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Proceedings of the operations research training workshop for program managers and researchers, January 15-21, 1996

Family Planning Service

The Family Planning Operations Research and Training (FPORT) Program

Population Council

Proceedings of the

OPERATIONS RESEARCH TRAINING WORKSHOP FOR PROGRAM MANAGERS AND RESEARCHERS

January 15-21, 1996
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sponsored by

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The Family Planning Operations Research and Training (FPORT) Project
The Population Council, Manila
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INTRODUCTION AND SUMMARY

This document contains the proceedings of the training workshop on operations research for program managers and researchers held last January 15-21, 1996 at the Puerto Galera Hotel in Mindoro, Philippines. The training workshop was co-sponsored by the Family Planning Service of the Department of Health and the Family Planning Operations Research and Training Program (FPORTP) of the Population Council, Manila.

Representatives from the health and population offices of ten local government units (LGUs) worked together with a select group of researchers during the five-day workshop to evolve a list of relevant topics for operations research (OR) and to develop a concept paper on a chosen OR topic.

The LGUs represented in the workshop were selected from a group of local governments participating in the LGU Performance Program (LPP) of the Department of Health. These LGUs include the provinces of Albay, Nueva Ecija, Pangasinan, Iloilo, Davao del Norte, Bukidnon and the cities of Baguio, Iloilo, Cebu and Cagayan de Oro. By being part of the LPP, these LGUs have already demonstrated the committment needed to undertake operations research for improved health and family planning service delivery in their localities.

The training workshop was conducted with the following objectives:

a. To demonstrate to program managers the usefulness of operations research (OR) in program development and decision-making;

b. To provide program managers with an understanding of the different types of OR and how these differ from basic research;

c. To develop and enhance the skills of program managers and researchers in identifying problems for operations research;

d. To enable the participants to develop a list of feasible and relevant OR topics; and

e. To facilitate the development of a concept paper on a chosen OR topic.

A series of lectures and paper presentations on three major modules comprised the training workshop. The first module presented the *new directions* of the Philippine Family Planning Program and set the context within which discussions about *reproductive health, gender-sensitivity* and *information-based decision-making* were made. The implications of the ICPD program of action on local programs such as the Integrated Family Planning and Maternal Health Program (IFPMHP) and the LPP were also presented.

The second module consisted of condensed lectures on the technical aspects of operations research. The topics covered included problem identification, objective formulation, study designs, sampling and data collection techniques and data analysis, with special focus on situational analysis, an OR methodology.

The third module provided examples of OR studies to demonstrate the utility and import of operations research to program managers and policymakers.

At the end of all these inputs, the workshop sessions provided the participating program managers and researchers with the opportunity to put all these new learnings into practice by working together on their concept papers. The training workshop was capped by the individual LGU presentations of their concept papers to a review panel which provided its critique and comments.

As Dr. Marilou Costello, host country advisor of The Population Council, Manila had said, "this workshop is just the beginning of a longer and broader process of institutionalizing operations research" in the Philippine Family Planning Program. The workshop proceedings documented herein are but a small contribution to that beginning.

Read on.

INTRODUCTION TO THE TRAINING WORKSHOP

Marilou Palabrica-Costello, Ph.D.
The Population Council, Manila

Good morning and welcome to this training workshop on operations research, which is co-sponsored by the Family Planning Service of the Department of Health and the Family Planing Operations Research and Training Program (FPORTP) of the Population Council.

What I would like to do in the next 15 minutes or so would be to share with you a little bit about, first, the background of FPORTP and, second, some ideas about the purpose of this workshop. Before I go into that, however, I just want to say how personally delighted I am to see all of you again, and to thank you from the bottom of my heart for the hospitality that you have shown me during my visit to your province or city. Puerto Galera, unfortunately, is not my home, but I made sure to tell our hosts that we have some really special people here, and that they should pay close attention to your needs.

Let me also take this opportunity to introduce to you our able workshop manager, Mr. Joe Obordo. Joe will be our guardian angel during the next five days as he will be making all the arrangements that will be needed to ensure that our stay here will be a pleasant one. In addition, he will follow up all of the working groups so that they can come up with good quality outputs at the end of the workshop.

At this point, I would like to personally acknowledge the presence of two very distinguished guests and participants: Dr. Carmencita Reodica, Undersecretary of the Office of Public Health, and Dr. Jovencia Quintong, Director of the Family Planning Service. Besides representing the Department of Health which is our co-sponsor for this activity, they will also be providing us with some very important inputs to guide our deliberations in the next five days.

The Family Planning Operations Research and Training Program (FPORTP)

As its name indicates, the FPORT is concerned with finding ways by which operations research (sometimes called "OR") can be used to improve the delivery of family planning services. The project aims to raise the awareness of and appreciation for this tool among program managers and researchers. Furthermore, and more importantly, the end goal of the project is to help in the institutionalization of this process within the health and family planning program as a mechanism for improving service delivery throughout the country.

The FPORT is being coordinated by the Asia Near East Operations Research and Technical Assistance (ANE OR/TA) Project of the Population Council in New York, under a grant from USAID. There are five other countries in the Asia Near East region undertaking similar activities. These include India, Indonesia, Bangladesh, Pakistan and Egypt.

The ANE OR/TA project is itself part of a worldwide operations research program of the Population Council, along with INOPAL in Latin America and the OR program in Africa. I mention

this to emphasize that we have a wide spectrum of resources to draw from should a need arise for additional technical assistance. In fact, completed studies from these other regions will be made available during this workshop to serve as references for our own activities.

I might mention as well that there is a core group of professional social scientists and program managers representing both the national and LGU levels that constitute a National Task Force for Operations Research, to help the FPORTP formulate its activities. This is an ad hoc group that meets whenever major activities are being planned. Many of the members are with us today, including Dr. Quintong.

The FPORT initiative, like the LPP, is being undertaken within the framework of a devolved system of health delivery, under the Integrated Family Planning and Maternal Health Program of USAID. Mr. Ephraim Despabiladeras of USAID will expound on this program later on.

For my part, I must admit that when devolution came about, it created a dilemma for us. This is mainly because the program simply did not have all the resources necessary for effectively reaching out to all of the hundreds of provinces, cities and municipalities found throughout the country.

Oftentimes, however, problems have a way of making people more creative. Our solution to this dilemma, therefore, was to coordinate our own efforts with the LGU Performance Program (LPP). The expectation here is that, by concentrating on the LPP areas and combining our experiences and resources with those of the LPP, we can maximize our impact with the LGUs. Eventually, the programs in the LGUs represented here today are expected to serve as centers of excellence for diffusion of improved service delivery activities throughout the various regions.

The program will therefore proceed by first working with you, and then with your neighbors, through you. We intend to work with 30 LGUs throughout the life of the project. All of the LGUs represented here today constitute the first wave, so to speak. By being part of the LPP, you have already demonstrated the requisite commitment and organizational capacity as far as health and family planning is concerned. This makes you the best candidates for serving as catalysts for change in the remaining LGUs.

I would like to go back to the concept of "institutionalization" which I mentioned earlier. By this we mean the setting up of a system whereby OR studies will be highly valued and routinely conducted. Results of these studies will be used as well, which is to say that they will serve as a basis for the decisions made by program managers. Utilization is a key concept in OR.

Another element of institutionalization comprises the need to build linkages. Perhaps the most important of these will involve links between LGU health and family planning programs with nearby research centers. That is why we have invited a number of regionally-based researchers to this workshop. In general, the FPORTP will be providing technical assistance to LGUs in collaboration with these research centers.

This workshop, therefore, is just the beginning of a longer and broader process of institutionalizing OR. In some cases, this will go beyond the provision of short-term technical assistance and involve the conduct of OR studies in the LGUs. There are of course, some financial

constraints because we cannot fund a large number of such studies. But we hope that the results of these few projects will generate some important lessons that could be disseminated and shared for the benefit of everyone.

OR Training Workshop Program of Activities

Let me now turn to the workshop program itself.

For those of you who already had a chance to review the program, you will note that our very first sessions will deal, not immediately with OR, but instead with something which we have called the "new directions" now being taken in the Philippine Family Planning Program (PFPP). And if you looked even more closely at this, you no doubt saw references to such terms as "reproductive health", "gender sensitivity", "quality of care", and the Cairo and Beijing conferences.

At issue here are some challenging new ideas--for example, that our focus should not be on "family planning" so much as upon the broader issue of reproductive health. It has also been argued that programs must pay attention to men as well as women. Actually, these are not entirely new ideas for the program. We know for a fact that they are now being discussed by researchers and program managers at the higher levels of the DOH. Fortunately, some of these very same people are with us here today so I am hopeful that we will be able to delve into these issues, particularly their operational implications, during the next few days.

Now, when I bring in this idea of "operational implications," I mean just that. For this section of the workshop should not be just an attempt to keep up with the latest ideologies and buzzwords. The emphasis here, is still very much upon improved service delivery and responding to the needs of our clients. And it is precisely here where OR will again be coming in, because there will surely be a whole host of new operational questions which these new perspectives will raise. For example, if it does work out that we move towards an improved integration of reproductive health into our family planning programs, what will this mean for our training programs? Our clinic facilities? For IEC? For our referral and outreach programs?

If we have succeeded in our efforts and OR has been properly institutionalized in your programs, you will be in a good position to answer these questions and to use your limited resources with the greatest possible efficiency.

In closing, let me again thank you all for coming. I express my hope that this will be a successful and productive workshop.

Thank you.

FROM FAMILY PLANNING TO REPRODUCTIVE HEALTH: A Program Manager's Perspective

Jovencia Quintong, M.D.
Family Planning Service, Department of Health

From the perspective of a program manager, the questions I would want to be answered in order to effectively implement or operationalize the reproductive health (RH) approach to family planning (FP) are the following:

1. What really is an RH program? Is it an RH approach to FP?

A reproductive health (RH) *program,* as opposed to a RH approach, is very comprehensive in nature and in scope. It entails not only family planning but also all other related programs, like maternal and child health (MCH), nutrition and the prevention of communicable and non-communicable diseases, to name a few. From the point of view of a program manager, I think that what the FP program needs is more of a RH *approach* than a RH program.

Reproductive health is defined as a condition in which reproduction is accomplished in a state of complete physical, mental and social well-being and not merely the absence of disease or disorders of the reproductive system and function. It follows the general definition of health but it is more focused on the reproductive process, function and system. Hence, the concern is not only on the physical and physiological aspects but also, and perhaps more importantly, on the social aspect of reproductive health. This means that there are many determinants of reproductive health that are outside the realms of the medical profession, and these affect the reproductive health of both men and women.

This definition of reproductive health therefore implies that:

a) Men and women have the ability to reproduce and that sexual need is a very basic need of any human being.

Here, the concept of fertility is introduced and the problems of infertility among men and women can now be addressed. Also, this implies that women go through pregnancy and childbirth safely. This is essentially what safe motherhood is about, and is certainly within the context of the maternal and child health (MCH) program. When reproduction is carried to a successful outcome, and the infant is assured of survival, this also falls within the MCH program.

b) Men and women have the right to be informed of access to safe, effective, affordable and acceptable methods of their choice.

This may pertain to family planning and spacing. It is considered a human right of men and women to decide when and how many children they want.

c) Men and women should have satisfying and safe sex that is free from STDs and AIDS.

These implications are actually the elements of reproductive health.

2. Why do I need the refocusing? Why are we offering or implementing an RH approach to FP?

The answers to these questions are as follows:

a) RH is a very basic component of general health because the reproductive system is part of the human body. It also has a developmental and intergenerational component. When you say reproductive health, it does not only imply the reproductive age years (15 to 49 years) but also your health status "from birth to tomb". A woman's reproductive health is a consolidative effect of her life cycle. For example, if you want to know an infant's chance of survival, you look back to the health status of the child's mother during pregnancy. This "life cycle" perspective is one important feature of RH.

b) The changing patterns of a woman's needs are the results of her changing lifestyles and roles. Program managers and even researchers have found that the MCH approach is becoming too narrow to meet the socio-demographic changes that have been happening over time, especially those affecting women. Women these days are no longer "just" mothers. They are also increasingly becoming active participants of the labor force. There is also a need to address the changing concerns of women, especially those who, though married, do not want to become mothers.

c) Cases of STDs and AIDS have increased in epidemic proportions. This can be attributed to the changing values, sexual behaviors and lifestyles of men, women and even adolescents. In the recently concluded Young Adult Fertility Survey, teenagers have been found to have distinct reproductive health needs. The RH of men also needs to be addressed because men are also part of the reproductive process.

3. What would be the minimum standard of RH care which we want and could afford to deliver? What would be the RH package?

The ideal RH care package for fertility regulation should address the needs of the client, such as spacing or limiting the number of children, for both demographic and health reasons. Also, it should address issues on infertility and sexual health as part of enhancing life and personal relations between husband and wife.

Safe motherhood or the mother-baby package is a minimal set of interventions centered around pregnancy and childbirth, addressing the needs of both the mother and the newborn. Reproductive health, on the other hand, implies that there must be a constellation of methods, techniques and services that contribute to RH care. Are services available? Are referral systems in place? Are there trained personnel available to deliver the services? Are there mechanisms for integration or referral? Are there ways of preventing and solving RH problems which could promote well-being? Well-being includes emotional satisfaction, enhancement of life and personal relations. Counselling is very important.

Problems of reproductive health cannot be solved by health or medical considerations alone because there are other factors which affect health. These determinants of RH include economics, education, employment, poverty, nutrition, living conditions, family environment, access to safe water, status of women, social and gender relations, traditional values, legal structures, lifestyle, sexual behavior, alcoholism, drug dependence, availability of FP-MCH services, breastfeeding skills, biological, cultural, psychological, technology, epidemiology and research. Thus, RH needs should be adressed using a multi-sectoral and multi-disciplinary approach.

4. Is the present FP program or system adequately prepared to offer the standard care?

To be able to answer this question, we should consider the following issues and concerns in RH:

a. There is lack of or weak understanding of the determinants of RH.
b. The knowledge, attitudes and skills of volunteer health workers to respond to the RH needs of men and women are inadequate.
c. There is an inadequate data base about RH status and service delivery.
d. There is a lack of or weak community involvement and people participation in the planning, implementation, monitoring and evaluation of RH needs.
e. The conditions at the workplace are poor and unsafe.

5. Are men and women receiving the intended health care?

Globally, reproductive illnesses acccount for 30 percent of the overall disease and disability in women and 12 percent in men.

6. How do we operationalize the RH approach to FP?

Here are some suggestions on how to operationalize the RH approach to FP.

a. Provide a mix of contraceptive choices that is responsive to the client's specific needs.
b. Develop information dissemination activities and services that target men, their roles and their responsibilities.
c. Offer post-abortion counselling and FP services.

d. Devise strategies that serve the special needs of young adolescents, married or unmarried.
e. Work with other sectors in developing guidelines on how to avoid unsafe sex, thus preventing the spread of STD/AIDS.
f. Develop linkages with other closely-related services.
g. Strengthen the referral system for management of side effects and complications arising from FP use.

7. What would be the expected impact of RH care that was given?

This question elicits the ideal goals of RH, which are the following:

a. A healthy sexual development and maturation for all;
b. Capacity for married couples to enjoy a healthy, equitable and responsible relationship geared towards satisfaction, family welfare and achievement of their reproductive intentions;
c. Appropriate care, counselling, and rehabilitation for disease conditions related to sexuality and reproduction.

8. How can operations research assist program managers in answering the above questions?

Operations research can serve as a/an:

a. Diagnostic study which provides systematic views on policies and existing operating procedures that characterize the program.

b. Feasibility study which tests the acceptability of a new policy or approach.
c. Impact study which can be used to link managerial decisions and plan outcomes.

In conclusion, I think that the primary role of OR is to bring scientific clarity to the management of RH, either as a program or as an approach.

THE ICPD PROGRAM OF ACTION AND ITS IMPLICATIONS TO POPULATION PROGRAMS

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What is the ICPD?

The ICPD Program of Action represents the culmination of many global efforts in many ways. As a document that reflects consensus on many important population and development concerns by delegations from 179 countries, it defines the principles and agenda on these concerns for the next 20 years. It is well grounded on substantive developments of major issues confronting countries of the global community as well as on international agreements and declarations in many spheres.

The ICPD builds upon a series of population conferences particularly the 1974 World Plan of Action in Bucharest and the 88 recommendations for further implementation approved at the subsequent International Population Conference held in Mexico City in 1984. It also builds upon the UNCED's agreements as embodied in agenda 21 and the Rio Declaration. Part of the core of the ICPD's concerns are the agreements in the series of international conferences/actions on human rights, children and women, for instance the 1990 World Summit for Children and the 1993 World Conference on Human Rights.

Having population, sustained economic growth and sustainable development as its theme, the ICPD is comprehensive in scope and took into account trends and developments in major issues confronting the world today. It considers and advocates a major shift in development paradigm particularly in taking into account the linkage between population and development. It advances the view that while sustained economic growth and population stabilization are necessary prerequisites for sustainable development, the primordial importance of putting people at the center of these development pursuits and in particular, meeting the individual needs of men and women provides the cutting edge in achieving long lasting progress.

A major paradigm shift involves the concept of sustainable development which rendered inadequate the previous economic growth and socioeconomic considerations in development. Sustainable development promotes the view that higher environmental performance can lead to more positive economic benefits instead of the inherently antagonistic perspective as formerly believed. It promotes inter- and intra-generational equity with a more appropriate valuation of resources and the environment. It also highlights the fact that pursuits to end absolute poverty, having adequate assets and meeting the social needs and aspirations of the majority need not be at the risk of the ecological support system of human beings and other species.

The ICPD calls for a change in the direction of population policies and family planning programs away from population goals treating people as demographic targets and family planning services as a key strategy to influence people's reproductive choices and fertility. Rather, family

planning is made available as a means to realize people empowerment and to uphold their human rights particularly that of reproductive rights in deciding the number and timing of their children. At the core of these considerations are the women who are recognized not only from the broad context of population and development nexus but also from the important role of their reproductive health and reproductive rights.

A Summary of Premises and Program Implications of the ICPD Programme of Action

1. Population, Sustained Economic Growth and Sustainable Development

Premises:- the important relationship between the activities and needs of a growing population and the finite capacity of the earth and natural resources to support such activities

- the need to change production and consumption patterns

- need to stabilize population growth in many parts of the world to free resources and buy time for sustainable development

Program Implications:

a. Promote a supportive economic environment thru measures such as debt relief, fairer terms of trade, human development and people-centered structural adjustment policies

b. Focus on the most vulnerable groups - one such group is women. This argues for women empowerment.

2. Gender Equality, Gender Equity and Women's Empowerment

Premises:- Gender equality and equity are ends in themselves as well as essential elements of sustainable development

- There is imbalance in the relations between men and women in almost all spheres of life.

Program Implications:

a. Enhance women's decision-making roles.

b. Promotion of education for women is necessary to meet their basic needs and to exercise their rights

c. Promote the economic self-reliance of women (less financial dependence on men)

d. Protect women from all forms of discrimination, violence, abuse, harrassment and exploitation

e. Focus on the girl-child; increase their value in society and protect them from discrimination and from harmful practices.

f. Measures to make men assume more responsibility on the following:
- their own sexual and reproductive behavior
- family planning
- family income
- children's education

g. Eliminate violence against women

3. The Family: Its Roles, Rights, Composition and Structure

Premise: The family is the basic unit of society and population and development policies should promote the various forms of the family.

Program Implications:

a. Social policies should pay particular attention to vulnerable (burdened) families such as single-parent and female-headed households; poor; those with elderly and disabled members; those with members suffering from AIDS; and those with domestic violence and child abuse

4. Population Growth and Structure

Premise: In areas where population growth outstrips economic growth, there are special challenges in ensuring the quality of life based on human rights and sustainable development.

Program Implications:

a. POPDEV programs must be socially, culturally and economically appropriate. "No one model suits different areas or varying conditions".

b. Provide opportunities for education and employment for women for their own merit and not only as a means to promote delayed marriage and lower

fertility.

c. Promote policies addresssed to the elderly that will guarantee their self-reliance, health and social care, and support whether these are coming from the society or from the family.

5. Reproductive Health and Reproductive Rights

Premises:- Every woman has a right to reproductive health.

- Reproductive health is defined as a state of complete physical, mental and social well-being in all matters relating to the reproductive system and its functions and processes.

- Reproductive health is rights-oriented in addition to being health-oriented.

- Recognizes that sexual as well as reproductive health and rights are vital elements of physical and emotional well-being.

- What does reproductive health include? (Cairo)

  - ability to have a satisfying and safe sex life
  - capability to reproduce
  - freedom to decide on the number and timing of children
  - right to information and means to regulate fertility
  - right to health care services for a safe pregnancy and childbirth
  - right to attain the highest standard of sexual and reproductive health
  - respectful and equitable gender relations premised on shared responsibility for sexual behavior and consequences, and full respect for the integrity of the human person

Program Implications:

a. An important step is the reorientation of the family planning program into a reproductive health framework.

b. Most urgent is to ensure the quality of care or service particularly in the areas of medical techniques, contraceptive choice, respect for client's choice, provision of full and accurate information

c. Reconsider the range of contraceptive choices to take the likely risk to STD infection.

d. Making investments in and experiments on programs for men to make condoms a real and attractive choice for couples.

e. Create programs to provide information and services for adolescent taking into account not only their sexuality but also gender relations.

f. Promote counselling that is truly empowering. This is one which ensures that women understand their fertility regulation choices, make decisions based on full and accurate information and can act effectively on their own decision. This will result in improved relations and negotiations.

g. In the fertility regulation research agenda, give priority to methods that give more control to women in protecting themselves against STD/HIV. Therefore, this can be either for contraception or other objectives.

h. Build systematic and functional relationships including effective referral mechanisms between family planning and maternal health, child health, gynecological, STD/HIV programs with the ultimate objective of integration.

6. Health, Morbidity and Mortality

Premises:- Recommitment to the provision of basic health care for ALL.

- Women as primary custodians of family health should be better empowered to protect their own health.

- Unsafe abortion is life threatening to women and is a major public health concern.

Program Implications:

a. Reproductive health and child health services should include safe motherhood programs.

b. Undertake measures to rapidly reduce maternal morbidity and maternal mortality with emphasis on maternal health within a Primary Health Care framework.

c. Reduce the need for abortion by women thru family planning services and to deal with the health impact of unsafe abortion. Women should have access to compassionate counselling and access to quality services for the management of complications arising from abortion.

NEW DIRECTIONS IN THE INTEGRATED FAMILY PLANNING AND MATERNAL HEALTH PROGRAM (IFPMHP)

Ephraim Despabiladeras
United States Agency for International Development (USAID)

The IFPMHP was designed in 1993, even before the ICPD. It is a five-year program which started some time between 1994 and 1995. It has a US$100 million grant from the United States. For the past several months, we have had dialogues with the DOH on how to implement this program, and there are developments in the program that I would like to share with you.

Re-engineering has made the IFPMHP a client-focused and result-oriented program. Thus, the project has the following objectives:

1. To reduce the unmet needs for family planning (FP)

According to the 1993 National Demographic Survey, we have about 25 percent of women in the reproductive age group with unmet FP needs. This includes 12.4 percent of women who would like to space their pregnancies and 13.8 percent who wish to limit their family size but are not practicing FP. Upon analyzing the survey further, we found out that:

a) The younger the mothers are, the greater is the need for spacing pregnancies.

b) The older the mothers are, the greater is the need for limiting the family size.

c) Majority of women with unmet needs belong to the 20-30 year age group.

d) The lower the educational attainment of a woman, the more the FP needs are unmet.

e) Urban women have relatively less unmet needs than rural women because of accessibility to the service centers. Migration to the urban centers can explain the opposite finding reported in the 1990 census.

2. To increase the use of FP services and to improve the contraceptive prevalence rate

There is a considerable gap between the use of traditional and modern FP methods. There is a plateau in the trend of the FP program, particularly in the 1980s when there was a standstill in the implementation of the program during the Aquino administration. The upswing in 1988 is due to the renewed commitment to the implementation of the FP program.

In 1993, the total CPR is 39.6 percent. Twenty four percent use the modern FP methods, with tubal ligation being the most availed of method, followed by the use of pills and IUD. In 1995, an FP survey showed that the CPR has increased to 50 percent; ten percent of which is accounted for by the practice of NFP. The increase in the use of modern methods was only 3 percent.

3. To reduce the number of high risk births

High risk births (HRB) are births by mothers aged less than 18 years or greater than 34 years, with birth interval of less than 24 months, or a birth order greater than three. According to the 1993 demographic survey, HRB constitute 62.4 percent of all births for the past five years.

4. To increase program sustainability

The USAID is the leading funding agency of the Philippine FP program, accounting for an 81 percent share. The next biggest source is UNFPA, with a 12.4 percent share. The Philippine government shoulders only 3.7 percent of the total funding for the FP program.

The USAID would very much like for the Philippine government to assume most, if not the full financial responsibilty of implementing the FP program. The strategic objective then is to reduce population growth rate and improve maternal and child health (MCH).

By the year 2000, we expect changes in the following indicators:

1. The total fertility rate will be reduced to 3.3 percent.

2. The infant mortality rate will decrease from 57 per 1000 livebirths to 49 per 1000 livebirths.

3. The maternal mortality rate will decrease from 209 per 1000 livebirths to 190 per 1000 livebirths.

4. The CPR will increase to 50.5 percent.

5. The high risk births will decrease from 62.4 percent to 56 percent.

How are we going to achieve these?

The IFPMHP has several result packages (RP).

RP-1 is aimed at increasing the public sector provision of FP-MCH services. This refers to the delivery of service in the government sector, particularly the LGUs and those retained hospitals of the DOH. Under this package, we expect the following:

1. The number of fully immunized children will increase from 88 percent (observed in 1994) to 90 percent by the year 2000.

2. The number of women immunized against tetanus will increase to 80 percent.

3. The number of children receiving Vitamin A capsules will be maintained at 90 percent.

4. The modern method couple years protection from the public sector will increase from 1.77 million to 2.6 million by the year 2000.

5. The aggregate number of LGUs enrolled in the LPP will increase to 100 percent by 1998. As of now, we have 30 LGUs in the LPP. In 1995, Laguna and Camarines Sur dropped out of the program because the elected governors are anti-FP. Because of the lahar, Pampanga could not deliver services. By 1998, we hope that at least 75 percent of the LPP participants would have achieved their LPP benchmarks.

6. The LGU-LPP will allocate 4 percent of their Internal Revenue Allotment (IRA) funds to the FP program, in accordance to Presidential Memorandum 61795.

The activities under RP-1 are the following :

1. Development of LGU annual plans and budget
2. Expansion of service delivery through the provision of modern FP methods
3. Meeting immunization/tetanus/Vitamin A targets
4. Conduct of LGU IEC programs
5. Conduct of training programs that will improve the quality of FP services

RP-2 is aimed at strengthening the national systems which promote and support the FP-MCH program. Under this package, we hope that:

1. The DOH assumes the operational responsibility for all components of the program which include contraceptive distribution, IEC, training, research, evaluation, technical support and monitoring.

By April 1996, the DOH will assume the responsibility of contraceptive distribution. By February 1996, the DOH central office, in cooperation with Johns Hopkins University will conduct an assessment of LGU needs, to be able to come up with an IEC strategy focused on LGU needs. Trainings will be competency-based. It will also include reproductive health (RH) issues. Workshops on how to use operations research (OR) will be conducted.

2. The DOH will allocate a bigger share in funding the FP program.

We hope that the DOH's share will increase from 0.1 percent in 1993 to 2 percent by the year 2000.

3. The DOH will be responsible for releasing annual LPP grants to 75 provinces by the year 2000.
4. The FP strategy will be updated.

5. There will be more support from professional associations, like the Philippine Medical Association and the Philippine Nursing Association.

RP-3 aims to increase the private sector provision of contraceptives and other FP services. The private sector pertains to the private commercial sectors and the NGOs. Under this package, we expect that:

1. The percentage of FP services provided by the private sector will increase from 27 percent in 1993 to 34 percent by the year 2000.

2. There will be an expansion of contraceptive social marketing (CSM) by December 1999 in 33 urban centers.

3. The number of pharmacists as a source of supply of modern FP methods will increase from 7.3 percent in 1993 to 10 percent by the year 2000.

4. There will be an expansion of the provision of FP services in the private and NGO hospitals and clinics.

5. The role of the private sector in the FP program will be enhanced. Our thinking is that the DOH and the public sector will cater to the poorest of the poor. On the other hand, the private sector and the NGOs will cater to the paying population. This way, there will be a segmentation of the market, and we can achieve sustainability of the program.

OPEN FORUM

What is the policy with regards the provision of reproductive health services to adolescents?

In providing FP services to a single adolescent, you have to weigh the benefits and the risks. From the point of view of health, we don't have any bias. When there's a demand for FP services, we provide them. However, since the client is an adolescent whose reproductive system is not yet fully developed, we are faced with legal issues especially when the client develops side effects or complications from the FP service provided. That is why we have to select the appropriate method for the client after an intensive counselling. Fortunately, there are still no reports of such cases.

- Dr. Jovencia Quintong
Department of Health

From the point of view of the ICPD, I think we are referring to what they call the "culturally appropriate" services. When it comes to the formulation of an adolescent RH policy or program, we can pull out agreements and provisions from ICPD. This will balance the confidentiality or privacy and welfare of the adolescent vis-a-vis the parental responsibility over his/her child. Since there are realities of incest and prostitution of young girls with their parents' consent, there is a move to protect the adolescent girls from parents who are not acting in the best interest of the child. Both conferences (Cairo and Beijing) invoked the rights of the child. In such cases, therefore, things will have to be decided in the best interest of the child.

With regards to the Philippines, a task force is being formed under the sponsorship of the World Health Organization (WHO). There will be consultative meetings with different sectors to formulate an adolescent health policy. I believe that these inputs -- the global commitment and the realities of Philippine situation, both legal and cultural -- will be very useful in the formulation of an adolescent RH policy.

- **Dr. Corazon Raymundo**
UP Population Institute

Do we have a timetable in coming up with this adolescent RH policy? The DOH has not articulated any adolescent policy.

The group is still to be formed. There is already a list of suggested names who will form this "expert" group for adolescent health policy formulation. They do have a timetable for the first quarter of the year.

- **Dr. Corazon Raymundo**
UP Population Institute

Dr. Quintong seems to be saying that there is already an adolescent RH policy. However, it is not clear how this policy had been communicated to the field. In what manner has this been communicated?

The policy is that when services are being demanded from us by a single adolescent who is at high risk of getting pregnant (e.g. she's sexually active), we provide the most appropriate FP method. Abortion is definitely out of the question. What is not explicitly stated in the policy is that the client should be married.

- Dr. Jovencia Quintong
Department of Health

I think we should begin to move from an implicit to an **explicit** policy on this. There a lot of indications that a large number of teenagers are engaged in sexual relations on a regular basis. This merits policies protecting them from pregnancies. From these adolescents, we have also learned that one of the reasons they are not using FP methods despite the fact that they do not want a pregnancy is that sex is a spontaneous experience. Contraception takes out the fun in having sex. Such a situation behooves an intervention because it is affecting a large segment of our population.

- **Dr. Corazon Raymundo**
UP Population Institute

Dr. Raymundo was suggesting that there is a need to move from FP to an RH program. In terms of political strategies, are there potential pitfalls? In FP, the very use of the word "family" is able to capture the more liberal Catholic tradition of responsible parenthood. Reproductive health seems to be opening the door for abortion. I'm just wondering if there might be a backlash if there were really to be a full-pledged RH program. I would like to get your comments on this.

This move towards reproductive health will be based on our experience in carrying out the FP program or the responsible parenthood program. This implies that sexual rights and health could really be a cause for the Catholic church to pick up their issue vis-a-vis FP. While this is politically something we would take care of, there's no other way to go.

One of the problems that the FP program has faced is that we have not addressed some of the key issues that would help men and women in pursuing a more healthy reproductive life. I think it is a challenge to the creativity of our policy makers, program planners and implementors if we are convinced that there is a need for reorientation. We just have to be prepared to handle the consequences.

- **Dr. Corazon Raymundo**
UP Population Institute

I would like to ask Dr. Quintong about her ideas on how to redirect the present FP policy towards a reproductive health policy.

The way the policy is being operationalized is not clear. We have already come up with a plan of integrating FP-MCH with other frontline services, like the TB program, although it is still not functional. This is where operations research (OR) should come in.

- Dr. Jovencia Quintong
Department of Health

Dr. Quintong made a distinction between an RH program and an RH approach to FP. If the RH approach will be taken, what kind of services will be provided?

What we need is a functional rather than an organizational integration of FP and RH. For example, a pelvic assessment before provision of pills can identify reproductive tract infections (RTIs) which can be referred for treatment. Another example is doing a pap smear on a woman with possible signs of cancer before an IUD insertion.

I would like to point out that there are missed opportunities where RH services can already be introduced. For instance, during a pre-natal check-up, a mother who is already considered at high risk for pregnancy should have been given information on the different components of RH such as FP, nutrition and others. But, we still need information on the most appropriate strategy to merge these services.

- Dr. Jovencia Quintong
Department of Health

I would like to say that it is a matter of consciousness and sensitization. It's not enough to have all the elements of a service. As Dr. Quintong said, there are still a lot of missed opportunities of promoting the reproductive health of a woman despite the availability of services and guidelines. We should start looking at a client differently per visit. We can begin to be more conscious of our client's health by asking her to identify factors that have affected her health (i.e., nutrition, activities). The health workers should have a common consciousness and sensitization, a common guideline on how to handle their clients. I know it would take so much more from our health workers, but there's no other way to do it.

- **Dr. Corazon Raymundo**
UP Population Institute

TOWARDS A MORE GENDER-SENSITIVE HEALTH DELIVERY SYSTEM

Cecilia Hoffman
WEDPRO

When we are discussing reproductive rights, reproductive health and family planning, what we are really talking about is sexuality. In my experience with WEDPRO and other women's organizations, we find that when we gather women to talk about their sexuality, it is not difficult for them to open up, especially if you establish good conditions of rapport and solidarity. Women have become more willing to confront their sexuality and problems related to it. What is difficult is to do it in mixed groups.

I am not a health worker, but what I will attempt to do is to raise some gender questions that relate to the issue of reproductive health. Why is this relevant? First of all, in this context, you want to make the reproductive health programs or approaches work better, and if they are not working, then you would want to understand why they are not working. What has been discussed so far is a very technical, medical approach to reproductive health, where you look at the density of services and service providers, availability of appropriate technologies and the allocation of resources. What we are not looking at is the wider context.

Sexuality doesn't happen in a mutual playing field. Your choice about reproduction and family planning does not happen just between you and your husband or you and your partner. All these things happen with all kinds of influences and internalized problems that are the result of culture and our education. What a gender perspective tries to do is to bring all these factors in, in addition to the technical and medical expertise that you have.

Why is sexuality such a battleground? The areas of sexuality are the ones most legislated upon. It is not true that sexuality is a private, personal concern or behavior. In truth, it is too fully regulated--by religion, by cultural traditions, by law. We need to do away with the idea that it is a private matter and that we cannot confront issues of our sexuality. That is precisely one of the key reasons and basis for our current behavior on family planning and the whole issue of reproductive health.

Why are there unplanned pregnancies? Why are there abortions? Why are people not using contraceptives when these are already being made available? Maybe there are technical reasons why they are not using them. But maybe there are also other reasons that go beyond the technical and medical. This is where the gender perspective comes in.

What comes to mind when we say gender? Gender concerns are the results of history, of culture, of economic arrangements in society. The category of sex has to do with biological givens, chromosomes and hormones. But gender is determined by social, cultural and economic factors. Is this to say that the "male-female" concept is a real dichotomy? While it is true that

you have these two main physical categories, nature is never really very exact about these things.

It has been known that along this continuum, there are certain variations that have come up.

One of the more controversial issues in both the Cairo and Beijing conferences was the question of homosexuality; and although it is not necessarily a physical phenomenon, there are really some cultural refusal to accept anything except those two binary opposites called the male and the female. And we define them in very close and narrow ways.

Apart from this sex or gender categorization, what do we know about the status of women in the Philippines? Let us look at these statistics:

a) Of the 24.7 million employed persons in 1994, women make up only 36%.
b) Labor force participation for females in 1994 is only 47% compared to 82% for males.
c) In administrative and managerial positions, there is only one female for every two males.
d) Female-headed households comprise 11% of the total households in the country.
e) At both the elementary and secondary levels, females demonstrate higher drop-out rates thatn males.

These statistics show that with respect to the position of women in society, they are disadvantaged, less empowered and perhaps less supported in education.

When we talk about the status of women, we cannot help but talk about violence against women. I do not know if the medical field factors this in sufficiently. It appears from our work at the Women's Crisis Center and other organizations that have done medical and psychological interventions, that health workers are ill prepared to handle cases of violence. We have not really been educated or trained in school to *recognize* violence, to *raise* it as an issue and to *respond* to it appropriately. Violence against women (VAW) has become a very important theme internationally. At the United Nations level, it has already been declared as a very serious human right, development and health concern. Here in the Philippines, when we are talking of reproductive health and we are not raising the issues of violence, then we are missing a very significant and often hidden structure.

In a study we did among women in two urban communities, it was estimated that about 80% of the women in these communities will probably experience violence in the hands of their husbands or live-in partners. More often than not, this violence will occur as a case of wife beating when there is a demand for sex from the woman and it is refused for reasons of fatigue or fear of pregnancy. How can we talk about family planning or choices when there is violence operating from a partner?

Another issue of reproductive health and human rights that is not often seen, except as a public health concern, is the issue of prostitution. When you had earlier expressed some concerns about a young, single adolescent woman being promiscuous with the availability of contraceptives, I wanted to ask "What should we do so as not to encourage an attitude of promiscuity?". Are we just as worried about possibly 7 million men who regularly use women and children in prostitution? We don't hear of promiscuous men, but we're very worried about promiscuous women. If we are so concerned that our making available contraceptive technologies and services to women will

unleash a wave of promiscuity among women, we should take note that the wave of promiscuity is already out there; not with women but with men and their prostitution behavior. We've already done so much research about women in prostitution, and we know why they are there. But nobody seems to be just as interested in finding out why these 7 million men go to prostitution houses and pay for the services of a woman prostitute. Nobody's worried about *that* sexual behavior.

Indeed, it is a willing blindness on our part when we talk of reproductive health and look only at the women's sexual behavior and worry about it but refuse to see the men's sexual behavior that has long been a reality. We take notice of it only when we're worried about AIDS and STDs. At this point, I would like to cite the very discriminatory function of the social hygience clinics. While I know that there is a good intention behind these clinics, there is still something grossly discriminatory in obliging women to undergo treatment which is often not very gender-sensitive, in the first place, in order for them to get a "clean bill of health" for their male clients when no one is making sure that their clients are at all "healthy". What we are doing in fact with these social hygience clinics is ensuring the supply of disease-free women to be used. And this is a discriminatory practice because no one is ensuring for the women that they will have a disease-free male client. Hence, we have some programs in place that do not examine the gender implications and perspectives of such programs.

Some of us have earlier commented, perhaps in frustration, why there are still women who have unplanned pregnancies, or who have abortions when there is already so much information and contraceptive services being made available to them. I think the answer to this is the issue of disempowerment. A woman in prostitution, for example, has no control over who her client will be, or what her client will want her to do. She has no control over her life, why do you expect her to have control over her reproductive system?

The entire issue of whether women will make decisions about their fertility is interrelated with how much decision-making possibilities they have over other aspects of their lives. If you are disempowered in other ways, you cannot be empowered in your sexuality. I think that this is one of the insights that we have to understand. To be able to decide about your body is totally connected with your status.

And whose body is it anyway? Do you think that it is yours? The answer is no. Your body, in fact, is a site of ideological struggle. Early on, girls and women are told by their parents, by the church, by society in general, what kind of sexual activity they can have and when they can engage in it. Everybody else is determining the use of their bodies. I think that the concept that women own their bodies and own their sexuality is something we have to question. It is difficult to make choices and decisions about our bodies because we do not own them one hundred percent. There are so many prescriptions about our bodies, not the least of which is what shape it has to be. Indeed, there are many deep, difficult and complex issues totally related to reproductive health and to decision-making on reproduction and on pregnancy. Unless we start thinking about that, and if we only think in medical and technical terms, then we will miss out on a lot of other determinants.

There is a lot more acceptance of contraceptive use among women in more developed countries because there are also a lot more areas of control for women in those countries. At least in these countries where women have more economic possibilities, dependence on families, husbands and partners is lessened. Of course, economic independence is not the sole consideration

but it is certainly an important determinant.

What kind of health services, then, will be gender-sensitive? If you only focus on maternal and child health and pregnancy-related issues, you will certainly miss out on a more holistic view. What about being conscious of the sexual abuse of children? Very often, health workers are not conscious of them. I think that it is important to institute ways to have dialogues with women that would be meaningful to them; dialogues that would help you as health workers to understand the situation that they are in, and to attempt to help them exercise more control over their lives.

We also have to remember that information is not enough. Even the service is not enough. We have to address the issue of women empowerment, of enabling women to act on what they know. When women talk of women's rights and women's issues, it is not so much equality that we are after. I think the goal is transformation. There is so much that needs transforming. It is not enough that we be equal with men. In what areas should we be equals in the first place? There is too much in behavior, in values that require a deeper transformation. The equal opportunities and equal rights approach, I think, is no longer satisfactory, if it ever was. There is so much that needs transforming in gender relations, in social structures, and even in economic arrangements of societies and nations. Equality is just not good enough anymore. You really need a transformative view, and the kind of work that we do in women's groups--consciousness-raising, human rights education and advocacy--we hope, will allow women to evolve a sense of "self" and a vision of society that will lead us somewhere fruitful.

There are already some programs that attempt to integrate men. These should be supported and continued since they offer a start and a possibility for arriving at this transformed gender relation that we are all hoping for.

INFORMATION-BASED PLANNING AND DECISION-MAKING/ RESEARCH DISSEMINATION AND UTILIZATION

Alejandro Herrin, Ph.D.
UP School of Economics

I. Brief Description of a Framework about the Relationships of the Services Delivery System and of the FP and RH Outcomes

Talking about a basic framework will help us understand the key relationships between the inputs (the service delivery system) and the outputs (the FP and RH outcomes). Normally, one looks at the relationship from the input to the output direction. But one can look at it in the reverse direction, particularly in this case, from the FP and RH outcomes to the service delivery system. The question that we raise here is "What are the determinants of the FP and RH outcomes?"

II. Identification of Major Decison Areas in Planning and Implementation

With this conceptual framework, there are six major decision areas in planning and implementation that can be identified. These are the following :

1. Objectives and priorities

Since the FP and RH program will take a new direction, we expect that there will be changes in the objectives and priorities of the program. Decision makers will then be faced with problems of defining new objectives and attaching priority values to each objective. They will also decide on what objectives they will pursue given the limited resources they have.

2. The service structure

Given that the range of objectives has been expanded, the decision makers have to decide on what services will be provided by the program. They will also need to see to it that the supply of services they had put in place is adequate to achieve those multiple objectives. The supply of services is in turn determined by the kinds and combinations of inputs.

3. The focus

Now that they have decided on what services to provide, the next step is to define the focus of the services. Are they to serve anybody or just a specific group? Who will be the beneficiaries of the program?

With the direction FP and RH would be taking, there will be new sets of focus like mothers for the Safe Motherhood Program and adolescents for safe sex and understanding of human

sexuality. New roles and responsibilities in FP and RH of men will be defined. Mothers will be treated as women with health rights.

4. The service utilization

Here, the decision makers will investigate the impact indicators of the program. How are the services being utilized? In what form? Are the services relevant? Problems of unmet needs, lack of quality service and inappropriate utilization usually are identified and addressed at this stage. Several kinds of services can be combined to efficiently achieve the objectives and produce the outcomes with the least cost.

5. The management of inputs

This refers to the logistics, handling of personnel, use of a management information system (MIS) and the mobilization of local resources.

6. The entire service delivery system

This refers to the organization of service delivery, within and outside one's locality. At this level, the decision makers have to identify those agencies that can cater to the needs of the paying population so that they can concentrate local resources to those who cannot afford the services. Also, they have to coordinate with the other systems within and outside their locality.

III. Development of an Information System

How do we make decisions? We make decisions from research-based information and not from hearsays. We need to develop an information system that will help us know what services are being provided and which of these services are actually producing an impact.

The first piece of information can easily be obtained from an inventory of services that are being provided. Many of the available data on the latter concern are, however, based on the national survey which reflects little about the locality. Thus, there is a need for an alternative method of approximating measures of impact. Of the research types, operations research (OR) is preferred because it deals directly with our service delivery system.

IV. Strengthening the Coordination of Delivery Systems

With devolution, there is a need to coordinate with the other service agencies, both in the public and private sectors. The previously mentioned major areas in decision-making could also be areas of coordination.

V. Research Dissemination and Utilization

What is it that we should disseminate? We need to disseminate the results of our research studies to validate and to add to the existing larger body of knowledge.

Why should we disseminate? Decision makers need to be informed of which kinds of options would likely succeed.

To whom should we disseminate? To decision makers, implementors, individual and community beneficiaries, and sponsors of the program.

How will we disseminate? Thru meetings with key persons, holding seminars, through publications.

How often do we disseminate? Research results have to be disseminated immediately after finishing the reasearch to add to the existing pool of information. Overall information with modifications from research results can be reported annually.

THE ROLE OF OPERATIONS RESEARCH IN THE LGU PERFORMANCE PROGRAM (LPP)

Jose Rodriguez, M.D.
Management Sciences for Health

I. The Local Government Unit Performance Program (LPP)

The LPP is a component of the USAID-assisted Integrated Family Planning and Maternal Health Program. It is the Department of Health's response to the challenge posed by the devolution of health services to local government implementation.

The LPP provides results-based financial and technical assistance to local government units (LGUs). LGU assistance is provided by supplementing funds for population, FP and child survival programs. Funds are released through a performance-based mechanism. Technical assistance, on the other hand, is provided to local-level program managers in the areas of program planning, logistics, IEC, training, operations research, management information system and general program management.

The LPP is being implemented in phases:

* 1994 : 20 LGUs
* 1995 : additional 10 LGUs
* 1996 : 18 more expected to be enrolled
* 1999 : total of 75 LGUs would have been reached

The LPP serves as an impetus for promoting operations research (OR) given the existence of grants, availability of technical assistance, focus on results and local-level decision making and the wide range of areas for technical assistance.

II. Suggested Areas for Operations Research

Given the thrusts and activities of the LPP, operations research (OR) studies could be undertaken in the following areas:

* Program planning
* IEC
* Quality of care
* Development of Urban-focused strategies
* Management Information Systems

* Clarifying LGU Relationships
* Operationalizing the Integration of Services
* Community Involvement
* Training

OPEN FORUM

This question is directed to Cecil Hoffman. I really admire the way you explained how the low status of women underlies the poor utilization of family planning. You even mentioned some suggestions for solving these problems, like transforming gender relations and lessening the economic dependence of women on men. But how do you think can we design an OR study with women empowerment as a program variable? Can that variable be manipulated? Do you think this is possible?

I must admit to you that I'm not someone who has worked in your sector. My area of expertise actually is violence against women. I was mentioning earlier to Dr. Marilou Costello that community-based responses have proved quite useful in deloading government agencies like DSWD and the police and also NGOs. From our experiences in Cebu and Metro Manila, those women who have approached the same agencies or are at the same stage in counselling were brought together to form a local support group that can carry out some of the counselling work. This support group-building is an empowering self-help effort at the community level.

Another component that happened in Cebu was that the local officials were informed and involved in the trainings. This could also be a community approach to integrate the activities of these agencies. However, I do not know if looking into these types of modules would provide ideas for similar pilot efforts to work on RH issues.

- Cecil Hoffman
WEDPRO

You are raising a methodological issue here. Actually, it depends on the design of the study you wish to make. I see that we are trying to define what an "empowered woman" is. Attendance to a counselling session might be one variable for comparison. It really depends on the study design, whether it is experimental or retrospective or observational.

- Dr. Alejandro Herrin
UP School of Economics

Maybe there is a dichotomous scale of low and high ratings that you can use to measure empowerment of women. From there, you can make comparisons.

- Dr. Jose Rodriguez
Management Sciences for Health

In some of my field visits, I came to know from the service providers that there were some women who had asked for pregnancy-related counselling and were found to be victims of violence. How did these service providers handle such cases, and how were they able to recognize that these women were victims of violence?

I would like to mention a project that resulted from a working group about two years ago, which recognized that the medical profession is in fact not prepared in its training to handle issues of violence against women. There is a pilot project which was started in Metro Manila with great difficulty and resistance on the part of the director of East Avenue Medical Hospital. This is a project that would house within EAMH a service desk for victims of violence against women to be managed by the Women's Crisis Center in Manila. The DOH promised to give us space on the 8th floor of EAMH for this project. However, EAMH later said that they needed the 8th floor for their hospital. As a result, we were transfered to a less desirable part of the hospital. Funds also became scarce.

I relate this to drive home the point that it is a slow process of realization, and that even the usefulness of such a joint effort is not yet fully recognized. There is insufficient understanding among medical practitioners that violence against women is a health concern. I think that our project with EAMH is now slowly getting off the ground, but not without tremendous struggle. This just goes to show that the consciousness is not yet there probably because there is no pressure from below, in the field, to integrate issues of violence with community health.

We all weren't born gender sensitive. In particular, the medical professionals' attitude and behavior towards prostitution and related works are sometimes discriminating, insensitive and punitive. We have stories of women in Olongapo who had abortions and who were made to wait and bleed for hours in the corridor before they were attended to. I think this gender sensitivity is sometimes difficult to bring out as a problem area. We have religious or moral abhorance to it without really understanding the phenomenon. We should really reflect what the realities are out there. Otherwise, you do a lot of remedial work without being able to address the very simple issues which are central to the status of women, gender issues and the whole social order.

- Cecil Hoffman
WEDPRO

Speaking as a male, I don't think men plan to treat their wives violently. Very often, it happens when they had too much to drink. And if you look at this society, there really are a lot of cultural forces that encourage overconsumption of alcohol, including those San Miguel advertisements. I wonder if the DOH really has an interest in addressing the issue of alcohol or substance abuse education and also of counselling people, especially men with drinking problems.

- Dr. Michael Costello
RIMCU, Xavier University

The usual explanation to all these sexual crimes we read in the papers is that they're on drugs. But we know that there are also men and women who take drugs and/or drink but are not carrying out sexual crimes. Alcohol and drug abuse clearly release inhibitions. They are contributory factors. However, there is also the factor of socialization. I would not want to put the entire

responsibility on alcohol and drugs because there is something even more basic to the issue of violence against women.

- Cecil Hoffman
WEDPRO

Are there studies about the men who engage the services of prostitutes?

May I just affirm what a large research gap that really is. If we are looking at FP and RH, we're just looking at part of the whole picture. It just reminds me of a research done by a very illustrious academic husband and wife pair on prostitution. It was a good study with lots of tables on where the women came from, at what age they had their first sexual intercourse, etc. However, there was not a single table on who their clients were. I would have asked who were the men and what their professions are. How frequent do they come? Are they drunk when they come? What sexual practices do they want? I think even in the academe, there are set issues. Very often they are only half of the issues.

May I just add one more comment? We also have to recognize the tremendous pressure on men to conform to a male norm. I hope I will not be misunderstood as male-blaming because their behaviors are blameable. But why men have been so socialized and what pressures have been brought on them for them to behave in such ways are just very difficult to explain.

- Cecil Hoffman
WEDPRO

What we have heard so far are ideas from members of the academe. How about hearing from our program managers?

Actually, I just want to be clarified on what constitutes prostitution. To me, prostitution is part and parcel of society. It dates back to biblical times. And it is not only poverty that drives women to prostitution because there are even high-income members of society who engage in prostitution. There are women who are not prostitutes categorically but are simply liberated and open about sex. In the urban cities of Dagupan, it has been observed that prostitutes may be the sources of sexually transmitted diseases since they are not subjected to medical inspection in the social hygiene clinic. This does not solely apply to women. This is also true among men.
Sexually promiscuous men also engage in prostitution. Our Filipino culture of machismo also dictates that it is all right for men not to be content with a single partner. I speak in behalf of the male group.

- Fred Cubil
Iloilo province

May I just say that it is very interesting that, in behalf of the male group, you want to say that prostitution was and will always be here. But if we had that attitude, that something which

existed way back is an indication of validity, then we will restore things like slavery, which most of us would not want to restore. In our framework, prostitution is a human rights violation of all women. It is not about women in prostitution. It is about the value of all women in general. If there is one woman in prostitution, the message is that any woman might be a public woman to be used by men. Why is women sexuality such a commodity?

Our framework is that prostitution is made up of three elements: the business, the buyer and the one being bought. Sexual exploitation is a global mainstream industry. WHO reported in 1988 that the users of prostitutes are much more numerous than the prostitutes themselves. However, the reasons and motivation for their behaviors are not known. The ones who are "bought" are girls, women and children in prostitution. They are the mere raw materials for the industry. If they don't walk in of their own accord into the bars and clubs, they are kidnapped, confined and tricked into prostitution. Why is this so? This is necessary to ensure a good supply of women. Prostitution for us is not women. It is a large scale business. Thailand, for instance, wants to include prostitution in their national accounting since it is a relatively profitable business. For us who work in this concern, it is mind-boggling. Pornography in the United States earns one billion dollars annually, so there is a huge stake in the commercialization of sexuality in all its forms. To reduce prostitution to some deviant women is very reductionist. Women is only one and probably the smallest element in the whole issue of prostitution.

- Cecil Hoffman
WEDPRO

With regards to prostitution, are we not concerned with its consequences and the need for FP referral? I think it is important to define who the prostitutes are. Are unfaithful women considered prostitutes because they have high risk behaviors? I think we need to have a workable definition of what constitutes the population at risk. What are the operational problems that need intervention of FP managers and researchers? There is also confusion regarding the expansion of FP into RH in crisis centers, for example. How can the FP program help women in crisis?

I really think that there is a great potential for responses to our concerns in violence in the medical profession and the health providers. Please don't construe my remarks to be only critical. In fact I think it is very promising with its future reorientation. I would like to set that straight.

- Cecil Hoffman
WEDPRO

You really have to decide on what really is the service focus. With all these happening around us, the ultimate implementing unit is the LGU. Are our LGUs receptive to change? Do these problems on women have an effect on the outcome of the demographic variables in our locality? Will there really be an impact on economic development? Can economic independence be directly related to a reduction in the fertility rate of that particular woman? Hence, within the context of Dr. Herrin's lecture, the service focus, whether it be a priority or an outcome, is really for the LGUs to decide.

- Dr. Marilou Costello
Population Council

SYNTHESIS OF THE PRESENTATION OF LGU PLANS

Alejandro Herrin
UP School of Economics

I. Common and Distinguishing Elements

Outcomes: usual outcomes of fertilty, population growth; more specific outcomes in terms of adolescent fertility (Baguio), STDs and perinatal mortality (Davao)

Utilization: continuing unmet needs. Determinants include side effects and husband objections (Pangasinan) or lack of information, norms and religious beliefs (Nueva Ecija). The side effect issue can be related to reproductive health concerns, while the husband objection factor requires addressing the role of gender in household decision-making.

Services: In addition to the main FP services, certain elements have been emphasized in the LGU strategies. These include:

* *expansion of VSS* (Nueva Ecija, Cagayan de Oro). There is an opportunity here to introduce gender concerns: why is VSS mainly participated by women (ligation); how do we make men participate more (vasectomy)?

* *provision of adolescent fertility services* (Baguio, Cebu, Davao). What is the content of these services? In Cebu, the youth will be used as advocates and counsellors. Both reproductive health and gender concerns can readily be incorporated here. Research leads: how effective are youth as advocates and counsellors? What is the impact on service utilization and adolescent fertility outcomes?

* *provision of natural family planning services* (Cagayan de Oro, Cebu). In Cagayan, regular service providers will provide information on how to use FP; in Cebu, volunteer health workers will be used to disseminate information. Possible research: which type of personnel would be in the best position to teach and provide information on NFP to what type of client?

* *advocacy*. In addition to traditional approaches, the use of youth as advocates (Cebu) to particularly focus on adolescents, and the use of satisfied users (Iloilo province) as advocates to increase acceptance. Research leads: how effective are youth compared to alternatives as advocates? What is the impact on utilization outcomes? How effective are satisfied users as advocates compared to alternative advocates? What is the impact on utilization and outcomes?

* *counselling* services (Albay) and counselling by the youth (Cebu)

* *IEC.* In addition to the traditional modes, to use community health workers trained in interpersonal communication (Davao)

Service Inputs: In addition to the usual inputs of manpower, facilities, IEC materials and even travelling allowances, the major required inputs are the trained manpower capable of delivering the new or expanded services: VSS, NFP, adolescent fertility services, IEC by community health workers, counselling and advocacy.

Management and Operations: Usual concerns with logistics, supervision, development and maintenance of reporting system, database and analysis. There are also concerns regarding personnel management and incentives (Bukidnon), and delay of LPP funds (due to usual bureaucratic procedures for which little might be done). Some research leads: which type of logistics system works better than others? what is the impact of the Magna Carta for Workers on worker morale, quality of service and cost of government provision of services?

Organization/Coordination: The need for better coordination was raised: coordination with the church (Albay); coordination among LGUs (Iloilo City, Bukidnon); coordination with NGOs (Bukidnon, Davao). Research leads: how is coordination operationalized? What are different ways of coordination? Retrospectively, which methods work better than others? Prospectively, which one will work better than others? What are the outcomes of better coordination and how are these measured? For example, better coordination within LGU, e.g., coordination between program and the executive and legislators could lead to either more funding for the program, or quicker release of funds.

II. Expansion of the Basic Framework to Incorporate the Production of New Inputs (e.g., trained manpower needed by the new services)

A majority activity in all the LGU plans is training, particularly for the delivery of new services, e.g., VSS, NFP, adolescent fertility services, counselling, advocacy and IEC. One could consider a production process whereby trained manpower is the output which is produced by a combination of various **inputs** in training: trainors (availability and adequacy), training materials (appropriateness, adequacy in light of new concerns related to reproductive health and gender sensitivity); curriculum (ability to incorporate new concerns); various training modes (short vs. long term, use of roving trainors, correspondence). Research leads: what are the different ways of training for a particular skill? Which of these is the most effective (produces the required trained manpower) and most efficient (least cost in producing the desired manpower)?

In addition to having the appropriate inputs, there is also a need for effective **management** of these inputs to produce the desired outputs. These management and operations issues include participant selection issues, appropriateness of venues, timely release of funds, etc.

III. Some Research Questions

How does one start thinking about research? One could start with the problems that are perceived to be related to the new initiatives. If there is a problem, then a solution must be found. If there is still no solution, what information is needed to arrive at a solution or alternative solution? This is a broad area for research. Secondly, if there is already a solution in hand, will the solution work? How effective and efficient would it be? This is a second area for research (more evaluative in nature).

Some research questions include the following:

* Effectiveness of alternative logistics system

* Effectiveness of training programs for new skills (in VSS, in NFP, in adolescent fertility management, in advocacy and counselling), and impact on service utilization, and on outcomes

* What is the best way to incorporate reproductive health and gender perspective in training programs? What is the impact of such training on service quality, and later on service utilization?

* What components comprise adolescent fertility services? Which of these components are effective in achieving adolescent fertility objectives?

* What is the best way to train people to use NFP effectively? Who is the best person to train them? What kind of training should this person receive? What other inputs are needed to train people to use NFP? Since the training of people to use NFP effectively is time and labor intensive, how does this activity affect other activities of the delivery system without adding new manpower?

OPEN FORUM

For the Cagayan de Oro team, would you say that your high growth rate of 4.1% could be due either to the high percentage of NFP acceptors with low literacy level or to in-migration?

The high growth rate is basically due to the high in-migration rate in Cagayan de Oro City.

For the Iloilo Province team, is it feasible to train FP users to promote the program?

I think it is feasible because we have already alloted a budget for that in the LPP for 1996.

For the Cebu City team, if this is your second year with the LPP, why will there be another LGE orientation?

We weren't able to conduct an LGE orientation during our first year, so we're planning to have it this coming year.

For the Cagayan de Oro group, NFP is good only for empowered women, for harmoniously related couples and for educated women. Considering this premise, is it a cost-effective and good FP strategy?

Since our goal in FP is to give the clients a wide range of FP methods, we are improving NFP for those who want to use NFP. Although it may not be cost-effective, at least we are providing an option to clients who cannot use artificial methods for religious or moral reasons.

I don't think NFP is good only for empowered women. In a survey done in Cagayan de Oro City, it has been observed that NFP is highly accepted by families and by the Church. It's very cost-effective. What we propose to do is to enhance knowledge on the female reproductive system so that they will understand why they have to abstain from sex in certain weeks of their menstrual cycle.

I have always been concerned about the situational analysis that is being conducted under the LPP. I don't know exactly what process went through when the LPP team went and worked with you. Apparently, some of your initiatives were based on the situationer. And so I am not sure if there was any attempt at all to check on the accuracy and validity of the data upon which you based your plans. I carry this concern to the LPP program and at the same time caution you that next time when you do your SA, try to call the attention of LPP to make sure that there is some kind of technical assistance that has to be provided to you. Your resource persons were precisely selected for you to contact them during this time of the year when you will be doing your SA.

- Dr. Marilou Costello
The Population Council

We do receive technical assistance from the LPP technical advisers. When we do our SA, we make use of data that is available to us. We are advised to use data from local surveys because they are more reliable. But in the absence of a local survey, we use the set of data we gathered through FSHIS, area cluster surveys and the National Census Board.

- Ms. Luz Muego
Pangasinan

This question pertains to the guidelines on how we are going to present our LGU reports. Most of us were only informed yesterday that we are to include RH issues and gender concerns in our comprehensive survey for 1996. I think we should be given more time and further orientation on issues like these before we could incorporate them in our plans. The problem is not whether to include these issues or not. The problem is that we are not very much oriented on these issues.

The problem seems to be the slow release of funds. I think it was the Iloilo team who brought up this issue last night. They had to drop their plans for research because the Sanggunian members are not too keen on putting up resources for research. So I'd like to raise that question to Dr. Lopez. Isn't it that the LPP fund is an augmentation fund? I was wondering if they have some built-in mechanism for ensuring that the release of these funds wouldn't be hindered by bureaucratic requirements and procedures.

- Dr. Marilou Costello
The Population Council

How can we solve the delay of release of grant money?

I think we have been talking about that since the LPP started. But we always find ourselves trapped by the bureaucratic "red tape" if funds are channeled through the city or provincial agencies. There is nothing we can do about it.

- Mary Edurese
Iloilo City

It will really go through the accounting rules of the LGU. But the time can be shortened. Of course, this is on a case-to-case basis. I think this is more a function of the management or leadership of those who are responsible in handling disbursements. We in Pangasinan do not encounter such problems. I suggest that you assign someone who knows the ins and outs of the procedure.

- Ms. Luz Muego
Pangasinan

INTRODUCTION TO OPERATIONS RESEARCH

Marilou Palabrica-Costello, Ph.D.
The Population Council, Manila

A. What is Operations Research?

Operations research (OR) is essentially similar to such other concepts as "applied research" or "programmatic research". It is a "way of identifying and solving program problems" (Fischer, et al.). It can be described as a "problem-solving activity" (Carpenter) or "decision-making research" (Stoeckel).

OR finds ways to improve family planning services through systematic research and management tecniques. It aims to diagnose problems in FP service delivery and to provide ways to correct such problems.

OR is a practical methodology which aims to solve problems of day to day operations encountered by program managers. It is the program managers, therefore, and not the researchers, who should set up the research agenda. The objective of OR is not necessarily to come up with a very sophisticated theory of human behavior or to use the most advanced statistical methods (although there is no reason why one cannot do that) but to find practical solutions to problems that serve as obstacles to effective service delivery.

We can note as well that OR is a continuous process consisting of five basic steps, namely:

1. Problem identification and diagnosis
2. Strategy selection
3. Strategy experimentation/evaluation
4. Information dissemination
5. Information utilization

It is vitally important that each step in the process be carried through to its full conclusion, and that the program managers be consulted at each step. In some cases, the program manager can play an even larger role; that of directing the study itself.

So many social science studies only get as far as carrying out the study, perhaps with a weak effort at research dissemination thrown in at the end. But if OR is to be truly a "decision-making research", then it must be brought to the attention of program managers and its findings must be used by them. This will require continuous consultations and follow-ups after the study proper has been completed.

B. How can OR be of help to program managers?

In order to answer this question, we must understand what OR can and cannot do.

We have said that OR is "decision-making" research. This means that it must focus specifically upon those factors that the program manager has some control over (factors that he can make a decision about). It is also undertaken on the basis of program needs and the local context and situation.

If someone, therefore, proposes to conduct a survey of attitudes toward FP in the general public, this will typically not be a good example of OR. Why? Because except for IEC, there is not much more that the program manager can do about such attitudes. Another way of saying this is that OR is largely "supply side" research. The emphasis is on program factors rather than social/economic factors that affect the demand for FP.

There are six general areas that OR tends to focus on:

1. Clinic and research activities
2. Supervision
3. Management activities (e.g. MIS)
4. Training
5. Logistics
6. IEC

In the Philippine FPORT program, we have conducted studies dealing with several of these areas. To wit:

1. Evaluation of DOH training program in CAR and Region II
2. Quality of care in clinic services in Bukidnon (as it affects FP drop-out rates)
3. Effectiveness of outreach workers in Iloilo and Regions XI and XII
4. DMPA monitoring study used for logistics planning

C. What are the different types of OR studies?

Four types of operations research will be discussed: a) exploratory/diagnostic; b) field intervention; c) evaluative and d) situational analysis. There are in fact only three basic types of OR--exploratory/diagnostic, intervention and evaluative--since these serve different purposes. Situational analysis is a specific methodological tool which can be used to gather data for any or all of the three other types.

1. Exploratory/Diagnostic Studies

This type of OR study aims to identify the factors which, if properly manipulated, would improve service provision. It usually employs a cross-sectional design and may use qualitative or quantitative research methodologies. It is conducted for a relatively brief duration of 4-7 months.

2. Field Intervention Studies

The purpose of field intervention studies is to test, on an experimental basis, new approaches to solving an operational problem. It is often based upon findings from a previous diagnostic study. The research design can be experimental or quasi-experimental. As such, data collection and analysis is longitudinal and quantitative in nature. Field intervention studies take longer to implement and are therefore more expensive.

3. Evaluative Studies

Evaluative studies assess the effectivity and impact of on-going program activities. They usually employ a cross-sectional or retrospective design.

4. Situational Analysis

Situational analysis is used for various practical objectives such as:

- To describe the availability, functioning and quality of FP activities in a sample of service delivery points.
- To analyze relationships involving such activities
- To evaluate program impact

Situational analysis uses key indicators to analyze various program subsystems. Standard data collection instruments are used. It involves research teams composed of at least one social scientist and one researcher with clinical training to conduct data collection.

D. Are there special methodologies for OR?

OR does not really require any special research methodologies. Although situational analysis may be considered a "special" methodology in that it was specifically designed and developed for collecting information on FP program operations and service delivery, it is certainly not a required methodology for an OR study.

OR studies can use either quantitative or qualitative techniques, or both, for data collection and analysis. Our DMPA study used both surveys and focus group discussions.

OR studies have been perceived to be the "quick and dirty" type of research, as opposed to the time-consuming, carefully conducted studies like the National Dempgraphic Survey (NDS). While it is true that we do need to carry out OR projects in a relatively short period of time (because program managers cannot wait), it is nonetheless important to be rigorous and accurate in our measurements. This can be possible if we focus on relatively small-scale, manageable problems affecting one component of the program.

Operations research could be contrasted to basic research which tries to test theories about human behaviour or which might be undertaken solely because of the researcher's curiosity.

PROBLEM IDENTIFICATION, DEFINITION AND JUSTIFICATION

Zelda Zablan, Ph.D.
UP Population Institute

A. Introduction

What is a researchable problem? How do we identify, define and justify a research problem?

All research is set in motion by the existence of a problem. A problem is something that you are uncomfortable with in your work situations.

Operations research is a way of identifying and solving program problems. A potential research situation arises when three conditions exist, to wit:

1. There is a perceived discrepancy between what is versus what should be. This leads to the formulation of a deviation statement.

2. There is a question about why the discrepancy exists.

3. There are at least two possible and plausible answers to the question.

What is usually our basis for our deviation statement?

The deviation statement is usually based on the results of last year's plans. In your plan, you have an overall objective which is oftentimes broken into specific objectives by program components. These program components are the following : financial management, operations management, logistics, personnel training, IEC, record keeping, planning and evaluation. You also have to realize that there is a hierarchy of objectives. If you have a higher objective, then you as a program manager would like to know the things that you can manipulate in order to achieve your objectives.

B. Problem Identification and Definition

How do we identify and define a research problem?

First, we have to make a simple statement of the problem situation. We add details from a review of literature and investigate the problem in greater depth. Then we focus on the most important aspects of the problem that are researchable. If there is only one possible and plausible answer to the question about the discrepancy, a research question does not exist.

We have a suggested format for problem identification and definition. The problem situation

is usually a short and simple paragraph that identifies the problem. The deviation statement usually states the discrepancy between "what is" and "what should be". With these, you are now able to write the central problem question. A research question must have at least two plausible answers; otherwise, there is nothing to be researched on. In your handout, as an example, none of the FP clients continued using the same method because of lack of supplies. This is not a researchable problem since there is just one explanation to the non-continuance of FP use. But a question like, "Why didn't the supplies come?" could be a researchable area because there could be several answers to this question. Therefore, even in problem identification, definition and justification, we already need to have possible answers that are hypotheses or guesses as to what might be the reasons to explain the discrepancy.

The next thing to do is to add details to the problem statement. These details will come from theoretical concepts and operational definition of variables which will provide answers to the following questions:

1. What is the incidence and prevalence of the problem?
2. What geographic areas are affected by the problem?
3. What population groups are affected by the problem?
4. What are the findings of other research studies?
5. What has been done to overcome the problem in the past?
6. What are the types of solutions tried?
7. What approaches to the problem have worked or not worked?
8. What are the major unanswered questions about the problem?
9. What aspects of the problem need to be researched further?

In answering all of these questions, you should be clear and specific about the researchable aspects of the problem.

C. Problem Justification

After identifying and defining the problem, we need to justify why we are investigating this particular problem. To justify a research problem, try to answer the following:

1. Is the problem a current and timely one?
2. Does it exist now?
3. How widespread is the problem?
4. Are many areas and people affected by the problem?
5. Does the problem affect special groups like mothers and children?
6. Does the problem relate to on-going program activities?
7. Does the problem relate to broad socio-economic and health issues?
8. Who else is concerned about the problem?
9. Are top government officials and medical doctors concerned with the problem?

D. Strategy Selection

When you already have a justification for your research problem, you then want to test

solutions to your problem. Using the Quality of Care framework, a range of potential strategies for solving the problems was formulated. They are:

1. Broaden the range of contraceptive methods available.
2. Provide clear and specific information to the clients.
3. Improve technical competence of service providers.
4. Enhance quality and quantity of client-provider interpersonal relations.
5. Promote continuity of contraceptive use.
6. Provide appropraite constellation of services.

E. How to Select a Strategy to Test

1. Identify potential strategies to solve the problem.
2. Indicate the most appropriate potential strategies to solve the program problem.
3. Identify your selection of one or two potential strategies by indicating:

    a. Past success with applying the strategy to a similar problem situation
    b. Simplicity of implementing the strategy over other strategies
    c. Potential for sustaining the stategy once OR study is completed

F. Guidelines for Selecting an Appropriate Strategy to Test

1. Review strategies used by other people in solving similar program problems.
2. Hold a meeting with people most affected by or most concerned with the problem, like program managers and service providers.
3. Identify strategies that can be implemented without overburdening the implementing institution.
4. Select strategies that can be sustained over time.
5. Seek strategies that are simple to implement.
6. Develop strategies where proposed solution is under the control of the program manager.
7. Avoid strategies where field test cost is higher than expected benefits.
8. Avoid strategies that are not consistent with the implementing institution's goals, objectives and developmental plans.

OPERATIONS RESEARCH CONSIDERATIONS ON QUALITY OF CARE

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We will try to answer three questions about "quality of care".

A. How did it get started?

In the 1970s, family planning programs were premised on the rationale of slowing population growth. The book "Population Boom" stated that the population of the world was growing too fast and that we had to control it by setting targets and averting more births. Things have turned around since then. Nowadays, we are no longer so eager in target setting. Rather, the focus now is more on health and the needs and reproductive goals of an individual woman. There has been a shift of emphasis from quantity to quality. The rationale of family planning programs now is less on target-setting and more on the quality of care.

B. What is quality of care?

Anrudh Jain defines "quality of care" as the way individuals and clients are treated by the system providing services. Lapham and Simmons considers it as an extent to which clients feel they have established a reliable relationship with a trusted provider and have achieved a substantial measure of safe, effective and comfortable control over their reproductive capacity. Some of the key words in this definition are "reliable relationship" which implies building a relationship by continuous visits, and "control" which infers empowerment.

Avedis Donabedian said that "quality of care" involves at least two dimensions, which are technical/clinical and subjective interpersonal. With the former dimension, we are interested with the competence of our service providers, while with the latter, we are interested in knowing how satisfied the clients are with the services offered to them.

Judith Bruce's definition of "quality of care" is the most familiar to us. Her idea stemmed from Donabedian's definition of the term. She said that "quality of care" consists of six main elements which are:

1. Choice of methods

It can be inferred that:

a. The decision to use a method is voluntary.
b. There should be a wide range of FP methods to choose from.

In our earlier discussions, the natural family planning (NFP) method was brought up. From a technical point of view, one might say that NFP is not effective because it has a high probability of method failure. Nonetheless, as many had pointed out, it could be good to the program as a whole because another method which is attractive to many women has been added. Thus, the probability that more women become acceptors of FP will be increased.

c. It should be an informed choice.

This implies that service providers are to put extra time and effort in explaining these methods to the clients.

2. Information given to the clients

Judith Bruce involves a number of dimensions that clients need to be informed about. Some of these are the method's side effects, contraindications, how to use it and follow-up instructions. Of course, there is the problem of misinformation. The service providers should use the interviewer counselling situation as a chance to overcome this misinformation. Various studies have shown that clients and even service providers do not necessarily have good information about FP.

3. Technical competence

We go back to the first dimension of Donabedian's definition. Does the provider, for instance, really know how to insert an IUD ? Does the provider follow protocols on cleanliness? In Bangladesh, it was found out, that more than half of the time, clinical personnel who insert IUD do not wash their hands.

4. Interpersonal relations

This is the human side of the picture. Does the client feel she can voice out all her doubts and fears? Do the providers care for her? This can be realized effectively by training and probably by hiring personnel with considerations on gender and education. There can be a communication gap between a male service provider and a female client or between a very highly educated female provider and a poorly educated farmer's wife.

5. Continuity and follow-up

We are not just aiming for a higher acceptor rate. What we are after is the provider's assistance to a woman who, for example, had experienced side effects. We expect that the SP

will either reassure the client and make her continue using the method or provide another method. The SPs should follow up their clients. In Bukidnon, previous studies have shown that a lot of outreach persons just sit in the clinics. They are not reaching out to the community and are not doing follow-ups on their clients.

6. Appropriate constellation of services

Are you broadening the FP program to bring in concerns on RH, gender relations, STDs, and RTIs? You might say that all these are just nice to know since implementing them can be very expensive and time-consuming. However, Anrudh Jain argued that "quality of care" can be cost-effective. You might have a slight decline in your new acceptors but you are doing a real good job in cutting on your drop-out rate because of follow-ups and close relations. So, in terms of your ultimate program impact it could still be very good.

There is an important connection between the FP services and their use. Originally, the talk is that we have to make services available and accessible. But, how come clients are not coming in despite the fact that services are available and accessible in barangay health stations? There must be another element.

C. Why is it important?

To answer this question, there is this article by Simmons and Simmons which gives us ideas on how to improve quality of care. They are:

1. Generate top-management commitment

Efforts should be made to encourage program managers to go out and show concern to their people. This will go a long way towards improving relations with clients and the over-all quality of care and services offered.

2. Stay close to the client

This has a big potential for OR study. You will be taking the "user's perspective" and will be focusing on the needs of your clients. A marketing survey or FGD can be done to facilitate this.

3. Consider service providers and field workers as program heroes

Midwives are the frontline workers. They are the cornerstone of your program. Find ways to keep them happy.

4. Measure quality

Go back to your management information system. If you are still collecting data about acceptors and your providers' ability to provide acceptors to the program, then you are still after quantity and not quality of care. A book published by the Management Sciences for Health contains some specific indicators of quality of care that can be put in your MIS. I copied down six which are meant to indicate the six elements according to Judith Bruce:

For method choice - number of contraceptive methods available at a specific SDP
For information given to the clients - % of counselling sessions with new acceptors in which provider discusses all methods
For technical competence - % of client visits during which provider demonstrates skill at clinical procedures, including asepsis
For interpersonal relations - % of clients reporting "sufficient time" with the provider
For follow-up - % of clients informed of timing and sources for resupply or revisit
For constellation of services - % of clients who perceive that hours or days are convenient. This is an indicator of acceptability of services.

5. Reward quality

Service providers who are really good in giving quality of care should be given incentives.

The potential problems in "quality of care" concern the reality factor. Do we really have enough resources and time in our programs? Does an overburdened midwife really have the time to give individual clients the needed attention? I am not sure if full implementation is possible given these constraints. I have learned that we already have developed a training package for quality of care. I guess that solves the training and materials problem I had earlier in mind.

OBJECTIVES, HYPOTHESES AND OPERATIONAL DEFINITION OF VARIABLES

Fely David
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A. Objectives of the Study

The objectives of a study stem from the research problem that you have identified. It is important that the objectives are clearly defined and stated at the beginning of your research. There are two types of study objectives:

1. Ultimate objective - This answers the question "What will the study contribute in the long run?". What is its significance to the program?

2. Immediate objective - This answers the question "What will you do in the study?". In cases where the answer to this question is still big in scope, it helps to state specific objectives that will answer questions of what, why, who, when, to whom and where the study will be conducted.

B. Hypotheses

A hypothesis is a tentative statement about an expected relationship between one or more independent variables and a dependent variable. Studies designed to make predictions of relationships between variables test hypotheses. In an experimental study, you have to formulate a hypothesis before you test your intervention. However, we don't formulate a hypothesis if our study is diagnostic in nature.

Why do we formulate hypotheses?

1. Hypotheses serve to direct and guide the research. They indicate the major independent and dependent variables.

   An independent variable is the "cause" of the dependent variable. A dependent variable is the phenomenon or problem that you are interested in.

2. Hypotheses suggest the type of data that must be collected and the type of analysis that must be conducted.

C. Operational Definitions of Variables

Operational definitions provide descriptions of how the independent and dependent variables in the study will be measured. All concepts and variables in your study should be defined clearly for the sake of your readers. The definitions are determined and provided by the researcher at the beginning of the study.

STUDY DESIGNS

Zelda Zablan, Ph.D.
UP Population Institute

A. Reliability and Validity

In a study, we are always concerned with reliability and validity of the results. Reliability is defined as consistency, dependability or stability of the results. It also means that your measurements are accurate. Validity, on the other hand, means that the results served the intended objectives.

Reliability does not guarantee validity. You may have an accurate measurement but if it has nothing to do with the objectives of your study, then it is not valid.

B. Threats to Validity

There are six threats to validity:

1. History

There are unpredictable events in the course of the study which may increase or decrease the expected outcome. For example, you wanted to know the effect of an IEC campaign on the KAP of the clients. However, right after your IEC campaign, the governor pronounced that he will distribute free contraceptives this constituents. During your post-test, you observed a 100% approval of the contraceptive practice. Was this a valid outcome of your IEC campaign or a result of the clients' increased access to free contraceptives?

2. Selection bias

It is important for researchers to have full control in selecting their subjects for the experimental group. Your control and experimental groups should be comparable with respect to the data you would like to measure.

3. Testing

A pre-test tends to have an "anamnestic" effect on the post-test if done on the same respondents, so be careful to take note of this in analyzing your study findings.

4. Instrumentation

A change in the form of instruments or questionnaires may affect your study results. Make sure that you use standard pre- and post-tests.

5. Maturation

Subjects change over time and can produce effects that are independent of your program intervention.

6. Mortality

Death or migration can produce a similar effect of selection bias to your experimental and control groups.

These threats to validity, if not controlled in the study design, may affect the conclusions of your study. Hence, it is important to be aware of them at the start, and to start thinking how they can affect your findings.

C. Types of Study Designs

1. True experimental design

Subjects are randomly assigned to an experimental or a control group. Baseline measurements on both groups are done at the start of the study (T1). An intervention is then given, but only to the experimental group. After some time (T2), measurements are done again on both groups. Comparison of measurements at T2 with T1 will tell you if there has been an effect with the intervention, and if so, what that effect had been. This study design is common in fully-controlled laboratory settings.

2. Non-experimental design

Unlike the true experimental design, this type of study is used for situations where you have no full control of and very little information. Studies meant to collect descriptive information such as a diagnostic situational analysis exemplify this type of study design.

3. Static group comparison

This is used when you want to find out if the results had happened anyway even if the program intervention was not applied.

4. Quasi-experimental design

There are three subtypes:

a. Time series design - The experimental group is subjected to repeated measurements over time in order to elicit a trend. This uses service statistics. It reflects long-term effects of an intervention.

b. Non-equivalent control group design - The experimental and control groups do not have the same characteristics.

c. Separate Sample Pretest-Posttest Design

In selecting a study design, we have to consider ethical, technical, practical and administrative issues, as well as the randomness of selection and equivalence of our study and control groups.

There are three principles to be followed to make a good study research design. They are:

a. Multiple data congruence - To check on the reliability of a result, ask three questions that will elicit the same result.
b. Multiple measurements of the same variable over time
c. Multiple replication of the study intervention in different settings.

SAMPLING TECHNIQUES

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The nature of the study and its objectives define the type of cases to be studied and the type of sample to be drawn.

A. Review of Terms and Concepts

A case is the unit of analysis which may be considered at individual or aggregate levels. Cases make up a sample, which is a representative subset of the total population or universe being studied. A sampling frame is a list of all the elements of the population.

There are different types of samples. A probability sample is one where each element of the population has a probability to be selected. A self-weighting sample is a probability sample where each element has an equal chance of being selected.

A non-probability or convenience sample, on the other hand, has some elements of the total population which are selected either accidentally or purposively depending on some control variable. A quota sample is a probability sample which is a proportionate representation of the various characteristics of the population.

B. Sample Size Determination

The sample size is often determined by the resources that are available to the researcher. In general, the larger the sample size, the better. However, large samples mean more expenses and resource requirements.

A sample size should be large enough to allow for a reliable analysis of crosstabulations, provide for desired levels of accuracy in estimates and test for statistical significance.

As a rule of thumb, there should be at least 5 cases per cell and at least 50 cases per category for analyzing cross-tabulation variables.

The following formula is often used to determine the smallest sample size that one would work with if the total population is larger than 10,000:

$$\mathbf{n = z^2pq/d^2}$$

where: n = desired sample size
z = standard normal deviate, usually 1.96
p = proportion of main interest in target population;
if no data are available, use .50
q = 1 - p
d = degree of accuracy desired, usually .05

Hence, given that there is no available contraceptive prevalence rate in Country A, the sample size needed to estimate the CPR, using the above formula, would be:

$$n = (1.96)^2(.50)(.50)/(.05)^2$$
$$= \mathbf{384}$$

C. Ways of Determining Probability Samples

Some of the more commonly used sampling methods are the following:

1. Simple Random Sampling
   - simplest and easiest but costliest

2. Systematic Sampling
   - still a simple random sample where elements are listed arbitrarily and selected every nth case

3. Stratified Sampling
   - separate sample for a given stratum

4. Cluster Sampling
   - selecting clusters of elements

5. Multistage Sampling
   - various stages of sampling

OPEN FORUM

This question is addressed to Dr. Huntington. In your discussion about the situation analysis method, you mentioned that there should be interview teams to conduct the data collection. Could you repeat who the members of the interview team are and what their roles are?

For the data collection teams, you will need to have:

1. A trained and skilled service provider, such as nurses or physicians who have been providing FP services, to conduct the actual observations of service delivery;

2. A researcher who has had experience in conducting surveys, to conduct the interview of clients; and

3. A supervisor who will do the inventory of the clinic.

It is possible to have two persons stay at the clinic for those three days, and have the supervisor go to the different clinics. So, you may have 3 teams with 2 persons each and one supervisor for all 3 teams. Alternatively, the supervisor could also do the interviews of medical staff. For a large study, you might think about having an area supervisor at different levels (i.e., district, provincial supervisors).

- Dr. Dale Huntington
The Population Council

You mentioned that SA data collection has to be done simultaneously. What if you're in Bukidnon and you need to do SA in 22 municipalities, with 5 or 6 SDPs each. Does that mean you're actually going to have 100 interview teams because they have to do it all in the same day, or can you say that you will do it in 2 or 3 weeks so that the same team can go around?

Within the limits of logistics and costs, 2-3 weeks' data collection is okay, but you have to do it quickly.

- Dr. Dale Huntington
The Population Council

Could you elaborate on the use of qualitative methods for women's studies?

You can use quantitative techniques to determine the incidence of certain feminist concerns such as the proportion of battered wives or the proportion of women who have undergone abortion. To get a more comprehensive understanding of these patterns, then we can use qualitative research

methods such as focus group discussions. A qualitative study will complement and provide a more detailed explanation for findings of a quantitative study.

- Dr. Josefina Cabigon
UP Population Institute

You can also think in terms of sequence: first a qualitative study, then a quantitative study. One purpose of a qualitative study is to generate hypotheses. Why are there battered women? We don't know, so we do FGDs and get some ideas. Later, you can have a follow-up survey.

- Dr. Michael Costello
RIMCU, Xavier University

In that sense, qualitative methods can also help you construct questions that you can later ask in your survey.

- Dr. Josefina Cabigon
UP Population Institute

What is the "rule" in determining the number of SDPs that you need to have for a situational analysis?

That's a difficult question. If you think of the sampling forumla, you have to remember that your unit of analysis in the SA are the SDPs and not the individual respondents, so you'll have to use those for your p and q. You can take a representative sample like you would any other quantitative study.

- Dr. Dale Huntington
The Population Council

Are there really more feminist methods (such as the qualitative methods) than other methods?

I think that this question has to do with the fact that the participatory action-research (PAR) approach is often characterized as a feminist approach because its principles are what feminists are more comfortable with. This approach does not treat respondents merely as sources of information, but are made a part of the research where they identify their own problems, analyze their own problems and utilize the information for their own empowerment.

- Dr. Marilou Costello
The Population Council

We're talking about research tools. Tools can be used by anybody. I'm sympathetic to PAR because it is a tool, but sooner or later, we have to have some quantitative indicator to measure, for example, how many battered wives there are, or how many cases of incest there are in the country. All these issues are very open to a strictly quantitative method that could be very useful for a feminist. It's also empowering to have statistics.

- Dr. Michael Costello
RIMCU, Xavier University

This question has to do with the fight between quantitative and qualitative methods. If you're going to ask me, there are certain research questions that will need a quantitative method, and there are other research questions that will need a qualitative method.

For example, if you really want to know how women feel about gender power relations, you cannot simply use surveys to generate information about domestic violence or key issues of sexuality. You must use more qualitative methods to be able to draw those kinds of information. If you want to get information on the magnitude of contraceptive practice, on the other hand, then surveys may be appropriate. Even if I am into qualitative work, I feel that both methods complement each other.

In doing research, it is best to triangulate, that is, to use different approaches to study reality. You cannot capture reality by just one method. Each method has its own limitation. I can understand the women researchers' bias for qualitative methods because, for a long time, they have not been heard in society, and FGDs have been effective venues to make their voices heard.

- Dr. Pilar Jimenez
De La Salle University

Operations research as a field of research is very comfortable with both qualitative and quantitative research methods. You will find that it's very common to use more than one type of research methods in OR studies. Increasingly, there has been more and more understanding among quantitative researchers of the importance of qualitative research. These old barriers are already giving way to an appreciation of both methods.

- Dr. Dale Huntington
The Population Council

Dr. Jimenez, could you explain to us the bias of feminist groups for the participatory action-research approach?

I just want to say that it's not only the feminists who are biased to PAR. There are many NGOs who are into PAR. It is a good approach because you get people involved in your study, they feel that they own the project, and they do something about the project they are involved in. However, it's a lot of work. You need a lot of patience and a lot of committment to do PAR.

- Dr. Pilar Jimenez
De La Salle University

I stood up in defense of the survey earlier, but I should like to footnote that comment by adding that the survey technique is a tool, but in a controversial sense, it's not always the best tool. In that sense, the feminists may have a point. I think that the estimated percentage of women who had undergone an abortion from the NDS was very low --about 2%--while most qualitative studies really show that it's much higher in this country. On topics like abortion or desertion, the survey may not be a good tool. As Dr. Jimenez had pointed out, there must be a triangulation of methods so you get a truer picture of reality.

- Dr. Michael Costello
RIMCU, Xavier University

I just want to put in my two cents worth on this issue. Surveys work best when researchers know how to ask their questions. When you ask a question in a standard questionnaire, you only have one shot, one chance to ask it. In a qualitative study, however, you can have different ways and many different times of asking the same questions. That is why, we'd like to use qualitative methods for diagnostic studies, to investigate, open up and increase our understanding. That's from a methodological point of view. From a political point of view, however, a lot of the feminist issues have really been neglected for so long, that we really don't know how to ask those questions. That's because we've never really looked into them.

The issue of abortion is a good case in point. For decades, the US government has banned any money going into abortion research, so it's a neglected dimension of women's health. We know that a direct question "Have you ever had an abortion?" doesn't work because we've never had the resources to develop survey questions about this particular issue. I'm sure that there are other types of feminist issues for which survey research still does not know how to ask questions because we have not been given the funding to do so. That's the political dimension.

I think that these are the issues where feminists feel more comfortable with--that qualitative studies are lower in cost, there's more control and they are able to talk about issues that have been neglected for so long.

- Dr. Dale Huntington
The Population Council

QUALITATIVE RESEARCH METHODS FOR DATA COLLECTION

Pilar Jimenez, Ph.D.
Social Development Research Center
De La Salle University

Qualitative research is a research method often used in anthropology, sociology and social psychology. It is often associated with "no numbers" although this is not entirely true.

A. Characteristics of Qualitative Research Methodology

1. It is meant to describe and analyze the culture, way of life and behaviors of human beings and social groups from the point of view of those who are being studied.

2. It provides a comprehensive, holistic perspective of the social setting we are working with.

3. As a research strategy, it is flexible and is supposed to be iterative, meaning that we can change our design and questions in the middle of the research, depending on changes that happen in the field.

4. It complements quantitative research methods which are more structured.

5. It gives answers to questions of how and why and provides context and setting to our findings.

B. When do we use qualitative methods?

1. when the subject matter is not yet familiar
2. when certain concepts are not clear; to generate meanings, definitions and symbolizations for certain concepts we are interested in
3. when you aim for more details and explanations about a subject; in this case, you can use an in-depth interview with a sub-set of your survey sample

C. Who can use qualitative research methods?

Those who have had the training to do so. Qualitative research methods require patience and skills as questions must have more depth.

D. Methods or techniques of qualitative research

Some of the more commonly used methods are--

1. Unstructured/open-ended interviews
2. Semi-structured interviews
3. In-depth interviews with key informants
4. Life histories
5. Free listing
6. Triads
7. Rank-order methods
8. Rating scales
9. Network analysis
10. Cases studies (which is actually a combination of different qualitative methods)

I will discuss some of these methods briefly in the following sections.

E. The Focus Group Discussion (FGD)

1. Characteristics of a FGD

The FGD is a group discussion of about 6-10 persons. You have a facilitator who guides the discussion (using a set of guide questions) and a documentor who records the process and proceedings of the discussion. The FGD is a discussion among the participants about a particular topic fielded by the facilitator. It is **not** a group interview where the facilitator asks a question and each participant is made to answer.

Participants of a FGD are chosen on the basis of some homogenous characteristic so that they will have something common to start the discussion with, and that no one will feel threatened or embarassed to talk because of a perceived difference in their status vis-a-vis the other members of the group. The basic rule of FGDs is that everyone has to talk and share his or her opinion about the topic.

It should be conducted in a place where there is privacy and people can talk freely about the topic on hand. There should be no other people present, although this can be very difficult, especially in a rural setting where everyone else in the community wants to hear what's going on. In these cases, experience has taught us that it has been helpful to have other members of the research team serve as some sort of a "pest-control" team who will keep the other relatives or friends of the FGD participants busy while the FGDs are going on.

2. Preparations for a FGD

Preparations for a FGD are many. First, you have to identify your participants, invite them way ahead of time and make sure they come on time. You need to make sure that you invite only

those who are willing to talk about the topic that you want to be discussed. You also have to find a venue that is accessible to the participants to ensure attendance. You need to prepare snacks to be served during the FGD. Guide questions should be prepared beforehand and the facilitator should know these questions by heart. The facilitator should be very encouraging to ensure that everyone participates. But he or she should also be able to recognize and "control" participants who end up dominating the discussions. In cases like these, it is wise for the facilitator not to look at that person all the time so as not to encourage him to talk again. He or she should also ask other members to speak as well so no one begins to monopolize the discussion.

After the FGD, you should thank your participants and ask their opinions about the discussion itself. Snacks are usually served after the discussion.

3. Analysis of FGD data

Content analysis is a common way of interpreting data gathered from a focus group discussion. Direct quotations are often used in the report to shed light on common concepts or issues that surface from the discussions.

F. Unstructured/Semi-structured Interviews

In an unstructured or semi-structured interview, there is a list of questions that a researcher asks a key informant, but the questions are not asked in a structured, standard manner like in a survey. New questions may come up in the course of the interview, depending on the information being provided by the informant.

G. Participant Observation

This methodology involves having the researcher take part in activities in the community he or she is studying. Ethical considerations dictate that we inform our subjects that we are studying them and that they should know what our study is for.

H. Life Histories

Life histories are biographies of community members. The in-depth interview approach is used in this case. Here, it is the "subject" that directs the researcher since it is they who determine what is important enough for them to share with you. With many life histories, you can construct a "pattern" to describe a common phenomenon among certain groups of respondents.

I. Case Study

A case study is an in-depth approach that uses several qualitative methods such as key

informant interviews, unstructured observations, FGDs and even surveys and other quantitative methods. It is very comprehensive and provides a holistic picture of the community being studied.

J. Conclusion

The choice of what method to use depends to a large extent on the objectives and design of your study. Qualitative methods are appropriate for some research issues while quantitative methods are appropriate for others. In general, I do not believe that we can study a phenomenon using just one methodology. A combination of both qualitative and quantitative methods is ideal.

QUANTITATIVE RESEARCH METHODOLOGY FOR DATA COLLECTION

Aurora Perez, Ph.D.
Office of Research Coordination
University of the Philippines

If we want to know how people feel, what they experience, what they remember, what their motives are, what their reasons are for acting as they do, then why not ask them? Survey research has been a good source of information about behaviors and perceptions of particular groups of people in the population.

What is the best way to collect data for a survey research? That really depends on what kind of information you want your study to produce. Do you want to produce precise, quantitative findings or do you want to produce qualitative, descriptive information? Another consideration, which you have to know at the start of your study, is what method of analysis you want to use--a quantitative or a qualitative method of analysis? Once you have decided on these two criteria, then you are ready to design your approach to data collection.

A. Data Collection Techniques

There are several data collection techniques that you can employ. The more common ones include the following:

1. Structured interviews

   Structured interviews employ a standard questionnaire or interview schedule to ensure that all respondents are asked the same questions in the same sequence. These are actual face-to-face interviews conducted by trained interviewers. Structured interviews are commonly used for surveys which are national in scope and are therefore more costly, and sample surveys, which use only a subset or subsample of the larger population being studied, and are therefore cheaper than national surveys.

2. Use of service statistics

   For data on FP use, service statistics are usually available thru the management information system of the Department of Health. This set of information usually provides data on indicators of performance of service providers such as the number of clients of particular methods.

3. Self-administered questionnaires

   These are questionnaires that are either mailed to or left with the respondents for them to answer. The problem with the use of self-administered questionnaires is that

some questions may not be understood by the respondent in the manner that the researcher wants them to be understood. Return rates are also usually low and may therefore not be a cost-effective technique as a face-to-face interview.

B. Pointers for Conducting a Structured Interview

1. Use simple language. Your respondent should be able to understand you easily.

2. Whenever possible, precode your responses to facilitate the speed of face-to-face interviews. However, as earlier pointed out, structured questionnaires may also have qualitative, open-ended questions to probe responses.

3. Try to avoid embarrassing or painful questions that would slight your respondents.

4. Avoid asking for more than one item of information in a single question.

5. Watch out for ambiguous wording of questions. As stated earlier, your questions have to be clear and easily understood.

6. Include all questions necessary to provide sufficient information for your study.

7. Start with easier questions and work your way up to more difficult topics.

8. Ask all respondents each question in exactly the same way.

9. Do not overload your interview schedule. Do not ask questions you do not need. This is where your study design comes in. It is important to be clear in your design, your hypotheses and objectives so as not to cause unnecessary fatigue to both your respondent and your interviewer.

10. Pretest questionnaires in actual field situations to know whether the questions were are asking are giving us what we expect. A pre-test using 30 to 50 questionnaires is often sufficient. Pre-tests are usually done by the field supervisors and not the actual field interviewers who will be doing the interviews. Expect to have **several** pre-tests as there may be a need to revise or add questions.

11. Provide a complete and comprehensive training for all interviewers. An interviewers' manual of instruction is a must in this case.

12. During the actual interview, an appointment should be made for a call-back visit. Allow for about 2-3 call backs before replacing the respondent with a substitute.

13. Interviewers must be given clear instructions for obtaining substitutes.

14. Isolate the respondent to avoid "response contamination".

15. Check questionnaires in the field to ensure that they have been completely answered.

C. Data Quality Checks

Data quality checks are important to ensure the validity and reliability of our data.

1. Include repeat questions in the questionnaire that can be used to check for consistency of responses.

2. Have your supervisors monitor the work of your interviewers in the field.

3. Reinterview a percentage of your respondents and look for inconsistencies while still in the field.

4. Recode a percentage of the questionnaires to be sure that their is no coding error.

5. Examine the frequency distribution of all variables to see if there are odd codes or items that are not logical.

D. Future Directions of Quantitative Data Collection

1. Panel studies or longitudinal studies (prospective)

   These involve the repeated measurement of the same units or cases over a period of time.

2. Multi-level longitudinal studies

   Here, data are collected not only at the individual level but also at the community level. We do not isolate individual respondents from their community so that our evaluation is contextualized.

SITUATIONAL ANALYSIS AS A TOOL FOR PROGRAM MANAGERS

Dale Huntington, Ph.D.
The Population Council, Egypt

I will be using the situational analysis (SA) study that we conducted in Turkey to describe how SA studies are done, what they are about and to give you examples of the types of analysis that can be done with the data that a SA study generates.

A. What is Situation Analysis?

A situation analysis methodology focuses on the "supply side" characteristics of a program. It uses standard methodology and standard questions to arrive at two objectives, namely:

1. Decribe the availability, functioning and quality of family planning services from a representative sample of service delivery points (SDPs); and

2. Analyze the relationship between each sub-system's functioning and the quality of services that are provided and received by clients.

It treats clinics or SDPs as being composed of different "sub-systems" that include:

1. Logistics/supplies
2. Facilities
3. Staffing
4. Training
5. Supervision
6. IEC
7. Record Keeping

The idea behind a SA is not to evaluate a particular SDP or to evaluate how well a particular group of providers are working in that system. Rather, it aims to provide an overview assessment of how well a service delivery system is working during the short period of time when data were collected. It is meant to provide a quick snapshot of what is happening in the SDPs in terms of the quality of care (using Judith Bruce's framework). There are three broad dimensions to the quality of care issue:

1. Technical competence: how well are the services being provided, given the resources and constraints?

2. Inter-personal communications: how well are the clients being managed? Are they being treated with dignity and in the manner where they get the respect they deserve?

Are they getting adequate and appropriate information?

3. Amenities of care: these include the availability of facilities that make a difference to the client (e.g., a waiting bench, functioning toilets).

B. Situation Analysis Methodology

A situation analysis study is a quantitative study. It generates data that are presented in numbers and it uses analytical, statistical techniques relevant to all quantitative studies. Data are collected by teams of interviewers that utilize 3 research methods, namely:

1. Direct interview techniques with service providers and clients
2. Structure observation of consultations using a standard questionnaire
3. Inventory of the facilities' equipment and materials (including service statistics); this is usually done by the supervisors.

The following data collection procedures are observed:

1. All consultations that are done in the SDP for a full day are observed.
2. All the clients for that day are interviewed.
3. All the staff that are working in that clinic during the time of data collection are interviewed.
4. An inventory is made with the assistance of a knowledgeable staff from the clinic

Traditionally, data collection teams have stayed in the SDPs for only a day. Over time, however, we have found out that it is better for the data collection teams to stay for a few days (i.e., 2 to 4 days), depending on the number of clients. We usually target about 15 clients.

C. The Turkey Study: Background information

The Turkey study investigated the family planning services, permanent contraception and pregnancy termination (abortion) services using interviews with staff and clients and observation techniques. Antenatal and post-partum services were investigated using staff and client interviews and inventory techniques. We did not do observations of the delivery because we did not have enough resources and objectives. Observations of abortions, however, were done because the Turkish government was quite interested in the quality of abortion services. It was recently legalized in 1983 and the government is very sensitive to provide that service correctly. So they asked us to develop instruments to observe abortions and score them using quality of care issues as criteria. Tubal ligation procedures were observed and scored as well as vasectomy

services since these are relatively new services and the government wanted to make sure that they are being done correctly.

We developed 10 questionnaires for this study, and we also had 47 facilities which included 26 hospitals and 21 MCH/FP centers. The data collection procedures turned out to be complicated

in the case of hospitals which were providing several services all at the same time.

The types of reproductive health services provided in the hospitals and MCH/FP settings that we observed for this study included the following:

1. Out-patient services
    a. Family planning services: temporary methods, counselling for permanent methods and vasectomy
    b. Ante-natal family planning counselling
    c. Pregnancy Termination

2. In-patient services
    a. Family planning services: permanent methods, long-acting temporary methods (under special circumstances)
    b. Post-partum counselling and services

The amount of time for data collection depended upon the service delivery setting:

1. Out-patient
    a. Hospital FP clinic: 3 days
    b. Hospital OB/GYN clinic: 2 days
    c. MCH/FP center: 3 days

2. In-patient
    a. OB/GYN clinic: 5 days

These are the types of issues that you have to grapple with depending on your own situations. What type of clinics do you want to look at in your study? What are the different service delivery structures that are available? Do you want to go into the private sector, or do you just want to stay with the public sector? What about the NGO clinics working in your LGUs? How many different types are there, and in each type, how are the services organized? These are only some of the issues and directions that you can delve on.

D. Framework for Analysis

In analyzing the data that we have gathered, we found it very useful to think about looking at three different things using these data:

1. **Readiness** and **ability** of the clinic to provide services and care (which we get from the inventory)
2. Quality of care actually **provided** to the client (which we get from actual observations)
3. Quality of care that was actually **received** by the client (which we get from interviews with the clients)

What were the different considerations that we looked at?

1. Interpersonal relations
   - percentage of providers trained in counselling
   - auditory/visual privacy at SDP
   - observed treatment of clients
   - client assessment of inter-personal care (friendliness/privacy)

2. Choice of methods
   - availability of methods
   - medical restrictions reported by the staff
   - non-medical restrictions reported by the staff
   - methods recommended/never recommended for spacers/limiters by the staff
   - number of methods discussed with the client
   - client choice solicited/provided
   - whether client was informed about the possibility of switching methods
   - referral to another SDP for methods that are not available

3. Information exchange
   - IEC skills training
   - IEC materials available/used, health talk, sign
   - provider gives information on method accepted
   - client correctly explains method chosen/pregnancy termination
   - client's questions answered; provider understandable
   - client received desired information
   - adequate background information obtained from client
   - client informed about medical procedures conducted, wound setrilization complications

4. Technical Competence
   - equipment available for delivering methods/PR services
   - items available for infection control
   - abortion and FP training/recency/adequacy
   - pregnancy termination and FP knowledge
   - medical history obtained from client
   - medical exam performed
   - provider demonstrates skill at clinical procedures
   - provider follows infection control procedures
   - client perception of provider skills
   - client discomfort

5. Continuity
   - client record-keeping system
   - client referral system
   - follow-up: postpartum, antenatal and post-service procedure (abortion/VSC/norplant/IUD)

- resupply for temporary methods (or supply for postpartum methods)

6. Constellation of Services
   - other services available aside from MCH and FP

7. Management
   - facilities (physical infrastructure)
   - operations (service hours, perception of waiting time, COPE exercise, commodity inventory (record-keeping, storage, stockouts, resupply) and service statistics

8. Personnel
   - staffing
   - supervision
   - management training

9. Financial management
   - audit procedures

10. Case load
    - volume of cases being handled

11. Accessibility and Cost
    - accessibility
    - methods and service costs

12. Client backgrond characteristics
    - prior method use
    - abortion history
    - current use
    - intentions for future use
    - breastfeeding
    - demographic characteristics

E. Examples of Findings that were Generated Using the SA Methodology

1. Frequency of linking FP and post-partum services for women who decided to begin FP method use: Of 390 women who gave birth, 89% were not given a FP method before leaving the hospital. Those who did get a FP method were more likely to get a tubal ligation than any other method.

2. Comparison between the physical infrastructure of SDPs for FP services and abortion services, using the availability of a waiting room, separate examining rooms, counselling room and counselling space as indicators. Whether these findings are good or bad can only be determined in the country by the program managers, as they relate to the national strategy.

3. Availability of infection control equipment or sterilizers in SDPs for the provision of temporary FP, permanent FP and abortion services

4. Availability versus actual use of IEC materials during FP outpatient visits

5. Comparison of information given to FP outpatient clients (new vs. method switchers) about the contraceptive method provided during the visit

6. Information about infections, pregnancy risk, pain, spouse content, timing of abortion and complications given to abortion patients

7. Type of method recommended by physicians by the reproductive intentions of clients (delay 1st pregnancy, space, limit pregnancy)

   For those who wish to delay first pregnancy, the condoms and pills are often recommended; for those who wish to space their pregnancies, the IUD or pills are recommended and for those who wish to limit the number of their children, permanent methods such as tubal ligation or vasectomy are recommended.

8. Knowledge of FP and post partum care among service providers

9. Infection control procedures for FP and abortion services

10. Type of pain control medication used during pregnancy termination

11. Management and supervision among all services

F. Concluding Remarks

What are some of the design issues that you would need to consider?

1. Sample

   a. number and type of the SDPs that wil be studied
   b. number of days of observation per SDP (which are largely determined by budgetary constraints)

2. Questionnaires

   The main consideration here is how to adapt standard questionnaires to the context of the area to be studied.

3. Data Collection

a. This should be done quickly, meaning that the teams work simultaneously.
b. Informed consent should be obtained especially when observing actual service delivery procedures.

4. Reporting

a. Selection of findings: determining what goes into the report (this requires close coordination with the program managers)
b. Seminars to prepare for the report writing

Situational analysis studies are complex to manage. They use multiple methods. They require a team of interviewers who have to work as a team. Trainings have to be done and coordination among different interview teams is essential.

SA studies, however, are easy to develop. There are standardized questionnaires available and the data analysis plan is also fairly standard and available. These types of studies are extremely useful for policy development, program management and service provision.

ANALYSIS OF DATA

Michael Costello, Ph.D.
Research Institute for Mindanao Culture
Xavier University

My almost 20 years' experience in data analysis have taught me a few pointers and insights which I want to share with you. I call them my *Twelve Commandments of Data Analysis*:

1. Data analysis is an art and not just a science. Two researchers can use the same dataset and come up with basically the same conclusions but there will always be some variation and "branching out". Much of data analysis is really left to the discretion of the researcher. And we can only learn it (data analysis) by actually doing it.

2. Program managers must be involved in data analysis. This is important because program managers know what the problem is and what matters to the program. If they do not participate in data analysis, they will not feel that they own the research, and may not therefore use the findings.

3. Plan ahead. Do not leave data analysis to the last month of your research. You should already be thinking about your plan for data analysis as early as when you are making the questionnaire so that you do not leave any crucial information out.

4. Collect and code data with as much detail as possible. You can always collapse your data into categories later.

5. Do not try to do everything when doing the final report. Stick to your study design and objectives.

6. In deciding what analytical tools to use, think about the standards of the scientific community, but also remember that you are a communicator. If your intended audience does not understand the findings of your research the way you have presented it, then it does no one any good.

7. Handle cases of missing values very carefully. Be careful especially about differentiating "no response" versus "not applicable" categories. Missing values can be confusing. Be careful with skip instructions in the questionnaire.

8. Do a univariate analysis (sometimes called marginals) first before making any multivariate analyses. You can already learn a lot from univariate analysis. Oftentimes, the program managers' concerns can already be answered by marginals.

9. Once data are collected, go back to the questionnaire to understand the responses better.

10. If you do not know what you are doing, get some help. Do not end up giving the wrong conclusions and advice to your program managers only because you made the wrong analysis of our data.

11. Recheck your data. Do they make sense?

12. Realize that every study has to have an end. Once you have your data, start writing and communicating, and finally give a closure to your research.

OPEN FORUM

Are the following indicators valid measures: a) house materials, source of drinking water, education of household head and occupation of household to measure the socio-economic status (SES) of the respondent; and b) number of children, marital status and relationship of spouse to measure status of women?

You must remember that an indicator is just an approximate measure of a particular concept. For your first question, I think all those variables are valid measures of SES. However, with regards to your second question, I think that those indicators may be poor measures of status of women, except the variable describing her relationship with the spouse.

- **Dr. Zelda Zablan**
  UP Population Institute

You may have to consider calculating a summary indicator for SES or status of women. When you want to quantify these variables, you have to ask different sets of questions which will help you come up with a definition of SES or status of women. In trying to find out their validity, you have to note their consistency in indicating SES or status of women. If they are not consistent, then they are not valid.

- **Dr. Josefina Cabigon**
  UP Population Institute

The status of women is a difficult concept. One way that this has been measured elsewhere is to look at the autonomy of women, like in economics and decision-making. The question "Does the woman contribute any money into the household economy?" has been used with some success in a number of places. It's a simple measure. When a woman can say "Yes, I contribute to the food budget or to the children's education", then that is an indicator that women are somewhat economically autonomous of their husbands. The question "Can a woman decide to travel on her own without asking permission from her husband?" shows that they have autonomy in terms of decision-making. This again relates to the status of women.

- **Dr. Dale Huntington**
  The Population Council

Our group is planning to do a study on NFP acceptors in our area. Our plan is to conduct scientific lectures on monitoring women's fertility. Is it all right to have three groups in the study--the first group to serve as the control group; a second group to be composed of all women who attended the lecture; and a third group to be composed of both husbands and wives who attended the lectures?

Essentially, you only have two groups: the control group and the experimental group. In this case, however, you made a distinction between two experimental groups. I would suggest that you have four groups instead. Each experimental group should have a control group as a point of comparison. Who will make up your control group--women alone or women with their husbands?

- **Dr. Zelda Zablan**
  UP Population Institute

If you maintain the three groups you mentioned earlier, I think you will have difficulty in analyzing your data since you only have one control group for two experimental groups. I would advise you to have only two groups: one control and one experimental. Just choose between your second and third groups which one will be the experimental group. Of the two, I would suggest that you choose the second group (women only) since it is easier to gather women than men for a lecture.

- **Dr. Josefina Cabigon**
  UP Population Institute

What I had in mind was to find out which is more effective--to give lectures to both husband and wife or just to women? But if this is going to be complicated, I am willing to change my study design for a simpler one.

- **Dr. Belen Ligo**
  Cagayan de Oro City

What is the difference between random allocation and random sampling?

I think they are synonymous.

- **Dr. Zelda Zablan**
  UP Population Institute

Randomization means that all areas under your jurisdiction will have an equal chance to be selected for your experimental group. But it is also possible that you, as a program manager, already know of a problematic area which can be improved by your intervention. In that case, you no longer need to select randomly. Your purposive sample can be your experimental group. The

issue however, will be how you are going to select your control group, to make sure that it will have the same characteristics as your study group.

- **Dr. Josefina Cabigon**
  UP Population Institute

I would just like to say that I quite agree with Dr. Zablan when she said earlier that a strong (univariate) study design is more preferable than a weak study design that employs multivariate analysis. I think this has an important implication on program managers. In order to set up a good study design, you need a very cooperative program manager who will be with you from day one.

- **Dr. Michael Costello**
  RIMCU, Xavier University

OR EXPERIENCE IN OTHER COUNTRIES: Post-Abortion Care and FP Counselling in Egypt

Dale Huntington, Ph.D.
The Population Council, Egypt

I will be presenting the results of an OR study on post-abortion care and FP counselling in two hospitals in Egypt to illustrate how operations research was used to test an intervention. In this case, we introduced the procedure of mini-vacuum aspiration (MVA) as an alternative to dilation and curetage (D&C) which is currently being used by physicians as part of the care for post-abortion patients. The study also sought to improve the present state of FP counselling in the study hospitals by training the nursing staff on counselling. A pretest-posttest design was employed to determine the effects of these new interventions in post-abortion care.

When you have a pretest-posttest study in two different sites and you want to explain the impact of an intervention, you are interested in seeing if there's a difference in your indicators between the two sites.

A. Results of the Pre-test

In our study in Egypt, the only significant difference we found between the two sites during the pre-test was on the average length of time that the physicians have been practicing medicine. The physicians in the post-test group were found to be slightly younger than the pre-test group. The reason for this could be the change in the residents that occured during the post-test period. The Ministry of Health hospital in Gallah was a teaching hospital that received residents for training. During the post-test, a new group of residents, who were younger, came in. Basically, however, there was not much difference between the two hospitals.

Patient characteristics were about the same for the pre- and post-test groups. The number of living children changed a little bit, however. In the post-test group, the women had slightly more children than the pre-test group. Literacy and previous contraceptive use were about the same for both groups.

There was, however, a substantial increase in the percentage of patients who reported that the pregnancy was unplanned or unwanted. This could have been due to the interviewers getting better in asking this type of question or it could have been an effect of intervention; that is to say that the women who were counselled about FP and their reproductive intentions became more at ease about discussing the unwantedness of their pregnancies.

Also, we noted some difference in the average gestational age. The percentage of patients presenting with an early gestational age (under 12 weeks) increased from 80 percent to 90 percent. The overall average gestational age however went down. Even in the pre-test, it was already under 10 weeks.

Basically, there was not much difference between the two samples and no substantial difference between the two study sites, so that simplified our analysis.

B. Results of the Post-test

The World Health Organization has a recommended protocol that lets you classify post-abortion patients to find out if these women had spontaneous or induced abortions. The presence of complications, general trauma or sepsis, for example, indicate that the abortion was induced, and will be so classified even if the patient reports that it was not. Also, if the patient says that she was not using a contraceptive and the terminated pregnancy was unwanted, that would probably be classified also as an induced abortion even if there are no signs of general trauma or sepsis. If she said that she did not use a contraceptive and that she wanted the pregnancy and there were no other signs to the contrary, then it would probably be classified as spontaneous.

In our study, about 40 percent of all patients had spontaneous abortions or miscarriages, while 60 percent had induced abortions.

C. Effect of the Intervention

There was a significant change in patient knowledge about warning signs, bleeding, cramps and severe pain. There was not much impact however on their knowledge about unusual bleeding, fainting or fever.

On infection control procedures, we had a lot of success in convincing the staff to wash their hands and to use antiseptics.

We had the same type of information--vacuum aspiration and dilation and curetage (D&C) as part of our study for the one-month pre-test and the one month post-test. Presented in a time series manner, the results show that before the study, almost 100% of the cases were treated with D&C. With the introduction of the study intervention, the number of D&C cases dropped and cases of vacuum aspiration increased. There were still some cases of D&C but the figure did not reach 100%. We introduced a new technique which is the vacuum aspiration technique and had an effect on physician knowledge and on the type of post-abortion procedure that they were using.

On pain control medication, pre-intervention general anesthesia was used in 90% of the cases. During the post-test, however, the use of general anesthesia dropped to 52%. Half of the cases were being treated with local anesthesis, some pre-operative sedation and paracervical block. Modest success was noted in that area. Let me point out, too, that a lot of the general anesthesia cases wer done on patients' request.

It is interesting that in the pre-test, patients were more likely to complain of severe pain than during the post-test. They were likely to compalin of severe pain when they were receiving general anesthesia than when they were receiving local anesthesia.

As far as management of interpersonal communication is concerned, we were able to increase the amount of information that the physicians knew. The questions however was, did they pass on this information to the patients? During the pretest, we saw that the physicians were clearly not doing anything, and that no information was being given.

If you talk about general anesthesia, the care-giving practice was something like this--the patient was knocked out, treated and then released. There was no information or care given to her. After the intervention, we were halfway successful in changing how patients were treated with information. It was a big change.

We also saw big changes in the range of topics that patients knew about reproductive helath and RH intentions in family planning. They started to talk about FP as a result of this study. Did it have any effect on the patients' use of services? We didn't actually provide FP services during the post-abortion treatment. The patients were referred to the outpatient FP services of the same hospital. But we did find out an outcome measure of intention of use. There was a big change from 32% to 62% of the patients intending to use FP as a result of our intervention. So the pilot study had a lot of success in terms of showing that it is feasible to change the services and its appropriate method.

D. Follow-up Activities

So what did we do about these results? We talked about developing and scaling up the study, and expanding the results. Three objectives to the follow-up activities will be:

1. To disseminate this improved care of vacuum aspiration plus local anesthesia with improved counselling into medical universities and to teaching hospitals to start to build a critical mass of physicians who are aware of this technique

2. To continue to use OR to document the impact of similar studies that were done but this time, focusing on costs, like mimizing hospital stay and maximiaing savings

3. To work on a strategy for importation of vacuum aspiration instruments. We are looking at commercial importation as well as getting the Ministry of Health to do some public sector procurement.

We have an on-going study that estimates the post-abortion case load of physicians. The pilot study showed that you can do something to improve medical care but the government needs to know the magnitude of this problem. We are working with a consortium of medical universities in this area.

We are also looking at improving FP counselling to include counselling for husbands of post-abortion patients. We did qualitative research and in-depth interviews with post-abortion patients to find out their concerns, anxieties and perceptions. They were clearly worried about their return to fertility, their ability to carry pregnancy to full-term and their ability to recover. Equally, they are worried about their spouses' and their in-laws' concerns about their ability to have children. So, counselling the husband to allay the patients' fears will help them recover. We're doing a small OR study to see if we could have an impact on the husbands.

E. Concluding Remarks

This study on post-abortion care in Egypt is an example of how OR can be used to look into an experimental intervention in the true sense of the word. We were able to demonstrate how an OR study can translate its findings for policy development. As a result of this study, we have now began working with universities to get the new intervention to the standard medical practice of the country, and institutionalizing it as quickly as possible.

TOOLS FOR ANALYZING SERVICE STATISTICS IN PUBLIC SECTOR CLINICS

Zelda Zablan, Ph.D.
UP Population Institute

A. Monitoring and Evaluation

Monitoring is the process of determining whether program inputs, activities and outputs are delivered or accomplished according to plan. It measures program efficiency.

On the other hand, *evaluation* is the process of determining the program effects and/or impacts on the target beneficiaries and the environment. It measures the effectiveness of a program.

To monitor a program, a record-keeping system is usually set up, or a management information system (MIS) is established. Three processes constitute a MIS:

1. recording;
2. reporting; and
3. utilization for management decisions on feedback.

In the Philippine Family Planning Program (PFPP), two independent systems exist to record and report program performance. These are the **FHSIS** which is used only by the Department of Health, and the **POPCOM/MIS** which is being used both by government offices and non-government organizations (NGOs).

Other information systems include the:

1. CDLMIS - which monitors the distribution of logistics/contraceptives to the different local government units (LGUs);
2. FPOP MIS - which monitors all aspects of FPOP operations;
3. PNGOC - which is used for financial reporting; and
4. HAMIS - which is a pilot system for the integration of data for graphic presentation at the local level.

B. Problems of Service Statistics

The present state of service statistics on FP in the country is besieged with several problems, including the following:

1. There is no unified MIS for reporting FP service outputs.
2. The FHSIS has no provisions to incorporate non-DOH service statistics.
3. There is no standard reporting of new acceptors and continuing users.
4. There is little use of FP feedback information.

5. There has been no training at the local/service delivery level on how to use FHSIS generated data; FHSIS and POPCOM MIS serve only the purpose of centrally controlled programs.
6. The FHSIS is a facility-based system and is not suited to a community-based program. It cannot generate information on contraceptive prevalence rates (CPR). It cannot track outreach activities like IEC and FU.
7. The responsibility of maintaining the FHSIS remains unspecified on account of the devolution.

C. FP Indicators of Performance

1. PFPP

    a. number of acceptors
    b. number of continuing users
    c. number of drop-outs
    d. number of clinic visits
    e. number of referrals

2. RHP (recommended as of Decemebr 1995)

    a. % women 15-49 infertile
    b. % drop-outs
    c. % women 15-49 with anemia
    d. % women 15-49 and men with genito-urinary tract infections (GTIs)
    e. abortion rate: spontaneous, induced
    f. % women in high health/pregnancy risks (too early, too soon, too many, too late, too sick)
    g. % women 15-49 who are physically abused
    h. age at first pregnancy
    i. % women with cancer of reproductive system
    j. % women with good knowledge of sexuality

Other related indicators:

    a. PGR - population growth rate
    b. MMR - maternal mortality rate
    c. IMR - infant mortality rate
    d. TFR - total fertility rate
    e. CPR - contraceptive prevalence rate (modern, all methods)
    f. FP Budget (% FP to total GOP/LGU budget)

D. Information Collected from Clients

1. FP Form 1

    a. age of client
    b. monthly income
    c. urban-rural residence
    d. source of FP information
    e. number of living children
    f. plan more children
    g. method accepted
    h. admission history: date of last delivery; LMP; height/weight;uterus position; uterus size; adnexa; erosion; discharge

2. FP Form 2 (Sterilization Logbook)

    a. method accepted
    b. previous method
    c. type of client (new acceptor, change method, change clinic)
    d. plan to have children
    e. age of wife
    f. number of living children
    g. date of last pregnancy
    h. place of service (main clinic, sub-clinic, home, others)
    i. person who gave service

3. FP Form 2-S (Sterilization Logbook)

    a. type of sterilization
    b. previous method
    c. type of client
    d. category of operation (postpartum, post-abortion, interval)
    e. age of wife
    f. number of living children
    g. date last pregnancy ended
    h. education
    i. payment for sterilization
    j. surgeon's name

4. FHSIS/M-6 (Monthly FP Subsidized Surgical Procedure Report)

5. FHSIS/M-1 (Monthly Report of Acceptors, Drop-outs, Continuing Users, Referrals made and FP visits)

6. FHSIS/Q-2 (Logistics Report)

   a. stock on hand at beginning of quarter
   b. quantity received during quarter
   c. quantity dispensed during quarter
   d. balance at the end of the quarter

   for - (1) contraceptives and supplies
   (2) growth monitoring chart
   (3) cord dressing
   (4) ferrous sulfate
   (5) others

7. FHSIS/A-2A (Annual Catchment Area Population Survey Form)

   a. province/city
   b. BHS
   c. catchment RHU/MHC
   d. RHU/MHC
   e. name of HH head
   f. number of MCRAs
   g. age and sex composition of HH: <1, 1-4, 5-6, 7-14, 15-49, 50-64, 65+; male and female

8. FHSIS/A-2 (Annual Catchment Area Population Summary Report)

9. POPCOM LOG-99P (Clinic stocks record for pills and condoms)

10. POPCOM LOG-99I (Clinic stocks record for IUD)

E. Utilization of Data Generated from Service Statistics

Below is a summary of the different types of information that can be generated from existing service statistics records and how they can be used by program managers and decision makers.

Information Type	Data to Gather	User of information	Decisions that could be made
1. Socio-economic characteristics of target population	- income - urban-rural residence - education	Program managers: what influences FP acceptance and use of services?	Allocation of effort and resources to maximize demand and utilization of FP services
2. Factors affecting fertility	- age at marriage - parity at acceptance - years married prior to acceptance	Program managers: whether current users will influence population growth	Formulation of program objectives, selection of targets for maximum program impact
3. Demand for and use of contraceptives	- ratio of permanent to temporary methods - source of supply for each method - unit cost of delivering each method - reasons for choosing FP method - reasons for practicing FP	Program Managers: whether FP supply and distriution system is compatible with user needs	Selection of contraceptive mix to achieve program objectives and satisfy FP users
4. Discontinuation/ user failure	- discontinuation rates per method - failure rates per method - side effects and complications - reasons for discontinuation - results of discontinuation	Program Managers: for determining client satisfaction with FPP	- Formulation of best method mix - Type of personnel to assign - To balance clinic and community services
5. Quality of services	- application of clinical protocol - behavior, competence, experience of staff - physical envt of clinic	Program managers can take action to improve existing services	- Formulation of best method mix - Training and supervision of staff - Choosing most effective delivery system
6. Characteristics of community participation and support	- level of community participation - amount of community financing - approaches to follow-up	Program managers: to decide on the best strategy to increase community involvement and motivation	- Assess prospects for community self-financing of FP program

OPEN FORUM

You earlier mentioned 10 recommended indicators of reproductive health. I am wondering, though, if these are viewed as ideal indicators to be used by the LGUs. Will these be adopted officially?

This has been adopted officially as of December 1995 in Binangonan. I do not know if the mayor of Binangonan was a representative of the LGU. It was supposed to be a multisectoral meeting. I was told by Dr. Quintong that it is the official expansion using the RH approach to the FP program.

- **Dr. Zelda Zablan**
  UP Population Institute

These indicators are currently being reviewed at the DOH. It is safe to assume that even the FP Office of the Public Health Service headed by Dr. Reodica is still studying these indicators carefully. We are not yet in the stage to recommend to the city health office because the central office is wary about doing such things. We are already in a devolved set-up. Certainly, consultations will be made on this. As Dr. Zablan mentioned, there will be difficulty in collecting information on these indicators. In line with the new directions taking place in DOH, all of these have to be taken into account. But this does not mean that they have already been decided upon.

- **Dr. Edwin Ilagan**
  FPS, Dept. of Health

This question is addressed to Dr. Huntington. Why didn't you use a control group for your study of post-abortion care?

The baseline, pre-test group was our control group.

- **Dr. Dale Huntington**
  The Population Council

Don't you think that the success of your study on post-abortion care in Egypt will encourage more abortions in the country?

The study didn't look at individual abortions. It looked at the treatment of post-abortion cases. Incomplete spontaneous abortions accounted for about 50% of the cases we studied.

- **Dr. Dale Huntington**
  The Population Council

How was the Hawthorne effect avoided in the study?

There was a very strong Hawthorne effect in our study. The Hawthorne effect was realized in the study through supervision. We encouraged supervision of the physicians working the post-abortion medical wards. We really stressed that post-abortion care should no longer be ignored but that it should receive the attention of the head of the OB/GYN departments and the senior medical staff, so that the junior staff and residents are practicing proper medicine. That was the Hawthorne effect.

- Dr. Dale Huntington
The Population Council

How was counselling done in the hospitals covered by the study?

The counselling was mainly done by the nursing staff. Prior to the study, each nursing staff had no role in the care of patients. They were there mainly to assist the physicians in surgical procedures. They didn't have counselling in their job descriptions. As part of the study, we made a role for nurses. Most of the counselling and impact of information provided to patients came from nurses.

- Dr. Dale Huntington
The Population Council

Did the hospital know that they will be evaluated later on, and was that communicated to the personnel? Do you want to make any comments about moving from a pilot project to upscaling it to an Egypt-wide program covering all hospitals?

The staff and the hospitals did know that they were taking part in a study and they did know that there would be a post-test to show changes in their practices, and that the post-test would receive close attention by the minister and undersecretary of health and some of the senior staff of the hospital.

In scaling up a study, you have to let go of the intervention and let it run a little bit more. In setting up an expansion study, the attention shifts from working with individual physicians and getting to know the personalities in the clinic and seeing how things are working, to looking at systems and managing procedures; and that's where the attention starts to go. We're starting to formalize the training materials a lot more in the expansion. We're starting to develop standard clinical protocols that will be written and approved by committees, and then communicated officially through the normal channels.

- Dr. Dale Huntington
The Population Council

Is mini vacuum aspiration (MVA) done using the carman cannula?

Yes. It's a soft flexible plastic cannula with a manual vacuum instrument that's shaped like a large syringe.

- Dr. Dale Huntington
The Population Council

Were the observers employees of the hospitals?

No, there weren't employees of the hospitals. They were independent OB/GYN specialists from the private sector.

- Dr. Dale Huntington
The Population Council

Were the subjects' consent obtained?

Yes. Patients' consent was obtained before the operation and then again before the intervention.

- Dr. Dale Huntington
The Population Council

Who spent for the training of the staff?

The training of the staff was done in conjunction with a foreign consultant, a Sundanese physician and also the heads of the medical university. The training was part of the entire study which was funded by USAID. USAID funds can be used for training post-abortion patients, monitoring their care, counselling, etc. One cannot use US government funds to purchase vacuum aspiration instruments, but you can use government funds for training people to use the vacuum aspiration.

- Dr. Dale Huntington
The Population Council

How did you facilitate the hospitals' inclusion in the study and their compliance?

The study was developed in consultation with the Ministry of Population and Family Planning. We worked very carefully on that level, and it was in consultation with the minister that we discussed holding the study. Deciding to do the study received the policy support at the highest levels of the Egyptian government and it was at the minister's designation that these two hospitals will be included in the study.

- Dr. Dale Huntington
The Population Council

What is the difference in the cost between the D&C and the MVA; general anesthesia and local anesthesia?

There's strong worldwide evidence that local anesthesia is always cheaper than general anesthesia. It reduces the length of stay of patients. Out-patient procedures of local anesthesia are cheaper than in-patient stay with general anesthesia.

With regards the different between D&C and MVA, I really don't know. The carmam cannula is very cheap and they're reusable as well, although in this study they were disposable. The cost savings will have to do with the procedure time, the length of patient stay and the rigorous infection control procedures that are used.

- Dr. Dale Huntington
The Population Council

Devolution created a gap between the DOH and the LGUs. As a result, reporting is now poorer. What has the DOH done about this?

The DOH is in the process of re-organizing its own information system. You're well aware that there are so many MIS currently existing in the department.

- Dr. Edwin Ilagan
FPS, Dept. of Health

I have suggested that municipalities and cities could actually set up their own geographical information systems (GIS). Technical assistance from the DOH or the IFPMHP could be provided to the LGUs in setting up this GIS. We're still waiting for DOH to act on this recommendation which we made way back in 1993. We have yet to hear from DOH what their next move is.

- Dr. Zelda Zablan
UP Population Institute

I would just like to mention that sometime in 1994, the DOH had already put out an integrated communications plan, and that areas have already been surveyed and mapped so that strategic information systems could be put up. Apart from utilizing existing information systems, we also need to enhance the capability of these networks to communicate with each other. As far as that plan is concerned, the different offices at DOH are now linked up. We're also linked up with PCHRD and UP. Hence, the DOH has already taken steps towards this direction. We must realize however that this is a big undertaking and it will take some time to realize it fully.

- Dr. Edwin Ilagan
FPS, Dept. of Health

We hope that the national policy makers would have proper consultations with LGUs before making any changes in the reporting system.

If you're a program manager, you would know which indicators you need to monitor on a day-to-day basis to be able to make decisions. It really is up to you, the local government officials to define the kinds of indicators depending on your situation and local context. Do not wait for guidance from central office. Think local and use local talents. This is empowerment.

- Dr. Zelda Zablan
UP Population Institute

This question is addressed to Dr. Huntington. Could you comment on the pain aspect of D&C versus MVA? Which would be more painful?

It wasn't indicated in the study. There wasn't any strong protocol on that. The dilation for MVA is smaller than that for D&C, so that could lead to a reduction in pain. The suction itself is more gentle than scraping, so there is no need for painkillers in MVA, whereas pain control medication is prescribed for D&C.

Sustaining the Commitment of Volunteer Health Workers (VHWs) in Baguio City

Felicidad Ganga, M.D.
Catherine Posadas, M.D.
Baguio City Health Department

A. PROBLEM SITUATION

In 1990, Baguio City had a total of 300 active VHWs. By 1994, there were only 80 VHWs left, signifying a drop-out of 73%. The CHO does not know when the bulk of the drop-out occurred between 1990 and 1994, or if it occurred steadily throughout the period. The group, therefore, wants to know the possible causes why this high drop-out of VHWs occured so that they will be able to sustain the commitment of the 80 remaining VHWs and the 220 newly-hired ones.

Some of the possible causes of the VHW drop-out forwarded by the group include:

1) The workload is not well-defined.
2) Incentives are not being given. If at all, they are very minimal or may not have been given to everybody.
3) There are no recruitment guidelines.
4) Supervisory monitoring may be poor or very strict.
5) Job expectations are not clear.
6) Socio-economic-demographic factors like age, gender, literacy, region, etc. may have also contributed to the high drop-out rate among VHWs.

Why is there a need to sustain the commitment of these VHWs? Volunteer health workers are very important to the City Health Office because they provide additional manpower vital to the delivery of health services in the area. At present, Baguio City has a population of 220,000 and 129 barangays with only 27 health fieldworkers. Also, there are only 5 population workers who help in advocacy work and IEC. The VHWs are the extensions of these fieldworkers. Hence, one cannot underestimate the services that they provide.

B. OBJECTIVES OF THE STUDY

The objective of this study is to develop strategies and modify existing approaches to improve retention rate. The immediate objective is to do a diagnostic study on variables associated with this drop-out.

The group plans to conduct interviews with the original batch of VHWs, including the drop-outs, and the existing VHWs who are still in Baguio City.

C. VARIABLES

The variables to be defined are drop-outs, incentives, monitoring, supervision and workload.

D. METHODOLOGY

The proposed study is a diagnostic and not an experimental one. Hence, there is no need for sampling because the group will be interviewing all (original) VHWs. The strategy is to interview first all those who are still with the program, and then, trace the whereabouts of the drop-outs. The group will also interview the new recruits after some time to determine if the same problems exist among them.

Structured interviews will be conducted by trained interviewers and supervisors. For coding, editing and data processing, the facilities of the Baguio City Health Department will be used. Since this will be the group's first attempt at research, only univariate analysis will be employed. Once adequately trained, the group plans to move towards doing bivariate and multivariate analyses.

The subject of the study will be the initial batch of volunteer workers. The group plans to disseminate the findings of the research to the policy makers, program managers and volunteer workers themselves.

The proposed time frame for the study is 12 months. The estimated budget is P376,825, of which 13.66% will be shouldered by the LGU and the rest by the funding agency.

OPEN FORUM

It looks like a good study. Since you are going to interview those who are still in the program and those who dropped out, I would really encourage you to use a bivariate analysis. Your independent variable is the "ins" and "outs". It is natural to want to know the differences in characteristics, satisfaction, complaints, supervision, etc. If you feel you are not yet ready for complex statistical issues, you could do any of the following : first, get a consultant from UP Baguio to help you; second, you could consider not having a statistical test at all. It is really better to use one, but if you are very uncomfortable, the least you could do is to present them in percentages. For example, you might find out that the drop-outs are women who were employed elsewhere. Results such as "80% of the drop-outs are employed in contrast to the 20% of those who stayed in", for example, would point to the problem. Maybe then, we could recruit housewives more than women with jobs. You could go much deeper if you compare your ins and outs.

- Dr. Michael Costello
RIMCU, Xavier University

The presentation and the study itself are very clear. I'd like to make a comment on the possible cause of the high drop out rate. This must be an opportunity to let us change the paradigm about how we think about community volunteers and health workers. If we could only look at the drop-out rate as success and not as failure of the program. I think it's time to think that community service serves as a revolving door to VHWs. Young people come in because they are very idealistic and they want to do some community service. That's why they have volunteered in the first place. And then they find something else, like work or school, which make them leave. I'd like to think that the community service has improved their lives and I think that you might want to capture and document that. One result of this program might be that the management of the community volunteer service would start to think about engaging these people for a limited time that could be renewed. There is some investment made in training these people. They come in and agree to work as a volunteer for a period of time that seems reasonable to everyone. And at the end of the year, there are tests. Do they still want to stay there, or do they want to change their circumstances? Perhaps there has to be some kind of mobility in the community volunteer program, so that, after working one level of community service for a year or two, they might move up and supervise other volunteers. There might be room for them to train other volunteers. For those who wish to go, maybe they should get a certificate which the government recognizes, so that when community volunteers leave, they won't see themselves or the program as a failure. There must be recognition of the service rendered. The high drop-out rate could perhaps be seen also as a success instead of a failure.

- Dr. Dale Huntington
The Population Council

I also thought of that. They spend so much on training and the turn-over is really fast. Perhaps, instead of giving them a formal training, we could just give them an orientation training for one or two days, sort of an overview of what the DOH program is all about.

- Dr. Felicidad Ganga
Baguio City

I think that's a very good point. Probably, the city health department can work with the universities which offer allied medical professions. I think the original worry is that there are no replacements to the drop-outs over the course of two years. Also, the training shouldn't be expensive.

- Workshop participant

The concept of this whole volunteer program is really to take in the form Dr. Huntington was just describing to us. There is still the need for them to stay for a significant period of time and perhaps that might be the thing you want to zero in, that they stay during the period of time that they have committed themselves. That might be the focus of the problem where you want to intervene, as well as changing the orientation regarding volunteer work. I think it's about time that we institutionalize the volunteer program. We have been putting pressure on our local government to give incentives just to make the VHWs to stay. It's about time we rethink that.

Actually, we have gone further in institutionalizing the VHWs. The VHWs start off as volunteers, then we make them into midwives, nurses and doctors. To what extent have we began to implement this?

- Dr. Marilou Costello
The Population Council

What is the involvement of the newly-hired 220 VHWs? How are they involved in this study?

The 220 are the newly recruited volunteer workers. They are the beneficiaries of the study. We'll know how to sustain their commitment by finding out the problems which drop-outs had.

- Dr. Felicidad Ganga
Baguio City

An Assessment of the Capability of Service Providers to Deliver Reproductive Health (RH) Services and RH Program Impact on the Reproductive Health of Women in Pangasinan"

Gil del Rosario, M.D.
Ms. Luzviminda Muego
Provincial Health Office, Pangasinan

A. PROBLEM SITUATION

Data from the 1995 Pangasinan Demographic Health Survey (PDHS) show that Pangasinan has a high total fertility rate (4.36) and a high unmet demand for family planning services. Moreover, its maternal mortality rate (183 per 100,000 live births) and infant mortality rate (52 per 1,000 live births) are much higher than the national and regional averages. Contraceptive prevalence rate for all methods was found to be 34%, with higher rates in the rural upland areas than in urban areas. There also appears to be more users of modern methods in the rural upland areas than in the urban areas.

These problems were attributed in part to the fact that family planning services in Pangasinan are not yet fully integrated in its maternal and child health (MCH) program. Taking its cue from the provisions of the World Plan of Action (Cairo, 1990) to provide reproductive health services, the Pangasinan family planning program (PFPP) intends to expand its services to seven new areas, and to redirect the delivery of FP services in the provinces through the integration of the reproductive health approach, to address the problems stated above.

B. OBJECTIVES OF THE STUDY

General objective:

To test the effectiveness of the RH approach in improving the delivery of FP/MCH services and in increasing utilization of FP and MCH services

Specific objectives:

1) To assess the number of RH services that service providers could effectively provide
2) To determine whether the RH approach to FP service delivery is more effective in increasing CPR and reducing maternal and infant mortality rates

C. HYPOTHESES

1) The RH approach through training will result to a more effective delivery of FP/MCH services
2) The RH approach through IEC will increase demand for FP/MCH services
3) The RH approach through monitoring and supervision will ensure quality FP/MCH services by the providers

D. INTERVENTION

Interventions will be in three key areas:

1) training of service providers
2) development of IEC materials
3) monitoring and supervision of FP clients

The RH approach intends to expand the present FP services in Pangasinan to include services for the following groups:

1) women with infertility
2) women with STD/AIDS
3) women in need of post-abortion care
4) women with cancer of the reproductive system
5) women with genito-urinary tract infection (GTI)
6) adolescents in need of knowledge about sexuality
7) women victims of violence
8) high-risk women (in reference to unmet FP need)

E. METHODOLOGY

The study will employ the following designs:

1) A time-series design will be used for the assessment of the number of RH services that the service providers (SPs) can effectively provide. Here the SPs will be monitored and supervised monthly for a period of twelve months. After the RH trainings, a checklist will be conducted to observe their adherence to service delivery protocols and standards. A pre- and post-RH training questionnaire will be given to the SPs to assess their skills.

2) For the MCRAs, a non-equivalent control group design will be used to measure the impact of the RH approach in the delivery of FP-MCH services.

All service providers who have undergone the RH training will form the experimental group while those who did not have the RH training will compose the control group.

For the survey of FP clients, 100 married couples, not just women, of reproductive age (MCRAs) who availed of FP and RH services will form the study group. The same number of MCRAs who did not avail of FP and RH services will form the control group.

Data collection methods will include:

1) An inventory of physical facilities in health centers;
2) A baseline survey and a follow-up survey (12 months after) of FP and RH clients
3) Time series information on service providers
   (a supervisory checklist will be collected monthly for 12 months; 3 months before intervention and 9 months after intervention)

Multivariate analysis of SP and MCRA data will be employed, as well as a content analysis of the qualitative data to be obtained from the supervisors' monitoring reports.

Results of the study will be used for policy formulation, particularly on how to redirect FP towards the RH approach. The findings will also be used as basis for determining how FP services could be expanded to include RH services.

Dissemination of data will be done thru conferences, meetings and publications.

The proposed time frame for this study is 2 years.

OPEN FORUM

What are your dependent variables and how do you intend to measure them?

There are two levels here. One is the RH score at the SP level, which measures the service provider's capability to deliver a full constellation of RH services. But the SP's ability will depend on the demand for their service. I could imagine that there will be a particular client who will use all of the additional serven RH services. The only requirement here is that she be an FP acceptor and whether she uses one or all seven additional services will be taken up and controlled statistically from the results.

The number of services availed per woman will no longer be our major concern here but the impact of those RH services on the quality of service she obtained with regards her FP needs. We are looking into the effect, for example, of going to a STD clinic and associating it with a woman's FP use. A couple who comes to a clinic for FP might learn that a constellation of RH services are also available. What we're trying to measure is the extent to which FP use has influenced the utilization of other RH services available in the clinic.

The statement has to do with what is the RH need of the couple and did they avail of the service. The reasons could be: It is the quality of service provided by the SPs or it is the couple's motivation for RH. There are gender issues at work which prevent women from availing of RH services.

- Dr. Gil del Rosario
Pangasinan Health Office

The topic of your presentation is very good. The questions on what to expect about RH services and their impact on RP are very important for us to understand. Your comments and explanations to the questions you've been given showed clarity of your thought. My comment on your proposal and concept paper is that you have set for yourselves a very difficult task of having to answer all these questions. To conduct in one study three separate designs that look at a range of hypotheses at different populations is quite challenging. I suggest that you narrow down your topic, reduce the number of designs and really think about it as a series of studies that you'd want to undertake, one leading to the next. That would help the funders to grasp the significance of your study.

- Dr. Dale Huntington
The Population Council

Is the constellation of services to be provided by the SPs or by the program? Your study focuses on SPs who would be having training on RH issues, but if there is no program in place,

that might be difficult. In other words, what is your intervention? Are you looking at the system or the SPs? I would expect that the impact of a system would be more dramatic than a training course for midwives.

- Dr. Michael Costello
RIMCU, Xavier University

We are assuming that in the devolution, the local government has a full say. Second, the expansion of the current FP services into the RH program will not be total. That is why we have to do a situational analysis first to find out the ability of the province to provide x number of the seven expansion area. We are assuming in this study that there is a system in place that needs coordinating and fine-tuning by retraining. You might note that supervisory protocols are there which will dictate the norm of conduct in service provision. The evaluation will be in terms of whether the agreed upon protocol is being followed or not and whether other services in the basket of the RH services can effectively be delivered by everyone in the system, in the experimental area. This is going to be compared with the control group, wherein admittedly there is already a set of activities/services being provided. The protocols will be our source of deviation and evaluation of the SP's performance.

- Dr. Gil del Rosario
Pangasinan Health Office

Towards Developing a Community-based FP Program in Nueva Ecija

Felicitas de Leon, M.D.
Provincial Population Office

Felicisimo Embuscado, M.D.
Provincial Health Office
Nueva Ecija

A. PROBLEM SITUATION

A marked decrease in CPR from 64% in 1993 to a projected value of 39% by 1995 has been noted, despite adequacy of FP supplies in service delivery points and the presence of community health volunteer workers (CHVWs). Male participation is also practically nil. Based on existing records, there were only 4 cases of vasectomy from 1994 to 1995. Also, only 12% of the total FP acceptors are male.

These could be attributed to the following:

1. Because of the devolution, the RHMs no longer go to their catchment areas. Instead they just stay in their barangay health stations where they wait for their clients, thus compromising the benefit of follow-up of their clients.
2. The religious beliefs and wrong information received by the clients could have been a factor. The Catholic church is very vocal in its campaign against artificial FP methods.
3. Only 20% of the facilities promote the NFP method.
4. Male participation is very limited.
5. CHVWs have low KAS (knowledge, attitude and skills).

Given the above, the provincial health office therefore seeks an alternative model for service delivery that could bridge the gap in the current flow of service. The project is an intervention scheme that will make use of the capability of the CHVWs to implement the FP program at the barangay level with minimum supervision.

B. OBJECTIVES OF THE STUDY

The ultimate objective of the study is to develop and test a sustainable model that can efficiently implement FP services. The immediate objective is to conduct an intervention that could test the effectiveness of a community-based approach.

The study shall consist of of 3 phases, namely:

Phase I. This will involve the conduct of a diagnostic study on the characteristics and KAS of CVHWs in 2 municipalities of Nueva Ecija. One will be the control group and the other will be the study area.

Phase II. This will include the training of CHVWs in the study area. This will serve to strengthen the CHVWs' capability for FP program implementation in the barangay.

Phase III. This will entail the determination of the effectiveness of a community-based approach in the implementation of FP program.

The specific objectives of the study are:

For Phase I: To determine baseline data on the socioeconomic status of the CHVWs in 2 municipalities of Nueva Ecija;

To compare the CPRs of barangays in the 2 study areas;

To compare the CHVWs' KAS on FP.

For Phase II: To develop training modules that address the training needs of CHVWs as reflected in the results of Phase I;

To conduct a training of 40 CVHWs from the municipality of Munoz, Nueva Ecija;

To conduct a post-test evaluation that would determine changes in trainees' KAS level.

For Phase III: To document the CHVWs' activities related to FP and how these were conducted using established protocols as basis;
To determine the effect of the intervention on CHVWs'performance.

C. HYPOTHESIS

The group does not have a hypothesis for Phase I because it is a baseline study. For the intervention study, the group's hypothesis is that an improvement of the KAS of CHVWs on FP will improve their performance.

D. VARIABLES

The independent variable in the study will be the CHVWs' exposure and non-exposure to training. The dependent variable will be the performance of the CHVWs. The intervening variables

are age, sex, educational attainment and presence of health facility in the barangay.

E. METHODOLOGY

There will be two study designs: the diagnostic and the experimental post-test design. Data will be collected using standard questionnaires and secondary data from the FHSIS-MS1 and FP-TCL.

The sampling design is a purposive cluster sampling.

For data analysis, univariate and bivariate analyses will be employed.

Meetings with municipal health officers, nurses, RHMs and barangay health workers will be held to disseminate the study findings. For utilization, the group plans to do an extension of the pilot study to other municipalities.

The proposed timetable for the study is as follows:

Phase I : April to September 1996
Phase II: October to November 1996
Phase III: December 1996 to March 1998.

The budget requirement is as follows:

Phase I: P200,000
Phase II: P78,000 (which will be paid for by LPP and LGU)
Phase III: Still to be determined

OPEN FORUM

Are there intervention studies that are available for reference?

- Dr. Felicisimo Embuscado
Nueva Ecija Health Office

Unfortunately, right now, we are not in possession of such services, and although our agencies have listed researches in their files, we have not yet really delved into these studies whether they have interventions or not.

- Dr. Edwin Ilagan
FPS, Dept. of Health

Who is really (in charge of) the clearing house for all these intervention studies - the PopCouncil or the DOH?

- Dr. Felicisimo Embuscado
Nueva Ecija Health Office

The DOH FP service plans to be the clearing house as far as RH researches are concerned. The essential national health research service in the department is supposed to be the clearing house of all researches being done in the area of health. The FP service wants to confine itself to women's health and RH because by itself, it is already a very big area. Unfortunately, there are no efforts of integration yet. We're still in the process of talking with other agencies as well as looking into our files in the FP service. But you will be informed when such structures have already been instituted.

- Dr. Edwin Ilagan
FPS, Dept. of Health

An Operations Research to Determine the Accuracy of the Family Planning (FP) and Maternal-and-Child Health (MCH) Reports of the Five Health Areas in Cebu City

Milagros Padron, M.D.
Cebu City Health Office

A. PROBLEM SITUATION

Cebu City is divided into five health areas. In the past two years, there has been a considerable variability in the performance of these health centers.

B. OBJECTIVES OF THE STUDY

The objectives of the study are:

1) To determine the accuracy of FP and MCH reports in the city health department;
2) To identify the sources of errors and other factors that could account for the variability of the performance levels of the areas.

C. METHODOLOGY

Several methods are proposed. First, the study will compare the information which are based in the health centers with the reports that are being submitted to the statistics section of the City Health Office. These records could include the MCH target client list (TCL), FP-TCL, individual records of FP clients and the monthly FHSIS reports.

Second, actual observations will be made on how service providers record data or fill up forms in the sample health facilities.

Third, an aptitude test on how to fill up forms and accomplish reports correctly will be administered.

Fourth, interviews with selected clients listed in the TCL will be conducted to determine if they really availed of the services at the health center. This will serve as a verification process.

For the sampling plan, it is proposed that 50% of the city's 62 health facilities will be sampled and distributed proportionately to the five health areas. In each health area, a mother unit or main health center and a mountain(?) barangay center will be included. The case observations will depend on the number of clients during the observation period. A total of 500 FP clients will be randomly drawn and interviewed.

For the data collection, the group plans to first call the health supervisors (e.g., area medical

officers or nurse supervisors) to discuss and agree on how to design the study instruments.

Study findings will be disseminated to the City Health Officer, Area Medical Officers, medical officers, nurse supervisors and field programs division staff and other appropriate health program managers.

The proposed duration of the study is six months, with a budget of P202,400.

Availability, Functioning and Quality of Formal Counselling Centers in the Province of Albay

Lazara Julianda, M.D.
Ago Medical and Educational Center
Phoebes Camba, M.D.
Provincial Health Office, Albay

A. PROBLEM SITUATION

Albay is faced with problems of high FP drop-out rate and low utilization levels of FP services by the target clientele. To address these needs, a study on the quality of FP counseling centers in Albay is being proposed.

B. RESEARCH QUESTIONS

This study hopes to answer the following research questions:

1. Are counseling facilities available?
2. Are they functioning?
3. Are there trained personnel available when needed?
4. Are services offered?
5. What kind of services (are offered)?
6. Are the reports accurate and complete?
7. Are the clients satisfied?
8. Do the clients ask questions freely?

Answers to these questions are perceived to be important in helping the Albay health office fulfill its initiative in the LGU Performace Project.

C. OBJECTIVES OF THE STUDY

The ultimate objective of the study is to improve the FP counselling center and its services. The immediate objectives are:

1. To conduct a diagnostic study in the counselling centers which will be done by the provincial health office (PHO) and the AMEC Graduate School;
2. To describe the availability, functioning and quality of services in counselling centers;
3. To identify areas for improving FP counselling

D. VARIABLES

Availability is operationally defined as the presence or absence of facilities and trained personnel.
Functioning is an attribute of the facilities and services being used.
Quality is the provision of effective and efficient services.

E. METHODOLOGY

This study is descriptive in nature. The group proposes to conduct surveys, actual observation and exit interviews. Random sampling will be done to come up with 50 counselling centers which will be distributed proportionately between private and public sectors. The respondent for the exit interviews will be composed of those who will visit the counselling centers on the scheduled observation day.

Data will be collected using the questionnaires in Appendix A, B and C of the guidelines circulated (FP OR manual). Some modifications will be done with the questionnaires to suit local conditions.

Data analysis will be mostly univariate analysis, including the ff:

1. Number of counselling centers in each of the three congressional districts;
2. Availability of a private room for counseling in the center;
3. Number of people trained in each counselling center-e.g. medical doctors, midwives, etc.
4. Number of days/weeks/months when trained counsellors are available in the center;
5. Availability of IEC materials.

To measure the quality of services, a Liekert-type scale will be used to gauge client satisfaction.

OPEN FORUM

What do you think of the idea of training non-directive counsellors?

It's expensive. We cannot afford to have them yet.

- Dr. Lazara Julianda
AMEC, Albay

Non-directive counselling really requires psychological background and skills. I am just wondering who will be trained for non-directive counselling, and for how long? And how much time will they need to do the non-directive counselling? We have a New York-trained psychologist for a counsellor in a women's crisis center in CPU. At the end of the day, she would feel exhausted. And we only had 78 clients in the past nine months. Seemingly, we need people who have this training but we do not have funds to train them and sustain their interest in volunteer work. Do you have provisions in your budget that would sustain them in their volunteer work?

But are you convinced that those clients who are satisfied with your counselling services could be a potential force in keeping the counsellors in the program?

- Dr. Lazara Julianda
AMEC, Albay

May I ask why you put the term "FP non-directive" in your proposal? Does this mean that a woman has to be a FP acceptor first before she is given a non-directive counselling? If that is the case, then there is no possibility to find out what the extent of an experience would be in preventing her from getting FP services.

Maybe Dr. Huntington can best answer that.

- Dr. Lazara Julianda
AMEC, Albay

What you presented was just fine. It was very clear. I only have an alternative suggestion to make. Counselling and qualitative methods are often very helpful for giving you some insight. In fact a lot of the issues that come out in the counselling, we talk about them in other proposals. They are difficult to measure in a quantitative survey. I am suggesting that you might think in this study or in another study about a qualitative assessment of counselling. One area of problem in counselling is that in general, FP clients are all, more or less the same in terms of their characteristics. Sometimes, someone who does not really fit the typical client profile comes in. Is she turned away? This type of issue is sometimes interesting to probe. One method that we used in the past to get at this is the (use of) mystery/simulated clients. You find someone of certain

characteristics and ask her to go the clinic for services. Tell her that she need not accept any method if she does not want to. She can just ask information. When she comes out, she will be interviewed. In that way you are complementing your quantitative method (of data collection) with a qualitative one.

- Dr. Dale Huntington
The Population Council

I think we will try it in our crisis center in Legaspi. Only 2% of the population are battred wives or victims of incest, are you willing to spend resources for this 2%?

- Dr. Lazara Julianda
AMEC, Albay

This is related to the question earlier raised. You said they are FP clients. Does that mean to say that only these people who are battered go to the clinic for counselling ? Most of the time, they go to the clinic because they have technical problems like side effects, complications or some unclarified information. These are the people who also need counselling.

- Dr. Marilou Costello
The Population Council

There are different groups. If they have technical problems, they need a medical doctor.

- Dr. Julianda Lazara
AMEC, Albay

An Experimental Study on the Organization and Mobilization of Satisfied Male and Female FP Users as Program Communicators in the Promotion of Family Planning Practice and Reproductive Health in Iloilo Province

Fred Cubil
Elizabeth Banez
Provincial Health Office, Iloilo

A. PROBLEM SITUATION

The CPR of Iloilo province in 1994 is 29%. The number of new acceptors has been on the decline. Moreover, an increasing number of artificial FP method users have been dropping out of the program. Despite the fact that health personnel have been trained on ICS, many eligible couples have not yet availed of the FP and RH services in their municipalities.

To solve these problems, the group proposes the mobilization of satisfied FP users to serve as communicators in promoting FP and RH in the communities.

B. OBJECTIVES OF THE STUDY

This experimental study will be conducted from 1996 to 1998 in order to determine the effectiveness of using satisfied male and female FP users in helping the program promote the use of FP and RH services in the province of Iloilo.

C. HYPOTHESIS

The group's hypothesis is that after the implementation of the study, there will be an increase in CPR, in the number of new acceptors and in the knowledge of eligible couples with regards FP and RH practices. Also, a decrease in FP drop-out rate will be expected.

D. METHODOLOGY

A quasi-experimental design will be used for this study. The major research activities will include: a baseline study (using both quantitative and qualitative approaches), intervention strategy (training and mobilization of satisfied FP users as program communicators) and a post-project evaluation.

For the baseline study, two municipalities will be chosen based on their population, geographic and socioeconomic characteristics. One municipality will serve as the control group while the other will be the experimental group. A systematic sampling method will be employed

in the selection of barangays.

Data collection will be done through personal interviews and focus group discussions. In-depth interviews with program managers, implementors in the field and LPP managers will also be conducted.

For the intervention phase, satisfied FP users, both male and female, who are also willing and committed to do volunteer work for FP and RH services will be identified and organized. These volunteers will be trained, using a module which will include RH, gender sensitivity issues and values clarification. These volunteers are expected to be mobilized within a period of 12 months. After this, an evaluation study will be conducted. It is expected that after the introduction of the proposed intervention, the expected changes and effects will be observed in the experimental group.

The research results will be disseminated to end-users, like the Provincial Health Office, the Provincial Population Office, LGUs and NGOs, as well as thru local media and publications in journals. The group also plans to sponsor research utilization workshops.

The proposed schedule of activities is as follows: 20 weeks for the baseline study, 8 weeks for training, 48 weeks for intervention and monitoring and 18 weeks for evaluation, or a total of 94 weeks.

The proposed budget is as follows:

P192,500 for the baseline survey (of which P13,000 will come from the LGU)
P 90,000 for intervention & monitoring (of which P59,300 will come from the LPP and P38,400 will come from the LGU)
P244,200 for evaluation (of which P14,300 will come from the LGU).

OPEN FORUM

Don't you think you should use continuing users instead of CPRs as one of your independent variables?

Continuing users are not as much of a problem as the new acceptors.

- Fred Cubil
LPP, Iloilo

You can increase FP acceptance levels because of your volunteers. However, you can increase your CPRs without necessarily reducing fertility. If you use "continuing users" (by computing the average duration of use) as your variable, you would also be measuring the quality of service provision of your outreach workers.

- Workshop participant

Just two quick comments. First, I didn't see anything about sampling. I didn't see how many you are going to interview and how you are going to select them. Second, I was just kind of puzzled that your study will take 96-98 weeks. I think one of the assumptions of doing an OR is that it is fairly quick. A 2-year study is unusual for OR. The program managers usually say, "I cannot wait that long. I need the information now." So, you might try to think of ways to shorten your study.

- Dr. Michael Costello
RIMCU, Xavier University

There has been experience in places using the satisfied users for IEC both in the clinics and in the outreach programs. It usually has shown some success. One issue, though, that comes up in any new intervention that is being tested is that of sustainability. If this satisfied user approach works, how is it going to be sustained after the training program/study is over? How can it be scaled up or expanded to new areas? What are the resources involved? How intensive an effort is it? When you design your interventions, you should take these things into consideration early on so that the experiment is limited to just data collection while the intervention is to be done very simply and carefully, as if creating a new routine management or program that could easily be adapted by other programs. So, I encourage you to think about these issues, because if this works, we would want to use it again and again in other places.

- Dr. Dale Huntington
The Population Council

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You can increase FP acceptance levels because of your volunteers. However, you can increase your CPRs without necessarily reducing fertility. If you use "continuing users" (by computing the average duration of use) as your variable, you would also be measuring the quality of service provision of your outreach workers.

- Workshop participant

Just two quick comments. First, I didn't see anything about sampling. I didn't see how many you are going to interview and how you are going to select them. Second, I was just kind of puzzled that your study will take 96-98 weeks. I think one of the assumptions of doing an OR is that it is fairly quick. A 2-year study is unusual for OR. The program managers usually say, "I cannot wait that long. I need the information now." So, you might try to think of ways to shorten your study.

- Dr. Michael Costello
RIMCU, Xavier University

There has been experience in places using the satisfied users for IEC both in the clinics and in the outreach programs. It usually has shown some success. One issue, though, that comes up in any new intervention that is being tested is that of sustainability. If this satisfied user approach works, how is it going to be sustained after the training program/study is over? How can it be scaled up or expanded to new areas? What are the resources involved? How intensive an effort is it? When you design your interventions, you should take these things into consideration early on so that the experiment is limited to just data collection while the intervention is to be done very simply and carefully, as if creating a new routine management or program that could easily be adapted by other programs. So, I encourage you to think about these issues, because if this works, we would want to use it again and again in other places.

- Dr. Dale Huntington
The Population Council

A Study on the Effectiveness of a Refresher Course on Interpersonal Communication Skills Integrating RH and Gender Sensitivity Among Trained Midwives in Davao del Norte

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A. PROBLEM SITUATION

Despite the trainings given to its midwives, Davao del Norte still has a relatively high FP drop-out rate of about 13%. The possible explanations to this are: 1) efforts to follow up clients are inadequate; 2) all trainings are method-oriented; and 3) counselling is not a priority among health providers.

A possible solution to this problem is to provide midwives a refresher course integrating reproductive health (RH) concerns and gender sensitivity.

The justification for the study is based on the following points:

1. This is the new thrust of the DOH FP program
2. This serves as a response to the challenge of the International Convention on Population
3. This is a priority of the LGUs

B. RESEARCH QUESTION

The proposed study aims to address the question:

"Is the refresher course on inter-personal communication skills (ICS) integrating RH and gender sensitivity an effective approach in improving the quality of service among rural health midwives in Davao del Norte?"

C. OBJECTIVES OF THE STUDY

The ultimate objective of the study is to improve the quality of FP, RH and maternal health (MH) services in Davao del Norte. The immediate objective is to investigate the effectiveness of the refresher course on ICS integrating RH and gender sensitivity among the trained midwives. This study will be conducted by the provincial health office in collaboration with Ateneo de Davao University from July 1996 to July 1997.

D. HYPOTHESIS

The hypothesis is that midwives who undergo the proposed ICS training integrating RH and gender sensitivity concerns will have more knowledge on these issues and as a consequence, their clients will receive a better quality of FP and RH services.

E. VARIABLES

The independent variable will be the the midwives' attendance or non-attendance of the modified ICS training. The dependent variables will include quality of care, perception of clients, exchange information, methods choices, interpersonal relations, and client assessment.

In this study, *exchange information* refers to the number of RH and gender sensitive issues discussed by the midwife with the client. *Methods choices* refer to the informed choices (e.g., did the midwife discuss the advantages/disadvantages of different methods with the client, did she provide alternatives of a FP method before the client made her choice?) *Interpersonal relations* pertains to the client's perception of how she was treated by the service provider (e.g. friendliness, respect for privacy, etc.). *Client assessment* will be measured by the number of complaints addressed by the service provider, or the duration of waiting time before client was attended to.

F. INTERVENTION

The intervention will be an improved course content for the existing training module of the ICS refresher course, where RH and gender sensitivity concerns will be integrated in the teaching of human relations skills and interpersonal communication skills.

G. METHODOLOGY

For the rural health midwives (RHMs) or service providers (SPs), pre- and post-tests will be given. The post-test for the SPs will be given immediately after the intervention (training).

For the FP clients, a quasi-experimental design will be employed. The experimental group will be composed of clients who were served by RHMs who attended the modified ICS refresher course. The control group, on the other hand, will be composed of clients who were served by RHMs who did not attend the revised refresher course. A post-test will be given to the clients after six months of intervention.

The unit of analysis will be the RHMs and their clients. Quota sampling will be done. There will be 15 facilities with trained midwives as our experimental group and 15 facilities with untrained midwives as our control group. A total of 250 clients per group will be interviewed.

To measure the impact of the training on the RHMs' knowledge of RH and gender issues, "knowledge tests" will be administered after the training. Ont the other hand, structured interviews and possibly, focus group discussions, will be conducted among FP clients.

In analyzing the data, a significant difference in the knowledge of RHMs about reproductive health and gender issues is expected between the two groups (trained vs. non-trained). Meanwhile, clients who were served by the trained RHMs are expected to have better quality of care than those who were served by the "non-trained" RHMs.

Results of the study will be disseminated to the provincial health unit staff, service providers at the provincial, municipal and barangay levels, local government executives, local health board, and partners in health service.

The research findings will also be used as basis to redirect the annual plans of the provincial health unit and in improving the succeeding training courses for service providers.

The proposed timetable for the study is one year, and the proposed budget is P823,000, which already includes a total of P88,500 as counterpart of the local government of Davao del Norte.

OPEN FORUM

The presentation is quite focused. I'd like to add that among your dependent variables, you should include discontinuation of FP method because that was in your original rationale. Secondly, if you are going to geneerate gender sensitivity, will the husbands be involved in the counselling? Think that through clearly because you did not mention it.

- Dr. Michael Costello
RIMCU, Xavier University

To make your topic more marketable or more convincing, I think you can enrich it by trying to provide the justification. What's the difference between the refresher course and the regular training program of your study? Since you said that it is already the priority of the FP program and the LGUs, what is that element then that you are adding to the regular contents of the training modules?

- Dr. Marilou Costello
The Population Council

We didn't deal with the details because we have limited resources for this workshop.

- Dr. Dolores Castillo
Davao del Norte

I really applaude your group. With the way you were able to put all your ideas together for the presentation, I think this is one of the best so far. I have one comment though. The issue about training in gender sensitivity for RH and planning is a new field. There is not much wealth of information that could make it go on. You have to create a bit in terms of this training. I was very pleased to hear that you would be using focused group discussions, that you can really probe into some issues about how women are appreciating the training. My suggestion would be to conduct the FGDs early on to help you define the content of the training a little bit more. That way, you can build on some of the women's perspectives, problems and concerns into the training you'd really want to provide.

A Situational Analysis of the FP-MCH Program in Bukidnon

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A. PROBLEM SITUATION

It has been observed and explicitly expressed by local government officials and program managers that FP data in Bukidnon are of poor quality. For instance, the contraceptive prevalence rate (CPR) is unrealistically high and the crude birth rate is suprisingly low, when observations point to the contrary. Moreover, there is no mention of quality of care in the present reports. Available information is limited to training and staffing.

The justification given for proposing this study is that any planning of intervention requires accurate, reliable and timely information. The proponents therefore hope to use the results of this study as baseline information and probably as a pre-test to the forthcoming LGU performance program (LPP).

B. OBJECTIVES OF THE STUDY

The ultimate objective of the study is to improve the FP-MCH program planning and service delivery in Bukidnon. The immediate objective is to describe the functioning of activities which would serve as baseline data for the evaluation of future LPPs.

This will purely be a descriptive study. The variables will be measured using a situational analysis instrument developed by Population Council in 1992.

C. METHODOLOGY

There will be 5 study teams. Each team will have a supervisor, a health officer and a researcher. A field coordinator will verify the data collected in each service point. Each team will cover 6 facilities for at least 3 days or until ten clients are interviewed. The minimum number of clients to be observed will be 300.

Univariate analysis will be used. For dissemination and utilization of study findings, a conference on research utilization will be conducted. The expected participants will include service providers (SPs), program managers, local executive and members of local media. Copies of the results will be distributed to all FP service points.

The study will take 2 months for preparatory activities, a month each for training and data

collection, 2 weeks for editing, one month for coding, 2 months for data processing, one month for analysis, 3 months for writing the report and one month for finalization of the report, or a total of 14 months.

The proposed budget is P700,550. Of this, P249,000 will come from the LPP, P100,000 from the LGU and P30,400 from the regional health office (RHO).

I fully agree with you on the need for a truly reliable baseline information. However, what you have listed as your problems are demographic and health data. I wonder whether a demographic and health survey could generate these data. Also, if you have a P249,000 support from LPP, I think you should get in touch with UPPI instead, unless you really want to focus on quality care redirected to the RH approach.

- Dr. Marilou Costello
The Population Council

I am answering, I am not asking a question. First, in 1993, there was a big survey, the Demographic and Health Survey (DHS). For the record, the DHS does not have a big sample from Bukidnon, although one can get regional estimates from it. Second, remember the early distinction between the supply side of the OR and the demand side? I think they really want a supply-side study, i.e. what's going on in the clinics, like a client observation, which you cannot get from a household survey. A (household) survey is nice and good but it's not really going to solve their problems, I believe.

- Dr. Michael Costello
RIMCU, Xavier University

Just a follow-up on that. That's a good question because people often ask, "Can the DHS answer these questions?" The DHS is a population-based study whereas a situational analysis is clinic-based. It takes place in service delivery points and collects information about materials, equipment, staff, quality of care and services provided in the clinics through observations. Those types of information are not collected in the DHS or a population-based survey. The client interviews are the closest that come to an overlap because you are interviewing FP clients. In demographic studies, you are interviewing women of reproductive age. Clearly, there's some kind of overlap and you might be able to get some of that information from a population-based survey. You get a user's perspective but it's not the same because you are not able to link it right to that health service or to the providers you saw. I just have a comment on your proposal -- it's very clear and well-developed. Thank you for such a good work. When it comes to doing your study, make sure that what you're using as a model contains the most current questionnaires. The guidelines that have been circulated in this workshop are a bit old. There have already been several iterations.

- Dr. Dale Huntington
The Population Council

Just a comment on all of the presentors who are having sections called dissemination and utilization lumped together. All of what I've seen so far is a discussion of dissemination and there's really nothing much of a plan to ensure that the findings are going to be utilized. Of course that wouldn't be a big problem because we've got the program managers right here. But in general, you

want to have a contact person inside the health office who's going to champion your cause. You can't just have a dissemination seminar and then just walk away. It's not going to happen. You'll need further follow-up, meetings and a planning task force. Utilization is a separate dimension in some ways and one of the most difficult tasks.

- Dr. Michael Costello
RIMCU, Xavier University
- Dr. Dale Huntington
The Population Council

Enhancing Knowledge of NFP Acceptors in Cagayan De Oro City: An Intervention Study

Belen Ligo, M.D.
Mirabel Tangcalan, M.D.
City Health Office, Cagayan de Oro

A. PROBLEM SITUATION

There is a high demand for NFP counselling in Cagayan de Oro City since it is very acceptable to users. The NFP management however has done little to make this method more effective. The discrepancy lies on the lack of initiative of NFP management to respond to the high demand for NFP.

B. RESEARCH QUESTION

The proposed study will address the question: *"How can NFP method be improved from a less effective method to a more effective one?"*

Despite the high demand and acceptability for NFP, this method appears to be less effective because of its high failure rate. The NFP lectures being conducted at present by some groups do not put emphasis on discussing the women's reproductive system. There seems to be no effort in simplifying lectures.

C. OBJECTIVES OF THE STUDY

The ultimate objective of this study is to integrate a more effective NFP method in all service outlets.

D. HYPOTHESIS

The hypothesis is that the intervention will improve the NFP from a less effective to a more effective method.

E. VARIABLES

The study variables include:

> *Use effectiveness*, defined as the percentage (proportion) of the study group who were able to avoid a pregnancy (through the use of NFP) at the end of the study period.

Knowledge of NFP refers to the understanding of NFP gained from the simplified lectures. This will be measured through a pre- and post-test design and expressed in percentage.

F. METHODOLOGY

The study will employ a quasi-experimental design, with a non-equivalent control group, since one cannot expect the samples to have the same characteristics. There will be 50 "high-parity" women (i.e., those with more than five children) in the sample group. The same number of women will be enrolled in the control group.

Data collection will be done using structured interviews to be conducted among all NFP acceptors in the experimental group, for both pre- and post-tests. The data analysis will be limited to univariate and bivariate analysis. Percentages, chi square, test of difference of proportions and of means, graphs and charts will be used.

Results of the study will be disseminated to FP counsellors, NGOs, health providers and schools. The final report will be based on feedbacks and comments. Revisions of the training module will then be made. LGUs will be informed about these findings for possible funding of additional trainings of FP service providers.

G. INTERVENTION

A sample of current NFP users will be invited to attend a special lecture. The lecture will be simplified, with emphasis on when a woman can get pregnant during her menstrual cycle. There will be a total of 10 training sessions. Pre-and post-tests will be given to the experimental group to measure their understanding of the lectures. The control group will not be exposed to the training. For this group, the pre- and post-tests will also be given. Comparison between the two groups will be done with reference to pregnancy occurrence.

OPEN FORUM

Because NFP is a decision of both husband and wife, the husband is a moderator variable in this case, and should perhaps be included in your study variables. I am also a bit confused with your use of the term "NFP acceptors". Why not use "calendar rhythm users" instead? From what I understand in your report, you want to upgrade the calendar rhythm use to NFP use.

- Workshop participant

There are many types of NFP, and all of these methods depend on the physiological way of how a woman can get pregnant.

- Dr. Belen Ligo
Cagayan de Oro

I'm a little bit confused about your definition of a NFP acceptor. Why can't we just agree to just upgrade the calendar rhythm method through the use of any of the modern NFP methods like BBT, cervical mucus and symptothermal? If we agree on this premise, then your intervention would then entail "converting" the calendar rhythm users to any of the three modern NFP methods mentioned.

You also said that you are going to interview NFP acceptors. How do you define an NFP acceptor? Are you going to interview husband and wife pairs?

- Dr. Zelda Zablan
UP Population Institute

Earlier, we thought of having three study groups, namely: the control NFP user, the women who were given lectures, and the husband and wife who were given lectures together. However, the feedback that we received is that there is no balance. It was suggested that we also interview husband-and-wife pairs, but this would make things complicated. We prefer to start our research in the simplest way.

- Dr. Belen Ligo
Cagayan de Oro

But your NFP acceptor is a combined husband and wife unit.

- Dr. Zelda Zablan
UP Population Institute

But my premise is that the husband's participation is always there.

- Dr. Belen Ligo
Cagayan de Oro

If you refer to the Philippine Federation of NFP protocol, you will learn quite a lot on how this can best be operationally defined.

- Dr. Zelda Zablan
UP Population Institute

I think what Dr. Ligo is trying to do is first, to include the fertility awareness module in the existing NFP training being provided by the parish councils. The intervention being described involves the provision of a scientific basis for the existing NFP lectures being given by the parish council.

- Dr. Marilou Costello
The Population Council

Actually, the lecture being given by the parish council includes anatomy and physiology of the female reproductive system. However, the lectures are not simplified, and there is not much emphasis being given to the woman's fertility period.

- Dr. Belen Ligo
Cagayan de Oro

It is not clear in your presentation what the less effective NFP practice is and what the effective practice is. If you want to move them from a less effective to a more effective practice, do you mean to introduce a change in the type of NFP or a more effective use of the present NFP method?

Also, the sampling formula used is for calculating the sample size needed to detect a certain proportion. Your study, however, looks at changing the proportion, which requires a different formula.

- Dr. Dale Huntington
The Population Council

I think we must understand some common terms. When we think of NFP in the Philippines, we mean only three methods, the cervical mucus, sympto-thermal and basal body temperature (BBT) methods. "Autonomous users" refer to NFP users. Other than that, they are considered non-NFP users. Hence, they are not part of the program. When we have to do this program, the couples must be registered or recorded in the FHSIS. And our current FHSIS includes only the autonomous users. Perhaps, you are talking of non-NFP users which are potential NFP users. We have to define our terminologies better.

- Workshop participant

Describe and do think carefully about your interventions. It is hard for me to believe that one lecture would have a powerful impact that you would see the difference at the end of the year. I know you wanted to keep it simple and I understand. But you might consider some of these ideas, like bringing in host friends or having a follow-up service, the kind to reinforce the service.

I'd like to comment on your immediate objective. It's fine if the CHO wants to conduct the experimental study. My personal bias is to get a specialist who has experience in conducting a research. You might think of subcontracting this out to a private organization in Cagayan De Oro. But generally speaking, you can be involved in the intervention but get a professional researcher to carry out the quasi-experimental study.

- Dr. Michael Costello

REACTIONS FROM HONORED GUESTS

Carmencita Reodica, M.D.
Department of Health

I welcome the effort of the Family Planning Operations Research and Training (FPORT) program of the Population Council to enhance the capacity of the selected LGUs to identify research needs and research agenda. As you know, this is one of the benchmarks of the LGU Performance Project (LPP).

I would like to stress, however, that more than identifying the research agenda and undertaking the research itself, we should focus our efforts on the utilization of the research findings for our own program and policy planning. During the Research Congress held by PCHRD about 8 or 10 years ago, I was shocked to know that research utilization was as low as 8 percent, while the money that have been poured into research ran into millions. The message that I would like you to remember is that you should not only conduct the research, but more importantly, make sure that the research findings are going to be used by program planners and decision makers.

Congresswoman Teresita Oreta
House of Representatives
Republic of the Philippines

I have been working with a group of women who have formed themselves into a group called the MAKATAO Foundation, Inc. These women have planned and designed a women's center to respond to the different needs and concerns of their fellow women. These women have identified related services, thus, in the proposed women's center, there will be a livelihood center, a halfway house for battered women, and also a birthing home. The big component will be the special hospital for women which we will call the San Lorenzo Ruiz Women's Hospital.

My job as a public official has been to support them and help them realize their plans. March 6 is a big day for us and the women in Malabon and Navotas because the groundbreaking ceremonies for the center will be held on that day. We know that we still have a lot to know and to master, but we try to start with the women themselves--their own statement of their own problems and needs and their aspirations. I hope that we followed correct operations research techniques at the time when we were planning and designing all these.

As you go back to your own stations and constituents, I hope that you will always be guided by the situation and the hopes for better lives of these women and men whom we have committed to serve, and for whom our work and our dreams for an uplifted life situation are dedicated. I sincerely believe that if we take genuinely their welfare at heart, if we take serious efforts in knowing their situation and hopes for the future, the path towards an enhanced reproductive health can be greatly sweetened and the paths to the achievement of our common goals cannot be too far. I am sure that with your team together at the local government level, you can explore other

possibilities, so that efforts can be more directed to a wider constellation of reproductive health elements that will inevitably converge to the promotion of women's health and that of their infants and children. Let these efforts here in Puerto Galera be remembered as a beginning of a new tomorrow for our women. Let us sing a song of praise for them. Let us work for them and with them, I am sure that we will be able to chart the path to women's health. Good morning and my best to everyone.