform the women from Davao about the schedules of immunization and family planning services (but not talk about the mechanisms of action of the various family planning methods work).

- In Lanao del Sur, of the seven women who participated in the focus group, four have either been visited at home by a barangay health worker, or have obtained family planning counseling at the barangay health center, or both; and three have never had family planning counseling because they have never been visited at home by a barangay health worker, and have never gone to the barangay health center for family planning counseling.

#### 8. Media messages on family planning

Did you hear messages from the radio, TV about family planning and/or maternal health? If yes, what message(s) do you recall?

What kind of messages or information on family planning would you like to receive?)

- Women who participated in the focus group discussion in Capiz mentioned that they listen more frequently to the radio than watch television. They are most exposed to the paid advertisements of Trust on condoms, which features Filipino action-movie star Robin Padilla. They are also aware of another brand, Filipinas, which advertises condoms, pills, and injectables.
- A few female focus group participants from Capiz and from Davao del Sur mentioned being aware of ABS-CBN Channel 2's weekly live medical TV program, *Salamat Dok* [Thank you, Doc]), and having seen an episode of it.
- When queried about the family planning/maternal health/child health messages they receive from the mass media, female focus group participants from Capiz mentioned the following:
  - The importance of exclusive breast-feeding for the first six months of an infant
  - The importance of proper spacing for one's children
  - The importance of a woman getting pregnant at the "right age" (*tamang edad*), which is "18–35 years old."
- The women from Capiz also said that they have received and read pamphlets on family planning, which they receive for free. They have also seen flip charts and posters on family planning. (Note: These materials are produced by HealthPro.)

#### 9. Assistance needed to access information and services on preferred family planning method

(What would help you access information and services on your desired family planning method?)

- Establishment of a health center in barangays without one, such as Madulano and Manoling (in President Roxas, Capiz)
- Providing *free* access to *all* forms of family planning

- Information on the effects (if any) of having an irregular menstrual cycle, information on menopause (Capiz)
- Information on how to raise children properly and address their various needs (whether biological or psycho-emotional) (Capiz)
- Invitation to and conduct of mother classes that would tackle topics such as breast-feeding (Capiz)
- Invitation to and conduct of monthly seminars on family planning, with a different family planning method discussed in-depth each month (Davao del Sur, Lanao del Sur)
- More information on contraceptive methods, specifically, on
  - The side effects of various contraceptive methods (Capiz)
  - Suitable family planning methods for a woman with a particular illness like goiter (Lanao del Sur)
- Provision of information on family planning by health workers when they do household visits, in addition to the information that they give on the schedule of the delivery of maternal and child health services at the barangay health center (Davao del Sur)
- Delivery of family planning messages through local stations and TV programs (e.g., ABS-CBN Channel 2's weekly live medical TV program, *Salamat Dok* [Thank you, Doc]) (Davao del Sur)

## HIGHLIGHTS OF THE FOCUS GROUP DISCUSSIONS WITH COMMUNITY HEALTH TEAM MEMBERS

### Profile of the Participants

Focus group discussions for CHTs were carried out in Digos City, Davao del Sur; Bacarra, Ilocos Norte; Wao, Lanao del Sur; and President Roxas, Capiz. Ilocos Norte represents a province without USAID assistance, although it is a recipient of assistance from both the European Union and Asian Development Bank. The CHT FGDs were participated in by both men and women members.

Table I shows the profile of CHT membership.

**Table I. Profile of FGDs of Members of the CHTs<sup>13</sup> in Davao del Sur and Ilocos Norte**

City/Municipality, Province	Date of FGD	No. of participants	Sex distribution	Age range	Role in CHT
Bacarra, Ilocos Norte	6 Nov. 2012	12	2 male 10 female	29–60	Barangay captain, president of health volunteers, midwife, barangay health worker, BSPO, RH Heals, day care worker, other outreach workers
Digos City, Davao del Sur	29 Oct. 2012	8	8 (all) female	--	5 BHWs, 1 BHW/secretary, 1 BHW/barangay, nutrition scholar
Wao, Lanao del Sur (called CHATs)	29 Oct. 2012	11	1 male 10 female	32–57	Barangay health workers (9), Nutrition volunteer (1), father (1)
President Roxas, Capiz	6 Nov. 2012	8	8 (all) female	38–55	Barangay health workers (all 8)

### I. Beginnings of the CHTs

- The CHAT in Wao, Lanao del Sur, has been operating for a longer time than the CHT in Capiz. Although the CHAT and CHT members have been delivering health services to their respective communities for a long time already (some of them for decades) as barangay health workers (BHWs), their formation into CHTs began only in April 2007 for CHATs in Wao, Lanao del Sur, and in June 2012 for CHTs in President Roxas, Capiz. The CHTs in President Roxas have been recently deployed, after undergoing a two-day CHT training in June 2012 which covered topics such as family planning, prenatal care for pregnant women, postpartum care, how to track community health needs through household visits, and how to refer clients to the Rural Health Unit.

<sup>13</sup> The Community Health Teams (CHTs) are called the Community Health Action Teams (CHATs) in the Shield Project.

- According to the health center midwife, the Bacarra Community Health Teams (CHTs) evolved from the Women’s Health Team (WHT) organized by the Department of Health (DOH) under the Women’s Health Project in 2007 funded by the World Bank. The team was then composed of outreach workers, nutrition scholars, and midwives. In some instances, they were joined in by the barangay captain and/or other members of the Sangguniang Barangay (Barangay Council).

## 2. The Coverage, Composition, and Management of the CHT

- Each CHT is responsible for a barangay. There are 43 barangays in Bacarra, hence there are also 43 CHTs. The already organized WHT structure paved the way for the CHTs. When the CHD implemented the Kalusugang Pangkalahatan (universal health care), the CHT was recommended as the main vehicle for its community-level approach. This made the convening of the Bacarra CHT simpler. Reflecting its emphasis on indigents, the CHT included the RN Heals, and the day care worker, in order to monitor the various requirements of the Conditional Cash Transfer (CCT) Program. At present the composition of the CHT in Bacarra includes the barangay captain, a midwife, BHW, BSPO, RN Heals, and a day care worker. During the week, the team is deployed in the field (where most of the members reside) and report to the health center once a week. They meet with the community management team (composed of the designated health officer of the municipality, the MHO, the nurse, and midwife).

## 3. The Function, Roles, and Responsibilities of the CHT

CHTs perform a *wide range of functions to serve the health needs of their community*. These include:

- Profiling and tracking the health needs of the residents of the community through household visits
- Aside from standard data on the household profile (e.g., number and ages of household members), CHAT and CHT members track the health needs of the residents. These include the unmet need for contraception of women and men; the need for prenatal and antenatal care of pregnant and postpartum women, respectively; the need for immunization of children; and illnesses requiring treatment. In President Roxas, Capiz, the number of households being monitored by a CHT member ranges from 20 to 37.
- In profiling the health needs of the people, CHAT and CHT members accomplish standard forms. For example, in Wao, Lanao del Sur, CHAT members use a one-page Community-Based Monitoring and Information System (CBMIS) form where information on family planning (e.g., FP method used, if any), number of prenatal visits of pregnant women, number of antenatal visits of postpartum women, tetanus toxoid vaccination for pregnant women, vitamin A supplementation for pregnant women, and the immunization status of children can be recorded.
- CHT focus group participants from Bacarra, Ilocos Norte, also conduct house-to-house visits and in so doing are able to identify the health needs of community residents.
- Referring community residents to the appropriate health facility for their health needs
- Besides monitoring CCT beneficiaries, the Bacarra CHT considers the achievement of the MDG goals particularly in reducing maternal and neonatal deaths as their main goal.

Hence, their time is spent locating pregnant women in the barangay and referring them to the health center. As previously mentioned, they do this by doing house-to-house visits. They likewise identify others who may need health services, in particular men and women in need of family planning. For ordinary deliveries, the women are referred to the health center. Clients who wish for more long-term methods (ligation) are told to go to the provincial hospital or to the Batac hospital.

CHATs (Lanao del Sur) and CHTs (Capiz), upon determining members of the community who require health services, accomplish a *referral slip*. Some of the health services for which CHATs/CHTs can make a referral include family planning, prenatal check-ups, postnatal check-ups (for women); and weighing and immunization (for newborns and children). Once a community member with a referral slip signed by the CHAT/CHT member presents this slip to the barangay health center, or to the rural health unit (RHU) his or her health needs can be addressed more expeditiously by the health facility.

- Providing information to the people on health programs

CHATs (Lanao del Sur) and CHTs (Capiz) disseminate information to community residents on health programs and services they can avail of (e.g., family planning, immunization). The means by which such information is disseminated include household visits; *tumpukan* sessions or community gatherings held every third Thursday of the month (in Wao, Lanao del Sur); barangay or community assemblies (held twice a year); posters, flyers, and leaflets (notably for Pres. Roxas in Capiz because of HealthPro's interventions); and SMS messaging to *purok* (area) leaders about available health programs.

- Providing family planning- and maternal health-related services

Apart from monitoring pregnant and postpartum women (for prenatal and postpartum check-ups) and tracking the unmet need for contraception of women and men through household visits and profiling activities, CHAT and CHT members in Lanao del Sur and Capiz, respectively, provide the following FP/MCH-related services: assisting midwives in tetanus toxoid vaccination for pregnant women, providing family planning counseling, and giving contraceptives such as pills and condoms to community residents who express a need for such (CHATs in Wao, Lanao del Sur).

- Assisting in the implementation of the Garantisadong Pambata Program.

In addition to monitoring the immunization status of children and newborns, CHATs (Lanao del Sur) and CHTs (Capiz) also provide child health services, specifically through the following: giving information to pregnant women and postpartum women on how to breast-feed, weighing of infants 0–72 months old, distributing deworming pills, administering vitamin A supplementation. In Bacarra, the CHTs are also involved in operation *timbang* (monitoring babies' weight).

- Other responsibilities

Based on the focus group discussions, CHATs (Lanao del Sur) and CHTs (Capiz) perform other tasks for the community, such as salt testing (to check if it is iodized), sputum collection (to test for tuberculosis), giving medicine to treat filiriasis (Capiz), and

providing information on barangay health programs such as the Clean and Green Program and the Kontra (Anti)-Dengue Program (Capiz).

As mentioned, CHTs in Bacarra, Ilocos Norte, are also tasked with monitoring the compliance of CCT beneficiaries with the various requirements of the Conditional Cash Transfer Program.

#### 4. Training and Supervision of the CHT

- According to the focus group participants, CHAT (Lanao del Sur) and CHT (Capiz) members are directly being supervised by midwives. Because most of them, as BHWs, have been delivering health services to the community even before they were part of CHATs or CHTs, they have all undergone training and attended seminars that have covered topics such as family planning, prenatal care for pregnant women, postpartum care, how to track community health needs through household visits, and how to refer clients to the RHU. Focus group participants from Wao, Lanao del Sur, mentioned that they received their CHAT training from HKI-SHIELD in April 2007. As for the CHT members from President Roxas, Capiz, their two-day CHT training took place in June 2012.
- CHAT members from Wao, Lanao del Sur, who participated in FGD expressed an interest in and need for updating their knowledge and skills through additional training seminars in the future.
- In Bacarra, CHT members are oriented on their tasks by the midwife, who basically acts as the team leader. They stay in the clinic one day a week, but on other days of the week are sent to the community.
- The municipal health officer (MHO) of Bacarra made it a point that the Bacarra CHTs underwent training before they started with their new responsibilities. An RN Heals member reported that she was trained in the identification of the CCT beneficiaries and she appeared to be quite knowledgeable of the program. The midwife was trained in the 1990s on basic and comprehensive family planning conducted by the DOH. Like the CHAT members from Wao, Lanao del Sur, the CHT focus group participants from Bacarra all felt that there is a need for refresher course in contraceptive technology.

#### 5. Incentives for CHTs

- CHAT and CHT members work on a voluntary basis. CHAT members from Lanao del Sur who participated in the focus group discussion mentioned that they do not receive an allowance. However, CHT members in Capiz receive a monthly allowance ranging from PhP 100 to PhP 500 (USD 2.50–USD 12.50), and also obtain a Christmas bonus. All CHAT and CHT members in Lanao del Sur and Capiz have been provided T-shirts.
- In Bacarra, Ilocos Norte, CHT members are given a minimal incentive of about PhP 500 a month (USD 12.50) supposedly to cover their travel expenses.
- Notwithstanding their meager allowance (if at all), CHAT and CHT members from Lanao del Sur and Capiz, respectively, who participated in the focus group discussion receive a lot of satisfaction from their work, mainly from the gratitude and hospitality of community members which they experience when they perform household visits. They believe that they are doing a lot for their community, particularly in *increasing* the

contraceptive prevalence rates, immunization rates, the skilled birth attendance rate, the facility-based delivery rate, and the proportion of women seeking prenatal and postnatal care. CHAT members in Lanao del Sur mentioned that the number of maternal deaths in Wao went down after the policy on facility-based deliveries was actively implemented beginning in 2010, a policy they helped to disseminate to pregnant women in their community.

## 6. Needs of CHTs

CHAT/CHT members articulated similar needs during focus group discussions conducted with them:

- Providing CHAT members (Lanao del Sur) with an allowance. For CHT members in Capiz, they would like their allowance to be increased to at least PhP 1,000 (USD 25). As per the FGD participants in Lanao del Sur, “Give us some money so that we can buy iced water at the very least.”
- Providing CHAT and CHT members with medical equipment and supplies (or give them new ones) so that they can carry on their duties. These include weighing scales, sphygmomanometers, stethoscopes, thermometers, and first-aid kits.
- Providing them umbrellas and kits (with monitoring forms, logbook/record book, ball pens).
- Updating their knowledge and skills through training seminars. This need was articulated by CHAT members from Wao, Lanao del Sur, who said that their last training was held in April 2007. The CHT focus group participants from Bacarra all felt that there is a need for a refresher course in contraceptive technology.

CHAT and CHT members mentioned in the FGDs that they will continue to perform their duties even with meager incentives from the government. However, they said that it would be good if they could receive such incentives in recognition of their contributions to promoting the health needs of the people in their community.

## 7. Other Issues

- The outreach workers from Bacarra, Ilocos Norte, mentioned that they have to look for pregnant women in the barangays because they hide from them. The reasons mentioned were the fact that women are embarrassed to see the midwives when they get pregnant, especially if they were not able to properly space their next pregnancy. Also, young mothers tend to avoid going to the health center. It is also possible that women who prefer to deliver their babies at home do not want to see the CHT for fear that they will be persuaded to deliver in the health facility.

## 8. Summary Findings

- Several CHTs are organized in a municipality to support the fixed facility in informing the community about the health services available in the clinics. More specifically, CHTs seek out pregnant women and advise them to go to the barangay health station (BHS) or rural health unit (RHU) for prenatal, delivery and postpartum, or immunization services. When applicable, they also refer women with unmet need for FP to the clinics.

- The main focus of CHTs is MCHN. Currently there is greater push for facility-based delivery (in Ilocos Norte, Lanao del Sur, Capiz). Family planning is just one area of concern that CHTs are addressing.
- The composition of CHTs is more complex than the original Women’s Health Team (WHT), which was the precursor of the CHT (at least in the municipality of Bacarra, Ilocos Norte). The composition of CHTs may also vary from one LGU to another. In Bacarra, for example, the CHT membership is composed of a barangay captain, a nurse, a midwife, an RH Heals, a BHW, a BSPO, and a day care center worker, many of whom are members of their own barangay or *purok* (zone).
- The presence of barangay service point officers (BSPOs) in CHTs ensures that family planning issues are covered. This varies, however, from one CHT to another.
- The RH Heals links the Conditional Cash Transfer (CCT) beneficiaries to the health system. This is in line with the president’s order to implement the Kalusugan Pangkalahatan (universal health care). The CHT is an approach adopted by the DOH to identify people with health needs (especially in MCH/FP) and get them to go to the clinic and obtain the service they need.
- The management and supervision of CHTs may vary from LGU to LGU. In Bacarra, for example, CHTs are managed by the community health management team composed of the mayor, the MHO, the midwife, and other local stakeholders. CHTs meet with the management team on a regular (monthly basis).
- CHTs are typically supervised by the midwife, who basically acts as the team leader and who orients CHT members on their tasks.
- CHT members are given a minimal allowance (as incentive)—if any at all. Other incentives they receive are free T-shirts (for most CHT members) and a Christmas bonus (for CHT members in Capiz).
- The CHAT in Wao, Lanao del Sur, provides an example of a functioning CHT. There is a clear mandate to identify people with unmet need for MCH/FP, and they link the women to facilities after they had organized them for discussion (*tumpukan* sessions) and counseling. They also use a master listing tool with a flow chart to profile their clients and identify their health needs.

# ANNEX H. STATEMENT OF DIFFERENCES ON GH TECH'S PERFORMANCE EVALUATION OF THE FP/MCH PORTFOLIO

Executive Summary, 2<sup>nd</sup> paragraph, pp. viii

“The factors that contributed to the significant increase in modern CPR for non-assisted provinces may include (but are not limited to) the political will of local executives to implement FP programs; funding or other types of support received by LGUs from foreign donors, non-governmental organizations (NGOs), and civil society groups; access of LGUs to Department of Health (DOH) grants; and public-private partnerships in provision of FP supplies and services.”

**USAID/Philippines Response:** There is no evidence or a clear basis for the above finding and conclusion.

Recommendations on Facilitating the Use of DOH Grants to Procure Contraceptives and Improve Facilities, pp. 20-21

“This intervention has been useful, particularly in the ARMM, for ensuring procurement of contraceptive commodities. However, the DOH should explore better ways of releasing and liquidating the grants to minimize the administrative burden of LGU beneficiaries. The team observed that in most cases, the funds have been used to upgrade birthing facilities, not for contraceptive procurement. Since a more stable and feasible option to procure contraceptives and improve facilities exists through PhilHealth, the team recommends to discontinue this intervention.”

**USAID/Philippines Response:** The MNCHN grant facility is a Department of Health (DOH) intervention. Thus, it may not be appropriate for USAID to recommend the discontinuation of this intervention. Besides, PhilHealth may not be a ‘more stable option’ since there are not enough PhilHealth accredited health facilities at this point.

Recommendation on Safe Motherhood Campaign, p. 23

“USAID should discontinue supporting the intervention (safe motherhood campaign) because it is being supported by other donors.”

**USAID/Philippines Response:** The reason cited in the recommendation is not accurate. More than the support from other donors, DOH itself has provided the most amount of resources for this intervention. USAID’s assistance for production and printing of materials has been minimal. In the future, USAID intends to continue providing technical support to the DOH on the design and development of its safe motherhood campaign, if the same is requested by the DOH.

For more information, please visit  
<http://www.ghtechproject.com/resources>

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