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Kalusugan Sa Pamilya

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Mobilizing Communities for Family Planning and Child Survival:

*A Lesson from the
Kalusugan sa Pamilya (KSP) Project*



Save the Children USA



Department of Health



The Johns Hopkins University



USAID



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Mobilizing Communities for Family Planning and Child Survival:

**A Lesson from the Kalusugan
sa Pamilya (KSP) Project**

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Mobilizing Communities for Family Planning and Child Survival: The Kalusugan sa Pamilya (KSP) Experience

1. BACKGROUND

The Kalusugan sa Pamilya (KSP) Project was initially conceptualized in 1997, when Johns Hopkins University was mulling over an approach to increase the utilization of family planning and child survival services in the public health centers. Patterned after the concept of the Gold Star Project in Egypt, KSP aimed to test an approach to “increase traffic” at the health centers using the family planning signage of “Kung sila’y mahal n’yo, magplano” (If you love them, plan them).

JHU identified Baguio City, South Cotabato, Iloilo City and Iloilo Province as the pilot areas for project implementation. As project conceptualization progressed, proponents realized that adding a component on community mobilization would complement the other communication strategies developed by JHU. Save the Children, which has an established presence in Iloilo province and recognized for its community based work in health and nutrition, was assigned to be take charge of the community mobilization component of the project in Iloilo City and province.

KSP has the following objectives:

- a. Increase the utilization of the linked services of child survival and family planning;
- b. Position family planning as a positive social norm;
- c. Advocate for municipal or city legislation providing support for the improved delivery of family planning and child survival services.

2. APPRECIATIVE COMMUNITY MOBILIZATION

Appreciative Community Mobilization (ACM) was the main intervention employed to ensure increased demand for family planning and child survival services. The latter included pre/post natal care, nutrition, expanded program on immunization, control of diarrheal diseases and control of acute respiratory infection.

The Appreciative Community Mobilization (ACM) is community development approach which is a combination of two processes: Appreciative Inquiry (AI) and Community Mobilization (CM). Appreciative Inquiry (AI) is a strength-based process of discovering of positive — and using community values, successful moments, achievements, best practices and resources in order to propel them to further development.

Community Mobilization (CM) on the other hand, is defined as *sustained action around a pre defined theme where such action is planned, implemented and monitored by the community through a highly participatory process.*

Thus, the Appreciative Community Mobilization component of the KSP Project enables communities to reach their dream of a healthy community, through sustained action in child survival and family planning. ACM, in contrast to problem-based mobilization, builds on the existing positive values and resources in the communities.



Figure 1.1 A Discovery session at the sitio level

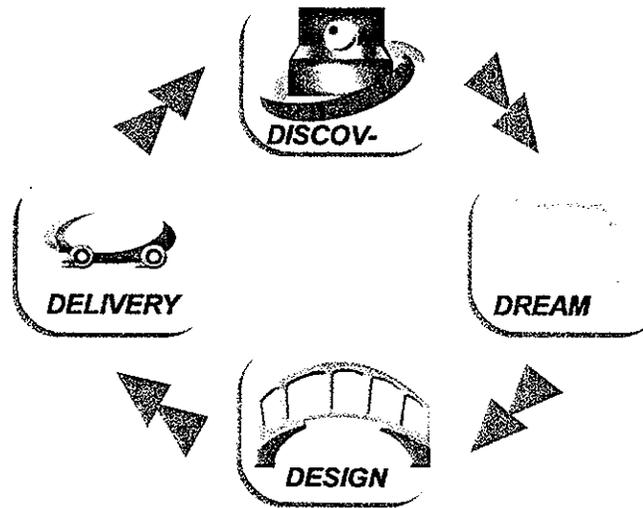


Fig. 2. The 4-D cycle of ACM

ACM follows what is generally referred to as the 4-D cycle:

D - iscover (WHAT IS). This is the first phase which looks at the strengths and assets of the community that can be used as a foundation for sustained efforts in child survival and family planning.

During the discovery phase, communities ask themselves the following questions:

- * What are our best practices in child survival and family planning?
- * What resources do we have in the community which we can use to enhance child survival and family planning outcome.

D- ream (WHAT MIGHT BE). In this phase, community members articulate their desires and aspirations related to health, particularly on child survival and family planning. The sessions being conducted among the sitios, and not just among the barangay officials, make it possible for the "voiceless" members of the community to express their desired future and become part of building the village's health dream.

D - esign (WHAT SHOULD BE). In the design phase, community members develop their short-term objectives (three years) to serve as the bridge between what they have now (discovery) and what they want to attain (dream).

D - eliver (WHAT WILL BE). These are the immediate steps that will ensure community action. Usually, this corresponds to a three-month action plan, mobilizing the broadest possible participation of village members.

2.1 The ACM Process Framework

As a process, ACM is implemented at different levels, even down to community neighborhoods, so as to ensure the participation and to reflect the concern of the marginalized sectors, in the community.

The schematic framework below shows the timing of the 4-D process at different levels (municipal, barangay and sitio):

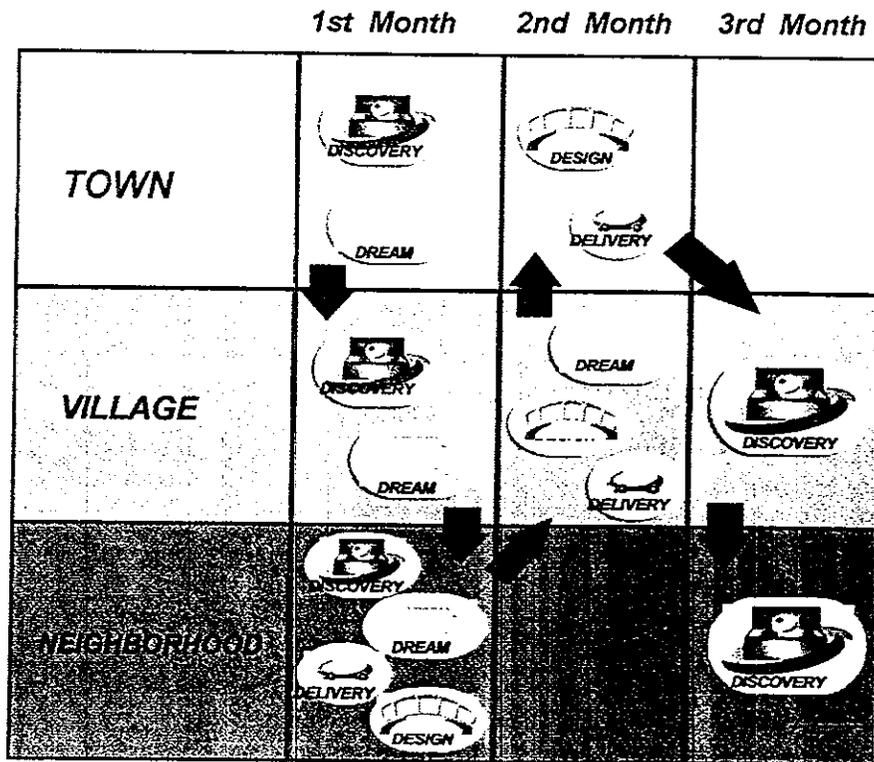


Fig. 2.1 The ACM process at each level of implementation .

The arrow shows the sequence of the various phases of ACM. The first interactions starts at the municipality, the process then moves down to barangay then to the sitios. The neighborhood officials undertake their own discovery and dream sessions, and the sitios, follow suit.

In order to ensure the participation of the priority groups, who might otherwise not be able to actively participate in a big crowd, the 4-D process is repeated from sitio to sitio.

The output of the sitio dreams are then consolidated at the barangay level.

As soon as the "delivery phase" of the 4D cycle is reached, the process goes back to re-discovery of the group's achievements, symbolizing the end of the first cycle and the beginning of a new one.



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The ACM Manual

An ACM Manual was developed to guide the process of the ACM. It is composed of 5 modules described below:

Module I: 'Pangarap Mo'y Pangarap Ko Rin' *(Congruence of Dreams: An Orientation on the KSP Project)*

This module is used at the municipal level to evoke personal and professional achievements and desires of the local leaders and health service providers.

This session establishes the shared values of the municipal level stakeholders, and how these value will help them in pursuing project objectives.

Module II: "Tuklas Lakas Tungo sa Pangarap" *(Discovering Strengths to Craft the Dream)*

This module introduces the concept of the ACM approach and its phases of Discovery and Dream. Through the dialogue, the municipal government and health service providers expand on their achievement and develop their dream of a healthy municipality.

Module III: "Sama-samang Pagbanghay ng Ating Pangarap" *(The Design to Achieve Our Collective Dream)*

The module consolidates the collective vision of the sitio and barangay. It is the venue wherein the



Figure 2.3.4. KSP asanapang conducting the household survey.





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Figure 2.3 A KSP researcher conducting the household survey

communities become conscious of their accomplishments in health development. It affirms and recognizes families' (at sitio level) efforts to influence their health situation.

As the collective vision is decided, community members identify milestones to be achieved in the next 3 years. The group selects indicators and priorities for the first year and discussed. Critical activities are identified and planned for the first 3 months. Resources are allocated from individuals and groups. Volunteer support is generated. .

Module IV: "Pagninilay-nilay sa Pagsasagawa" (Reflective Learning While Delivering)

The plans are developed by the different groups and lead persons per area. During this module, individual/group commitments are generated (e.g. health sessions by health service providers). This is also the time when emerging challenges and opportunities are recognized.

In anticipation of opportunities for interaction, designs on "meeting challenges, effective communication, community data tools for monitoring and evaluation, and participatory action research" are prepared.

Module V: "Pasinaya sa Naisagawa Tungo sa Panimula" (Celebration of Achievements for a New Beginning)





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In this module, the different groups (project barangays) come together to publicly affirm what the approach enabled them to achieve. It focuses on sharing of experiences and building on what they have accomplished.

The Implementor

Central to the ACM approach is the role of the implementor or community facilitator. KSP initially inventoried the structure and mechanism existing in the city and province are conducted in order to determine the best organizational structure for the project

Aside from Save the Children KSP staff, barangay-based KSP teams are formed to spearhead the ACM process within their respective communities. ACM generated and enhanced the spirit of volunteerism of the barangay health leaders, workers and ordinary community members who became part of the barangay teams. Consequently, a capability enhancement program on these ACM advocates was conducted among 120 volunteers from the 16 communities in Iloilo City and Province.

Initially, these advocates served as support to the project staff however, as they increasingly gained confidence, they took on the lead role in community mobilization.

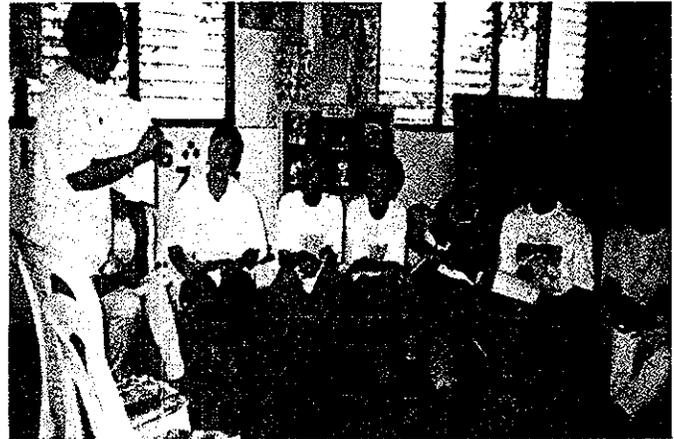


Figure 2.6 Learning family planning



Figure 2.7 Learning how to plot a child's weight and to interpret the growth curve.

3. PROJECT EVALUATION

3.1 Evaluation Design

A quasi-experimental design, with pre and post intervention measurements in control and study municipalities and barangays, was used for evaluating the KSP Project. The intervention, which is *appreciative community mobilization (ACM)*, was given only to the study or the experimental communities; no activities related to ACM were implemented in the control group. The study deviates from that of a real experiment since the sample municipalities and barangays were not selected at random; hence the use of a quasi-experimental design. This is illustrated in Figure at 3.1

	<i>Baseline</i>	<i>Intervention</i>	<i>Endline</i>
<i>Control Group</i>	✓	<i>None</i>	✓
<i>Experimental Group</i>	✓	<i>ACM</i>	✓

Figure 3.1 Study Design for the Evaluation of the KSP Project

The pre and post intervention measurements were collected using a variety of data collection modes, namely: cross-sectional household surveys, focus group discussions (FGDs), key informant interviews (KIIs), as well as the review of records of health centers. These were conducted in both the control and experimental areas at the start and at the end of the project. Participatory evaluation methods were likewise used towards the end of the project to provide deeper understanding of the factors which led to project outcomes.



their health centers in an integrated manner;

d. Determine the perceptions of women on who should have responsibility for health problems and services in their communities;

e. Determine the practices of women related to their utilization of basic health services like immunization, health education, consultation and treatment, and prenatal care;

f. Determine the extent to which the women use the different types of health facilities in their area, and the corresponding reasons for using or not using such health facilities;

g. Determine the extent to which the women are aware of, and/or utilize the various services for women and children offered by the health centers in their barangays;

h. Determine the proportion of women who are aware of, and/or are currently using a family planning method; and

i. Determine the women's perceptions regarding ways to improve the health status of the residents in their barangays, and the extent to which community members can be mobilized to achieve this end.

3.2.1 Selection of Samples

Samples for the study were selected from project sites using a multi-stage stratified sampling design. In Iloilo province, a three-stage design was used with the municipalities, barangays and the households as the primary, secondary, and tertiary sampling units, respectively; In Iloilo City, a two-stage design, with the barangays and the households as the primary and secondary sampling units was used. Stratification was applied in the selection of sample households, to ensure that the marginalized and non-marginalized groups are the number of respondents taken from each barangay was determined by proportional allocation, based on the population size of the place. In the local language, those in the priority or marginalized groups were called "pigado". The community members themselves made the definition below, referring to the marginalized or priority groups:

a. economic characteristics (household head without a job)

b. type of materials used for the house (temporary/ makeshift materials)

c. assets (owns less than 500 sq. meters of land in the rural areas; no land at all in the city)

d. number of children and use of family planning (with four or more children, and non-FP user)



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The household surveys had a sample size of 1016 respondents at baseline and 1019 respondents at endline. The distribution of respondents according to the selected variables are shown in Table 3.2.

Table 3.1 Comparison of endline and baseline distribution of sample according to marginalization, urban and rural, control and experimental.

Time and Place of Residence	Marginalized			Non-marginalized			Total		
	Control	Exptl	Total	Control	Exptl	Total	Control	Exptl	Total
Baseline									
Urban	179	179	358	74	74	148	253	253	506
Rural	176	183	359	80	71	151	256	254	510
Total	355	362	717	154	145	299	509	507	1016
Endline									
Urban	86	193	279	41	68	109	127	261	388
Rural	271	171	442	105	84	189	376	255	631
Total	357	364	721	146	152	298	503	516	1019

From the province, four (4) study or experimental municipalities were purposively selected for inclusion in the project, based on the following criteria: nutritional status of children under five years old, use of family planning, childhood immunization and presence of Save the Children in the municipality. Two pilot barangays were selected for each of the four municipalities.

Four (4) municipalities which matched each of the municipalities in the experimental group were

selected as control areas. Comparability in the population size of the control and study municipalities was considered important since this factor was deemed to affect the extent and ease to which the community can be mobilized.

In the absence of any available data regarding the distribution of the population according to economic characteristics, it was assumed for purposes of planning for the survey, that the priority groups, on the average, comprise 70% of the total population of the area. Hence the samples taken from each of the



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16 areas for the whole study were likewise broken down into 70% belonging to the priority group and 30% non-priority group. Those in the priority groups were pre-identified prior to the conduct of the interviews, with the help of rural health midwife, the barangay officials and the residents themselves.

Table 3.2 List of Sample Municipalities and Barangays in the Province and City of Iloilo, and Corresponding Population Sizes.

Experimental Group	Population Size	Control Group	Population Size
ILOILO PROVINCE			
1. Agusipan, BADIANGAN	1094	1. Alabidhao, BINGAWAN	1066
2. Sariri, BADIANGAN	474	2. Cairohan, BINGAWAN	499
3. Sinibaan, DINGLE	1700	3. Talacu-an, LEON	1480
4. Tula-tulaan, DINGLE	1649	4. Lanag, LEON	1159
5. Bagacay West, MAASIN	753	5. Sulong, ALIMODIAN	789
6. Mandog, MAASIN	888	6. Bagumbayan, ALIMODIAN	821
7. Ilong-bukid, SAN RAFAEL	1402	7. Igtambo, SAN MIGUEL	1486
8. Poblacion, SAN RAFAEL	3338	8. San Jose, SAN MIGUEL	3458
ILOILO CITY			
1. Compania	3038	1. Bolilao	3072
2. Gustilo	2938	2. Cuartero	3029
3. Rizal Palapala I	1963	3. North Baluarte	2063
4. Sta. Cruz	1660	4. Lopez Jaena Norte	1693
5. Tabucan	3102	5. Dulonan	3282
6. Tacas	3939	6. Sto. Nino Sur	3309
7. Ticud	1667	7. San Roque	1625
8. Ungka	2124	8. Tanza-Esperanza	2203

3.2.2 Survey Respondents

The situation analysis of the households in the project areas revealed that women were the main caregivers, and that they were the most affected regarding the use or non-use of family planning methods. The study therefore focused on women

respondents in the reproductive age-groups (15 to 49) who had any of the following characteristics

- pregnant at the time of the survey; or
- had at least one child 0-6 years old.



All women within a sample household who had the above characteristics were included as possible samples in the study, although the wife was given priority for interview. Data for the household survey was collected by means of personal interviews of the respondents in their place of residence.

3.2.3 Data Collection Tools

The interview schedule for the Baseline Survey had 47 questions, which were divided into 11 blocks as follows:

- A. Identification and Other Information
- B. Interview Status
- C. Demographic Profile
- D. Educational Attainment/Literacy
- E. Economic Characteristics
- F. Housing
- G. Knowledge
- H. Practices
- I. Skills
- J. Utilization of Health Services/Facilities
- K. Community Mobilization

The interview schedule for the endline survey was basically the same as that of the baseline survey, except for a few modifications made to the wording and formatting of some of the questions which were found to be problematic during baseline. In addition, the section on skills (block I in the baseline survey) was deleted, hence there were only 43 questions which were divided into 10 blocks.



Figure 3.6 Putting together a picture of the sitio dream.



Figure 3.7 Jaro II District Health Center

4. SITUATIONAL ANALYSIS OF HEALTH CENTERS

The KSP project implementors were aware that creating demand for services was just one side of the coin. The other side, which is the quality of health services, determined whether demand for child survival and family planning services will be maintained or increased.

To better understand this aspect of the health system, a situational analysis (SA) was conducted in May 2000. The SA covered the 22 health facilities serving the KSP project sites. The facilities included in the SA were composed of four Rural Health Units (RHUs), six district health centers (DHC) and 11 barangay health stations (BHS).

4.1 Objectives of the Situational Analysis

Specifically, the SA aimed to:

- Examine the availability and functioning of family planning, reproductive and maternal and child health services offered in the targeted health facilities.
- Assess the capability of health service providers to provide quality services according to program policies and standards.
- Describe the actual quality of care received by clients.
- Evaluate the level of client satisfaction, contraceptive use, and fulfillment of reproductive intentions.

4.2 Results of the Situational Analysis

The SA revealed the state of reproductive and maternal/child health services in the public health sector, according to the following aspects:

a. Technical Competence

- * Only 20% of the health center staff assigned to remove and insert IUDs are competent in this procedure;
- * 90% of health center staff are not trained on the diagnosis and management of reproductive tract infections
- * 90% of the staff have expressed a need for them undergo a refresher course on FP/MCH.

b. Access

- * 90% of the health service providers have expressed reluctance to provide family planning services and supplies to clients who are adolescent, unmarried or engaged in commercial sex;
- * RH services in most health centers are limited to family planning and maternal and child health. Diagnostic and management services for reproductive tract infections and HIV/AIDS are inadequate.



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* Outreach health education activities such as *purok* meetings and bench conferences are not conducted regularly.

* The centers lack information, education and communication materials on child survival and family planning services. Although there were materials on family planning, these were not adequate in number, and unsuitable to the educational level of the target clientele.

c. Effectiveness

* Written guidelines and protocols on the delivery of reproductive health services in health centers are not available

* Only two methods for family planning are usually mentioned by health service providers giving the participants very limited options;

d. Continuity

* Typically, only verbal reminders to the clients for their next visits were given. Written reminders are not the usual practice.

e. Equipment

* Only half of the target number of health centers are clean;

* There is no auditory and visual privacy in most of the centers;

* Only 5 out of 22 health centers are equipped for proper medical examination procedures like internal/speculum examination.





5. RESULTS

Table 5.1.1 Comparison of Percentage of Marginalized and Non-marginalized Groups in Control Areas, According to Highest Educational Attainment of Mother (Urban and Rural)

EDUCATIONAL ATTAINMENT	TREATMENT	MARGINALIZED				NON-MARGINALIZED			
		BASELINE		ENDLINE		BASELINE		ENDLINE	
		Expt'l (n=192)	Control (n=166)	Expt'l (n=193)	Control (n=86)	Expt'l (n=75)	Control (n=83)	Expt'l (n=68)	Control (n=41)
Urban									
Elementary		19.8	17.5	22.3	19.8	4.0	6.0	7.4	12.2
High School		53.6	51.8	54.9	54.7	30.7	27.7	44.1	34.1
College		21.9	29.5	16.1	18.6	58.7	61.4	33.8	43.9
Rural									
None		(n=178)	(n=181)	(n=171)	(n=271)	(n=62)	(n=79)	(n=84)	(n=105)
Elementary		1.1	0.0	0.0	0.0	0.0	0.0	1.2	0.0
High School		27.5	23.2	42.1	25.8	9.7	5.1	10.7	4.8
College		51.1	49.2	43.9	47.6	29.0	32.9	36.9	41.0
College		17.4	24.9	8.8	19.6	51.6	59.5	35.7	44.8



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Table 5.1.2 Comparison of Percentage of Marginalized and Non-marginalized Groups in Control and Experimental Areas, According to Household Member Receiving Cash Income on a Regular Basis (Urban and Rural)

FAMILY MEMBER	TREATMENT	MARGINALIZED				NON-MARGINALIZED			
		BASELINE		ENDLINE		BASELINE		ENDLINE	
		Expt'l (n=192)	Control (n=166)	Expt'l (n=193)	Control (n=86)	Expt'l (n=75)	Control (n=83)	Expt'l (n=68)	Control (n=41)
Urban									
Both Mother and Father		3.6	4.2	2.1	8.1	24.0	18.1	2.9	24.4
None		13.5	17.5	45.6	46.5	5.3	3.6	35.3	19.5
Rural									
		(n=178)	(n=181)	(n=171)	(n=271)	(n=62)	(n=79)	(n=84)	(n=10)
Both Mother and Father		4.5	0.0	6.4	4.8	24.2	20.3	7.1	8.6
None		18.5	23.2	48.5	41.0	6.5	2.5	35.7	21.0

Table 5.2 Comparison of Marginalized and Non-Marginalized Household Members According to Place of Residence, Type of Group and Selected Socio-demographic Characteristics: Baseline Survey

Selected Socio-Demographic Characteristics of Respondents	MARGINALIZED				NON-MARGINALIZED			
	BASELINE		ENDLINE		BASELINE		ENDLINE	
	Expt'l (n=1115)	Control (n=893)	Expt'l (n=1051)	Control (n=1062)	Expt'l (n=364)	Control (n=370)	Expt'l (n=301)	Control (n=376)
Median age of the population	12.0	12.0	12.0	11.0	19.0	21.0	17.0	17.0
Mean age of the household head	34.2	33.7	36.2	34.7	34.8	32.2	35.2	34.5
Mean household size	5.8	5.4	5.9	5.9	4.8	4.4	4.8	4.8
Mean number of children <6 years	1.7	1.7	1.5	1.7	1.3	1.4	1.2	1.3
% households headed by a woman	4.2	3.0	1.7	0.6	1.3	1.2	4.8	2.5
% of household heads who are unemployed	1.0	3.6	0.0	2.8	4.0	0.0	1.6	1.3
Sex ratio	94	97	93	105	97	100	99	111
Dependency ratio	128	118	126	126	95	84	93	101

$$\text{Sex Ratio} = \frac{\text{No. of males}}{\text{No. of females}} \times 100$$

$$\text{Dependency Ratio} = \frac{\text{Popn (<15)} + \text{Popn (>64)}}{\text{Popn (15-64)}} \times 100$$



Table 5.3 Comparison of Percentage of Respondents based on Awareness and Exposure to KSP

LOCATION \ TREATMENT	CONTROL			EXPERIMENTAL		
	Baseline	Endline	% Rel. Diff.	Baseline	Endline	% Re Diff.
Marginalized						
Urban	73.2	64.0	-12.6	74.9	89.6	19.6
Rural	77.8	70.8	-9.0	80.3	95.3	18.7
Total	75.5	77.4	2.5	77.6	92.8	19.6
Non-Marginalized						
Urban	68.9	75.6	9.7	86.5	83.8	-3.1
Rural	80.0	70.5	-1.2	76.1	96.4	26.7
Total	74.7	71.9	-3.7	81.4	90.8	11.5

Note: % Relative Difference = $\frac{(\% \text{ at endline} - \% \text{ at baseline})}{\% \text{ at baseline}} * 100$

The table above shows a significant increase in the level of awareness of both urban and rural marginalized groups in experimental areas, regarding the goals, objectives and methodologies of KSP.

Overall, awareness for KSP has greatly increased in the experimental, compared to control communities.

The largest positive increase in exposure to KSP is observed among rural non-marginalized households.

The only ones in the experimental group which showed no improvement in exposure to KSP are the urban non-marginalized households.

Table 5.4 Comparison of percentage of Respondents Based on Attendance of Health Education Classes

LOCATION \ TREATMENT	CONTROL			EXPERIMENTAL		
	Baseline	Endline	% Rel. Diff.	Baseline	Endline	% Re Diff.
Marginalized						
Urban	34.6	24.2	-30.0	42.5	56.0	31.8
Rural	42.0	46.5	10.7	45.9	75.4	64.3
Total	38.3	41.2	7.6	44.2	65.1	47.3
Non-Marginalized						
Urban	23.0	29.3	27.4	32.4	44.1	36.1
Rural	46.3	38.1	-17.7	42.3	75.0	77.3
Total	35.1	35.6	1.4	37.2	61.2	64.5

Table 5.4 shows a marked increase in the attendance of both marginalized and non-marginalized groups in barangay health education classes.

Corresponding increases in the control group were significantly lower, with some sub-groups even showing declines in attendance.

Relative increases in the percentage of women attending health education classes were greater among those in:

- rural areas compared to urban areas
- non-marginalized compared to marginalized households



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Table 5.5 Comparison of Percentage of Respondents based on Current Use of all Kinds of FP Methods

LOCATION \ TREATMENT	CONTROL			EXPERIMENTAL		
	Baseline	Endline	% Rel. Diff.	Baseline	Endline	% I D
Marginalized						
Urban	35.8	58.1	62.3	40.2	56.0	39.3
Rural	37.5	44.6	18.9	31.7	51.5	62.5
Total	36.6	47.9	30.9	35.9	53.8	49.9
Non-Marginalized						
Urban	44.6	53.7	20.4	32.4	57.4	77.2
Rural	45.0	58.1	29.1	45.9	53.6	16.8
Total	44.8	56.8	26.8	39.3	55.3	40.7

Looking at the current use of all kinds of FP methods between the control and experimental groups, overall, there is a significant difference in FP use between experimental and control groups among marginalized population (49.9% for experimental versus 30.9% for control).

For the non-marginalized groups, there is still a greater increase in the use of FP methods among KSP respondents, compared to non-KSP respondents (40.7% for KSP versus 26.8% for non-KSP).

Table 5.6 Comparison of Percentage of Respondents based on Current Use of Modern FP Methods

TREATMENT LOCATION	CONTROL			EXPERIMENTAL		
	Baseline	Endline	% Rel. Diff.	Baseline	Endline	% I D
<i>Marginalized</i>						
Urban	26.3	47.7	81.4	29.2	42.5	45.5
Rural	21.9	32.1	46.6	20.5	25.7	25.4
Total	24.1	35.9	49.0	24.9	34.6	39.0
<i>Non-Marginalized</i>						
Urban	29.6	36.6	23.6	28.0	39.7	41.8
Rural	24.1	30.5	26.6	24.2	27.7	14.5
Total	26.9	32.2	19.7	26.6	33.1	24.4

Referring to Table 5.6, increase in the use of modern family planning methods were observed in all sub-groups of women, both in the experimental and the control groups.

Increases in the use of modern family planning methods were generally higher among:

- urban compared to rural women
- marginalized compared to non-marginalized

There was a higher increase in the use of modern FP methods among non-marginalized experimental, as compared to non-marginalized control groups.



Table 5.7.1. Summary of Community Monitoring Activities in Urban Areas.

Barangay	Description of Monitoring System	Remarks	Available?	Used?
Compania	The KSP team members and Barangay Kagawad assigned to the project site are responsible for the continuous operation of the public faucet. The residents pay everytime they use the faucet. A project treasurer was appointed to collect the payment. The money collected is used to pay the monthly bill of the project.	An assigned person keeps the list of members	✓	✓
Tabucan	The community residents observe the schedule for disposing of their garbage. Penalty of P50.00 for those who do not comply.		✓	✓
Rizal P.	The barangay appointed a caretaker who is responsible in maintaining the water-sealed toilet. Anybody who uses the toilet will pay an amount to help maintain the continuous operation of the project.		✓	✓
Ticud	A KSP team member or a sitio rep is responsible for maintaining each project.	The IRA of the brgy. Will fund the maintenance of the project.	✓	✓
Gustilo	A KSP team member or a sitio rep is responsible for maintaining each project.		✓	✓
Tacas	A KSP team member or a sitio rep is responsible for maintaining each project.		✓	✓
Ungka	A KSP team member or a sitio rep is responsible in maintaining each project. Monthly contribution by the residents is collected to pay for the bill.		✓	✓
Sta. Cruz	The residents formed an organization to ensure the continuous operation of the project. A project treasurer was appointed to collect the monthly contribution of the residents. A list of members is posted near the project.		✓	✓

Table 5.7.2. Summary of Community Monitoring Activities in Rural Areas.

Barangay	Description of Monitoring System	Remarks	Available?	Used?
Mandog	The barangay designated a sitio rep for each cluster of families to be responsible for maintaining their water project. The barangay IRA fund will be used for the maintenance of the water pumps.	Used only during project installation	✓	✓
Bagacay	Sitio rep for each cluster of families to be responsible for maintaining their water project ____ of the project.	Used only during project installation	✓	✓
Tulatulaan	The residents formed an organization to ensure the continuous operation of the project. The residents pay a monthly contribution for the maintenance of the project.	Used only during project installation	✓	✓
Sinibaan	The barangay designated a sitio rep for each cluster of families to be responsible for maintaining their water project.	The barangay made a checklist of activities for their vegetable garden.	✓	✓
Ilongbukid	The barangay designate a sitio rep for each cluster of families to be responsible for maintaining their water project.		✓	✓
Poblacion	The barangay used a checklist of activities during the installation of the project, a spotmap was also used in identifying residents who did not have a water sealed toilet and who did not have a water source.		✓	✓
Sariri	The barangay designated a sitio rep for each cluster of families to be responsible for maintaining their water project		✓	✓
Agusipan	An organization of residents was formed to ensure the continuous operation of the project. A knowledgeable and responsible person was appointed to operate it. Monthly contributions were set for the electric bills and maintenance of the project.		✓	✓



6.0 PRELIMINARY CONCLUSIONS AND RECOMMENDATIONS

6.1 Community acceptance of KSP and ACM

Aside from the results of the household survey, focus group discussions conducted during the participatory evaluation indicated overwhelming community acceptance of KSP and the ACM approach.

Community members cited the appreciative approach as “non-threatening” for it did not try to pin the problems and who were to be blamed for those problems. Rather, according to them, the approach made them see problems as challenges that they can hurdle in order to reach their dream. ACM also did not make them feel helpless, but showed them that they have resources in the community which they can build upon to address the challenges and pursue their dream.

While community members initially expressed skepticism that the project will go the way of previous ones that were mainly dole out, they took their participation seriously when they saw that community health projects were being implemented.

One of the things that the participants in the various FGDs cited that was beneficial to them was the confidence that they gained, through their involvement in KSP. Where before, they were reluctant to participate and speak their minds, they no longer wanted to be absent in the community activities. This observation is much more meaningful coming from the marginalized groups in the community, who have now assumed responsible positions in the village. Moreover, they were shy to discuss family planning concerns before, now they are the ones who are bringing the other members of the community to the health center.



6.2 Ensuring meaningful community participation

"Go sitio!" is perhaps the most important slogan which spells out the best strategy for ensuring genuine participation in KSP activities, particularly of the marginalized groups. Targeting those members of the community who were oftentimes geographically and figuratively, on the fringes, meant that project activities had to be done in the neighborhoods, and not in the traditional "seat of power" in the village, such as the village halls.

Ensuring genuine community participation also meant that neighborhood or sitio representatives coming from the marginalized groups became part of the barangay KSP Team. Thus the concern and interest of these priority groups are now mainstreamed. However, care had to be taken in order not to overplay the divide between the marginalized and non-marginalized groups in the community. While it was deemed important to target the marginalized groups, the strategy for doing so should not create an obvious differentiation between the marginalized and non-marginalized groups. Towards this end, it is important that those who are planning for project activities should aim for an inclusive approach between the marginalized and non-marginalized groups.

6.3 Timing for Introduction of family planning in the community

ACM activities did not target family planning at the outset, but started with health topics and concerns which were "safer" in the context of what was perceived as very conservative Ilonggo attitude towards family planning. Previous work done by Save the Children in the realm of family planning in these areas have shown very strong church influence in the delivery of family planning services, thus the decision to work on other health projects first.

On hindsight, however, KSP project team members concluded that serious discussions on family planning among target couples in the community should have been introduced earlier. This late introduction of sessions focusing on the unexpressed fears and barriers on family planning resulted to some delay in the adoption of modern family planning in the target communities. Had the timing been earlier, the project would have had more time to implement behavior change strategies, such as the couples' decision-oriented family planning sessions. Thus, it was only towards the latter part of the project that FP intentions were seriously discussed, although as a result of this, there has been noticeable increase in the number of couples who opted for modern family planning methods.



7.0 CHALLENGES IN PROJECT IMPLEMENTATION

7.1 Limited access to family planning services and information.

Although there has been a major improvement regarding clients' access to family planning services, there are still areas where FP access continues to be limited. In these places, clients need to go to the municipal health centers for counseling and prescription, which still poses a barrier to FP practice.

Pills may be available at the barangay health stations but the staff are not allowed to dispense them without doctor's prescription. On the other hand, doctors are based at the municipal health centers and only visit the BHS periodically, obliging clients to visit the main health centers. The distance and cost involved in these visits were seen to discourage clients.

Majority of the health service providers in the project sites still refuse to provide family planning supplies and services to adolescents, unmarried women, and commercial sex workers. Despite a Department of Health policy which provides contraceptives to unmarried women and adolescents, health service providers interviewed during the SA claimed that their conscience would not permit them to provide

family planning supplies and services to those three groups of women.

7.2 Challenges in engendering community participation among urban population

While the project has made a breakthrough in increasing participation among urban communities, mobilizing this highly diverse and fluid group is decidedly more difficult than their rural counterparts.

Unlike rural households who could easily block time for education sessions, urban group find much more difficult to do so. It has been doubly more challenging for the barangay KSP team to ensure participation in family planning sessions among males in urban communities. Their schedules, especially if they are daily wage earners, could hardly permit them to attend sessions even during nighttime, and on Sundays when they are free, they are more likely to be inebriated when attending the sessions.

The barangay KSP teams have been, and still are, studying ways to increase male attendance in family planning sessions.



7.2 Challenges in further improving service integration in health centers.

To their credit, health center staff who have undergone KSP orientation and training sessions, and those who have been involved in the dialogues with communities for improving service quality, have taken steps in implementing family planning and child survival services integration.

However, there are still some health center staff who feel that it is the clients who should adjust rather than the health service delivery system, thus they continue with their vertical scheduling. Perhaps if there was encouragement from the provincial health office for these RHUs to practice integration, then the concepts would have broader implementation. Right now there are still service providers who think that it is enough to ensure that within the week, all the child survival and family planning activities have their specific days rather than have them available on demand. Yet, these service providers still refer to this weekly schedule as integration.



8.0 NEXT STEPS

8.1 Continue gaining lessons from the project

Three years is not enough time to work on a community-managed project such as KSP. Already, elements of the project that have been introduced during the latter part of the timeline, are showing results in a more sustained manner. It is thus imperative that developments that are unfolding, such as the behavior change that are resulting from the new generation of family planning sessions, should still be monitored and studied.

It is also important to know the degree of sustainability of community efforts six months, one year, and two years after the project has ended. Towards this end, Save the Children is committed to continue its work with the community, albeit in progressively declining levels.

8.2 Application in other areas and projects of Save the Children

The lessons gained by working in Iloilo will be applied by Save the Children in the other projects being implemented. The Couple's Family Planning Sessions that have shown good results over a short period will be adapted by the agency in another community-managed reproductive health cum environment project.

Urban programming linking family planning and child survival will certainly be a major project strategy in Save the Children communities in Metro Manila.

8.3 Application outside of Save the Children

Upon hearing of the positive experience of Save the Children in community mobilization, a standing invitation has been issued to Friendly Care Foundation for a partnership around appreciative community mobilization. Towards this end, discussions will be pursued with Friendly Care in the near future.

The experience in ACM has also been incorporated in the standard national training program of the Department of Health, which was used to train some 150 national trainers of Community Volunteer Health Workers. Plans to extend the training to the Doctors to the Barrios Project and possibly with Sentrong Sigla, are likewise under consideration.

Recently, a team of national trainers for Healthy Indonesia 2010 had a training on Appreciative Community Mobilization here in the Philippines, which included exposure to KSP communities. Because they have seen the approach viable for their project in Indonesia, the Muslimat women's organization has requested for technical assistance from Save the Children to customize a training program and manual for their use in Indonesia.