AN ASSESSMENT OF THE METRO MANILA FAMILY PLANNING OUTREACH PROJECT

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ABSTRACT

After five years of implementing the Metro Manila Family Planning Outreach Project, systematic information on its effectiveness in promoting family planning practice among the target population was desired. The study attempted to do this through a non-experimental study design. The results showed that contraceptive prevalence was significantly higher in Outreach than in non-Outreach areas. Other findings suggest that augmentation of family planning clinic services by Outreach did not represent a substantial advantage. A major weakness was the lack of clear-cut delineation between clinic and Outreach worker responsibilities which led to overlapping functions. A number of organizational, managerial and operational weaknesses were uncovered and suggestions towards their improvement indicated.

INTRODUCTION

The Outreach project is a project of the national population program which deploys non-clinic affiliated full-time outreach workers (FTOWs) in the rural areas of the country to bring family planning information and services to the "doorsteps" of its target population – the married couples of reproductive ages (MCRAs). While principally designed for rural areas, it was implemented in urban areas as well, in keeping with the program objective of providing adequate coverage for family planning information and services in urban depressed areas.

In Metro Manila or the National Capital Region (NCR), the Outreach project was launched on a pilot basis in 1978, covering the selected areas of Malabon, Mandaluyong, Marikina, San Juan and Quezon City. It is implemented by the local governments under the leadership of the municipal/city mayors, with the assistance of the population program manager (PPM) assigned to each municipality/city and the field support teams. Some differences in the structure of the Outreach project are found to exist in rural and urban areas. The NCR Outreach project has the PPM whose counterpart in the rural Outreach project is the district population officer (DPO). The FTOWs in the rural Outreach project have the population field officers (PFOs) as their counterparts in the urban Outreach project. However,

the PFOs are oftentimes midwives or nurses who, in addition to their information and service activities, do clinic work.

The PPMs supervise the full-time PFOs and maintain a coordinative linkage with the city health officers (CHOs). An exception is the Outreach structure in Quezon City where the PPM is under the direct technical and administrative supervision of the CHO.

The NCR Outreach project structure consists of a cadre of full-time PFOs deployed to provide free contraceptive supplies and information to MCRAs in depressed communities. The PFOs coordinate a team of development workers from various agencies to effect a more efficient family planning information, education and communication (IEC) and referral services. Volunteer workers, called the barangay service point officers (BSPOs), are recruited to support the IEC and referral services of PFOs by making family planning services more accessible in the barangays. These Outreach workers augment the family planning services provided by the static clinics and health centers in the area.

In areas not covered by the Outreach project, family planning services are mainly delivered through static clinics and health centers. These facilities cater mostly to "walk-in" clients and provide basic health services which include family planning. The family planning services of clinic personnel are being supplemented by community development workers who provide family planning IEC support.

Thus the Outreach areas are differentiated from the non-Outreach areas in that the latter lacks the specialized delivery mechanism for family planning IEC and services provided by Outreach workers.

Recently, efforts have been exerted to expand Outreach operations to the other cities and municipalities of Metro Manila. However, these efforts have not been quite successful in view perhaps of the costs involved in maintaining the Outreach project and of the difficulty in soliciting political support for family planning as a priority program.

There exists no systematic information to date on the effectiveness of the NCR Outreach project in promoting the practice of family planning. This information is crucial for the identification of the strengths and weaknesses of the present Outreach structure and the ways in which it can be modified before any efforts to expand its coverage are made. The 1983 NCR-FP Outreach Evaluation Survey was conducted to meet this need.

STUDY OBJECTIVES

The NCR-FP Outreach Evaluation Survey was designed and conducted for the purpose of assessing the effectiveness of family planning Outreach workers in promoting contraceptive use in Metro Manila. To do this, comparable sites in Outreach and non-Outreach areas were selected and compared with respect to the nature of performance and effective-

ness of family planning workers, and to the levels of contraceptive knowledge, attitudes and practices of wives in the reproductive ages of 15 to 44 years.

The specific objectives of the study are two-fold:

(1) to compare the nature of performance and the effectiveness of family planning workers in promoting contraceptive use in Outreach and non-Outreach areas; and

(2) to compare the levels of contraceptive knowledge, attitudes and practice as well as access to family planning services of MCRAs in Outreach and non-Outreach areas.

STUDY DESIGN

The study used a non-experimental design called the static group comparison which can be illustrated by the following:

TIME	
X	0_1
	0_2

As indicated by the symbols, study sites which have experienced the intervention of the Metro Manila Outreach project (0_1) are compared with sites which have not (0_2), for the purpose of establishing the effect of the intervention (X).

The comparisons involve the difference-of-proportions test on the proportions having a desired characteristic from the Outreach and non-Outreach areas. It is assumed that the two samples are independent and the following null hypothesis is taken: that the proportions observed in the Outreach and non-Outreach areas do not differ. It is assumed that the two population standard deviations are equal. A one-tailed test is performed on the t-statistic by comparing it with its tabular value at a 95 percent level of confidence or a critical area of less than five percent (Blalock, 1972).

Sampling Design and Selection

A two-stage purposive sample was drawn for the MCRA survey[1] with the BSP areas as the primary sampling units and MCRAs as the secondary sampling units. Each of the five Outreach areas was divided into clusters of contiguous areas which contain BSPs in order to maximize heterogeneity between clusters and promote homogeneity of BSP areas within clusters. A list of BSP areas was prepared from where the sample was drawn at random. In consideration of the relative MCRA sizes of the Outreach areas, three BSP areas were randomly drawn in each of the four Outreach municipalities and eight BSP areas in Quezon City. The choice of the non-Outreach areas was guided by the National Housing Authority (NHA) depressed area list and similarity in population density, general socio-economic conditions and access to family planning clinics with those in the Outreach areas after a verification by ocular inspection of these sites. A

total of 20 BSP areas and 20 non-Outreach *puroks* were drawn (see Appendix Table 1 for the list).

In the second stage, MCRAs living in households were enumerated in each of the 40 sampled areas. The enumeration started in households nearest the family planning clinic and moving away from it. Enumeration stopped when 100 wives were identified. The enumeration avoided upper status households which sometimes were found to be interspersed among depressed households. From the enumeration list, every fifth wife was selected subsequent to the first one who was drawn at random. The resulting sample yielded 20 wives for each of the 40 Outreach and non-Outreach areas drawn in the first stage who were then interviewed using the wives questionnaire.

The respondents to the five other questionnaires were family planning personnel identified to be working in the areas drawn in the first stage sample. They constituted a convenience sample out of the family planning workers in both areas (see Appendix Table 2a). Since the ratio of the sample to the total population is large, its representativeness is of a less important consideration.

Criteria for the Selection of Outreach and Non-Outreach Areas

The static group comparison design of this study did not use a random allocation process to create the Outreach and non-Outreach groups that are compared. Rather, the wives and family planning workers in non-Outreach areas were used as a control group with which wives and family planning workers in Outreach areas were compared.

The 20 Outreach areas were selected from a list of all BSP areas that were operating in Metro Manila for at least one year and whose PFOs and BSPOs held their posts there for the same period of time. Likewise, family planning clinics in the areas must at least be operating for a year in both Outreach and non-Outreach areas.

The selection of the 20 non-Outreach areas was guided mainly by the *purok's* close resemblance with Outreach BSP areas in terms of: 1) the SES level of the area, and 2) access to family planning clinics.

Survey Instruments

The NCR-FP Outreach Evaluation Survey was in fact six different surveys conducted at the same time. The respondent consisted of wives, PFOs, BSPOs, clinic officers-in-charge (OICs), midwives and IEC personnel. Each group was asked different types of questions but shared a common set dealing on selected personal characteristics, knowledge, attitudes and practice of family planning. The wives were asked questions about the family planning program and service providers. Program personnel, both Outreach and non-Outreach, were asked questions about their duties as family planning workers. Table 1 below shows the number of sampled respondents in Outreach and non-Out-

reach areas for each of the survey instruments used. In addition, field observations of PFOs as well as personal interviews of PPMs were also undertaken.

Twenty PFOs (or 28.6 percent) were sampled and interviewed out of the 74 who were operating in the areas of their assignment for at least one year at interview date. Twenty BSPOs (or 5.2 percent) were likewise sampled and interviewed out of the 383 who were appointed as such and residing in the area for at least one year at interview date. The 400 wives were sampled from the 56,211 depressed families estimated to be living in the Outreach areas and another 400 wives from the 71,550 families in depressed areas estimated in the selected Non-Outreach areas of Manila, Caloocan, Makati and Pasig (see Appendix Tables 2a and 2b). Although the sampled wives constituted a small proportion of the depressed families in both areas, it is large enough to be able to make statistically sound comparisons.

The validity of the comparison in effectiveness of family planning workers in Outreach and non-Outreach areas rests on the soundness of the selection of the control group. The following section discusses the selection process as well as the household and individual characteristics of MCRAs in the Outreach and non-Outreach samples. If the housing and individual characteristics are found not significantly different between the two samples, the comparison on effectiveness of family planning program workers can thus be made.

Table 1: Sample Sizes in the NCR-FP Outreach Evaluation Survey

Survey Instruments	Outreach	Non-Outreach
1. Wives Questionnaire		
a) Main	400	400
b) In-Depth	40	40
2. PFO Questionnaire	20	—
3. BSPO Questionnaire	20	—
4. Clinic OICs Questionnaire		
a) Main	10	10
b) In-Depth	10	10
5. Clinic Midwives Questionnaire		
a) Main	10	10
b) In-Depth	10	10
6. IEC Personnel	10	10
Total	530	490
	1,020	

NATURE OF OUTREACH AND NON-OUTREACH AREAS

Access to Family Planning Clinics

The study design ensured the comparability of Outreach and non-Outreach areas in all program inputs except the presence in the study areas of Outreach workers. Specifically, listing of MCRAs living in households started with the first household nearest the family planning clinic if one existed in that particular Outreach area. The distance of this first household from the family planning clinic facility was observed in the listing of the first non-Outreach household if a clinic also existed in the non-Outreach area.

In cases where a family planning clinic existed in the Outreach but not in the non-Outreach area, the choice of the first Outreach household to be enumerated was guided by the distance between the nearest family planning clinic facility outside the non-Outreach *purok* and the nearest depressed household in that *purok*. This condition was similarly kept in cases where the reverse situations held.

In the majority of the cases (see Appendix Table 3), no family planning clinic was found to have existed within the territorial boundaries of the Outreach BSPs and the non-Outreach *puroks*. Here, the choice of the first household that was listed was guided by similarities in the indicators of access to the nearest family planning clinic facility. Such indicators included physical distance from the clinic and time spent to reach the clinic by different routes.

Housing Characteristics

Selected housing characteristics as indicators of the socio-economic level of the household were analyzed (See Appendix Table 4.) Close similarities between Outreach and non-Outreach households in terms of these characteristics were observed. Although Outreach households appeared to be of slightly higher socio-economic status than non-Outreach households, the differences did not turn out to be statistically significant.

Individual Characteristics

Demographic, socio-economic, cultural and other background characteristics of wives in Outreach areas were compared with those in non-Outreach areas. None of the characteristics (shown in Appendix Tables 5, 6, and 7) compared showed statistically significant differences. In fact, wives in Outreach and non-Outreach areas shared most of these characteristics.

The typical wife was 29 years of age, with three living children and married for over nine years. She spoke Tagalog and professed the Catholic faith. She was born outside of Metro Manila and lived there for about 14 years, but have resided in the sampled barangay for only about five years. She was likely to have been to an elementary school, and stayed home as a housewife. Her husband was likely to have reached high school but did not acquire a high school diploma, and held a blue-collar occupation.

The absence of statistically significant differences attests to the comparability and sound selection of the control group with which family planning program effects in the study areas are compared.

THE OUTREACH PROJECT INPUTS

The NCR-FP Outreach Project aims to augment family planning services that are currently provided by static clinics and health centers. By program inputs are meant the Outreach project's efforts to:

(a) provide free contraceptive supplies and information at the doorstep of MCRAs in depressed communities through the deployment of a cadre of PFOs and BSPOs;
(b) coordinate with development workers from various agencies to effect a more efficient family planning information, education and communication (IEC), as well as referral services; and
(c) recruit volunteer BSPOs to support the IEC and referral services of PFOs in the barangays where they live and to dispense contraceptive supplies.

The following sub-sections are devoted to describing the project's inputs. The information reported below is based on personal interviews with PPMs and on field observation notes.

Outreach Structure, Organization and Administration

The NCR Outreach sturcture is very similar to the national Outreach project. The head is the PPM who supervises the PFO who in turn supervises the volunteer BSPO. Each PFO is assigned to a territory inhabited by 1,948 MCRAs which is close to the 2,000 MCRAs in each FTOW territory in the national project. Each NCR BSPO has 376 MCRAs living in her BSP area compared to the 200 MCRAs in a national BSP area. Five PFOs are supervised by a PPM in Metro Manila, while five to six FTOWs are supervised by a DPO in the national program (Table 2).

The compactness of residential sites and the relatively high concentration of family planning services in Metro Manila imply that NCR Outreach workers could reach their clientele with greater ease than other Outreach workers. On the other hand, this presents organizational problems particularly in the delineation of the areas of coverage between stationary clinics and Outreach workers. In order to coordinate the family planning activities of both stationary clinics and Outreach workers, the territory was divided between them. The PPMs reported that the areas covered by them lie outside a defined radius from the stationary clinics. These boundaries were not, however, rigidly followed. The setting up of territorial boundaries did little to effectively divide up the family planning work between Outreach and clinic personnel.

Except for Quezon City, all PPMs claimed that the Outreach project personnel were administratively under the municipal mayor's office and tech-

Table 2: Distribution of Outreach Workers and Population/Worker Ratios, Metro Manila, 1983

Outreach Areas	No. of PPMs (1)	No. of PFOs (2)	No. of BSPOs (3)	No. of MCRAs Surveyed in 1983 (4)	PFO/PPM Ratio (2)/(1)=(5)	BSPO/PFO Ratio (3)/(2) =(6)	MCRA/PFO Ratio (4)/(2)=(7)	MCRA/BSPO Ratio (4)/(3)=(8)
Quezon City	4	47	162	40,754	11.8	3.4	867	252
District I	1	9	38	–	9.0	4.2	–	–
District II	1	17	54	–	17.0	3.2	–	–
District III	1	6	29	–	6.0	4.8	–	–
District IV	1	15	41	–	15.0	2.7	–	–
Malabon	1	6	53	26,616	6.0	8.8	4,436	502
Mandaluyong	1	8	46	28,333	8.0	5.8	3,542	646
Marikina	1	7	50	31,022	7.0	7.1	4,432	620
San Juan	1	6	72	17,390	6.0	12.0	2,898	242
Overall	9	74	383	144,115	8.2	5.2	1,948	376

Sources: Appendix Tables 2a and 2b.

nically under the NCR Outreach office/POPCOM. In the case of Quezon City, the Outreach personnel is technically and administratively under the City Health Office. The funds to finance the Outreach structures are jointly borne by POPCOM and the local government. The local government's counterpart to POPCOM's funding varies within a range of from 60 to 70 percent and is used to pay for salaries and transportation allowances of the Outreach personnel, while POPCOM's share goes to the provision of training needs, IEC support and family planning commodities.

Coordination with other Community Workers

In the interest of promoting the coordination between family planning clinic and Outreach activities, a clinic duty day was included as part of the activity routine of all Outreach structures. The ability of the NCR Outreach project to provide clinical services rested, of course, on the fact that all PFOs were nurses and midwives, a case unique to Metro Manila. During clinic duty days, PFOs reported to the stationary clinics. Their activities there consisted of collecting pap-smears, prescribing pills, inserting IUDs, dispensing condoms, and assisting in sterilization operations.

IEC services were, by and large, shared with a host of agencies serving the community at national or local level. These services were mainly premarital counselling with the Ministry of Social Services and Development (MSSD) workers; motivation through participation in the activities of the barangay nutrition and health scholars

(BNHS); sex education of the out-of-school youth; and establishment with the NHA workers of income-generating activities to sustain the interest of couples in family planning activities.

The combination of field and clinic activities of the NCR Outreach structures made them more able to serve the family planning needs of the community at large. However, the ability of PFOs to render clinic services may have worked to the disadvantage of Outreach.

San Juan is an extreme case where PFOs provided all family planning services, from pill prescription, IUD insertion, condom dispensation, assistance in sterilization operations as well as service in satellite health clinics during "free-clinic" days. For the San Juan PFOs, their heavily clinical functions limited their field motivational activities to two out of five days of the work week. On the other hand, the coordinated activities of family planning clinic and Outreach personnel in Malabon, for instance, permitted the PFOs to conduct field visits daily.

Three out of the five Outreach structures have formally established coordinating bodies for family planning activities. Although no formal coordinating committees existed in two Outreach structures, some degree of coordination was implicit in the participation of PPMs and PFOs in the municipality's periodic review of program activities as well as in the formulation of the municipality's development plans. In all Outreach structures, the PPMs and PFOs were often tapped to participate in community activities.

Formal coordinating bodies for family planning activities at local (barangay/town) level rarely existed, and where they did, Outreach and clinic workers were not aware of their existence nor were family planning workers involved in coordinating committee work. Of the 10 OICs and 10 midwives interviewed in the Outreach areas, no one was aware of the presence of a coordinating committee, but three OICs and three midwives out of the 10 OICs and 10 midwives reported some kind of coordination in their activities with other agency workers like the Outreach, MSSD, and BNHS workers. These activities consisted of OIC requests for follow-up of their clients, and resupply of pills and condoms. The PFOs were similarly asked if a coordinating committee existed in their territory. Of the 20 PFOs interviewed, only three were aware of such a committee, and only two reported to be members of this committee. These two PFOs also reported re-survey and IEC work as the committee's activities in the past years. They further reported that the committee met quarterly or bi-annually. Apparently, stationary clinic personnel were never involved in coordinating committee work. Outreach workers were involved but at a low level.

Majority of clinic and Outreach workers, however, reported having some functional coordination activities such as referrals, replenishment of family planning clinic supplies by PFOs, and service during clinic duty

day.

All OICs and midwives said they undertook coordinating activities with PFOs and BSPOs. Table 3 shows the frequency of reporting coordination activities between clinic staff and Outreach workers by OICs and midwives.

Table 4 presents the frequency with which PFOs and BSPOs reported selected fieldworkers who did family planning work in their territory in the last three months prior to the survey. By far, the BNHS was the most frequently reported fieldworker who did family planning work in the territory/barangay. The PFOs (14 out of 20) more than the BSPOs (five out of 20) tended to report the municipal/city

Table 3: Frequency Distribution of Clinic OICs and Midwives Who Reported Specified Coordination Activities, Metro Manila, 1983.

Nature of Coordination	OICs		Midwives	
	No. who reported	Total who said "yes"	No. who reported	Total who said "yes"
Referrals:				
(a) PFOs/BSPOs refer potential FP acceptors to the clinic for examination	3	10	3	10
(b) OICs/Midwives refer sterilization cases to PFO	3	10	6	10
(c) OICs/Midwives refer users to BSPO for resupply	1	10	1	10
(d) OICs/Midwives request PFO/ BSPO to follow-up FP users	1	10	0	10
Replenishment of FP Clinic Supplies:				
(e) PFO supply FP-clinics with pills, condoms and IEC materials	3	10	2	10
Functional Coordination:				
(f) PFO reports to clinic once a week to help provide FP and general health services	1	10	4	10
(g) PFO conducts papsmear collection in clinic	1	10	0	10
(h) OICs/Midwives submit report of FP acceptors to PFO every end of the month	1	10	2	10

health personnel as having done family planning work in their territory. These workers were likely to be the midwives doing follow-up visits and family planning motivational activities in connection with their health work. Surprisingly, seven out of 20 BSPOs reported the barangay captain as having rendered family planning work in the barangay. The MSSD worker was rarely reported to have rendered family planning work in the PFO territory (six out of 20 PFOs) or in the barangay (four out of 20 BSPOs) over the past 3 months. The MHS/NHA workers appear not to have rendered any family planning work at barangay level although four out of 20 PFOs reported them to have rendered family planning work in their territory.

The extent of coordination among family planning workers may be gauged from Table 5 showing the distribution of acceptors in clinics found in Outreach areas by source of referral. Over a third of clinic acceptors in the three months prior to the survey were referred by PFOs and BSPOs, while only 17.6 percent were referred by medical practitioners. Less than half were "walk-ins."

Allocation of Work Hours

Five types of activities have been identified as constituting the activity routine of Outreach structures in Metro Manila. They are: 1) clinic day, 2) field day, 3) pre-marriage counselling day, and 4) free day (to do other family planning-related activities such as mother's classes, satisfied acceptors/users club activities.)

Results of field observational studies showed the allocation of PFO working hours to be deficient. During the "clinic day" only half (four hours) of the working hours were spent in the actual execution of the various

Table 4: Frequency Distribution of PFOs and BSPOs Who Reported Specified Fieldworker Did Family Planning Work in the Territory in the Past Three Months, Metro Manila, 1983.

Type of Worker	PFO		BSPO	
	Number reporting "yes"	Total Interviewed	Number reporting "yes"	Total Interviewed
Barangay Officials	NA	NA	7	20
MSSD Social Worker	6	20	4	20
Barangay Nutrition Scholar (BNHS)	17	20	15	20
Municipal/City Health Personnel	14	20	5	20
MHS/NHA worker	4	20	0	20
Other FP clinic Personnel (e.g. Project Tulungan, INC. IMCH)	7	20	5	20

Table 5: Percentage Distribution of Clinic Acceptors Over the 3-Month Period in Outreach Areas by Source of Referral, Metro Manila, 1983.

Area	Source of Referral						Total	
	Walk-ins	Medical Practitioner	PFO	BSPO	Other Government Workers	Other Non-Gov't Workers	Per-cent	N
All	44.3	17.6	23.1	14.3	0.0	0.6	100.0	523
Calumpang, Marikina	12.2	68.9	11.1	7.8	0.0	0.0	100.0	90
Barangka, Marikina	50.0	50.0	0.0	0.0	0.0	0.0	100.0	20
Ibaba, Malabon	0.0	80.0	20.0	0.0	0.0	0.0	100.0	10
Mabini, Mandaluyong	63.1	0.0	21.1	15.8	0.0	0.0	100.0	95
Barangka Drive, Mandaluyong	58.9	0.0	25.7	7.7	0.0	7.7	100.0	39
Hulo, Mandaluyong	3.2	0.0	48.4	0.0	0.0	0.0	100.0	93
Little Baguio, San Juan	0.0	0.0	100.0	0.0	0.0	0.0	100.0	24
Galas, Quezon City	100.0	0.0	0.0	0.0	0.0	0.0	100.0	100
Baesa, Quezon City	83.3	16.7	0.0	0.0	0.0	0.0	100.0	12
Escopa, III, Quezon City	16.7	33.3	33.3	16.7	0.0	0.0	100.0	30

Table 6: Percentage Distribution of a Typical PFO "Clinic Day" by Type of Activity and by Area, Metro Manila, 1983

Outreach Area	Activity Type							
	Coordinating with FP clinic Personnel	Conducting FP Client to Clinic	Report Writing	Home Visiting	Supervising BSPO	Attending to non-job related matters	Total	Total Time Spent (min/hrs)
Bagong Bantay, Q.C.	85.7	0.0	0.0	0.0	14.3	0.0	100.0	140/2.3
Sto. Nino, Marikina	100.0	0.0	0.0	0.0	0.0	0.0	100.0	60/1.0[1]
Barangay Halo-halo, S.J.	8.3	66.7	25.0	0.0	0.0	0.0	100.0	180/3.0
Dona Imelda, Q.C.	23.3	0.0	20.6	37.0	2.7	16.4	100.0	365/6.1
Project 3, Duyan-Duyan, Q.C.	17.6	0.8	15.5	38.2	10.3	17.6	100.0	484/8.1
Barangay Onse, San Juan	13.3	0.0	0.0	80.0	6.7	0.0	100.0	150/2.5
Nitang Ave., Novaliches, Q.C.	7.8	43.7	0.0	31.5	17.0	0.0	100.0	412/6.9
Libis Proper, Q.C.	2.0	39.2	0.0	58.8	0.0	0.0	100.0	102/1.7
All Areas	32.2	18.9	7.6	30.7	6.4	4.2	100.0	
Mean (Minutes)	76.3	44.7	18.0	72.6	15.1	9.9		236.6/4.0

[1] *The following was transcribed from the field observer's notes:*
"The morning was spent meeting with local officials for the usual Friday morning reporting. The afternoon started at 2:00 PM and the PFO was physically at the clinic until 4:00 PM. The only PFO activity was attending to a client seeking advise on tubal ligation. Papsmear was collected from the clients by the clinic OIC. Three other current users who came to visit the clinic for check-up were seen by the OIC and PFO. These PFO activities took a total of one hour."

Table 7: Percentage Distribution of a Typical PFO "Field Day" by Type of Activity and by Area, Metro Manila, 1983

Outreach Area	Activity Type									Total Time Spent[1] (min/hrs)
	Home Visiting	Lecturing	Group Discussion	Coordinating with Clinic, other worker	Supervising BSPOs	Conducting FP clients to clinic	Report Writing	Attending to non-job related matter	Total	
Bagong Pag-asa, Q.C.	63.5	0.0	0.0	0.0	36.8	0.0	0.0	0.0	100.0	190/3.2
Bgy. Mariana, Q.C.	41.4	1.7	2.6	2.6	10.3	41.4	0.0	0.0	100.0	480/8.0
Addition Hills, Mand.	40.3	0.0	0.0	34.1	25.6	0.0	0.0	0.0	100.0	353/5.9
Barangka Drive, Mand.	23.8	4.0	0.0	18.8	35.6	0.0	0.0	17.8	100.0	180/3.0
Catmon, Malabon	2.3	4.7	0.0	0.0	3.8	84.5	4.7	0.0	100.0	213/3.6
Niugan, Malabon	66.7	0.0	0.0	0.0	0.0	33.3	0.0	0.0	100.0	180/3.0
Potrero, Malabon	52.9	0.0	11.8	5.9	11.8	17.6	0.0	0.0	100.0	170/2.8
Barangka, Marikina	17.5	8.8	3.5	26.3	0.0	0.0	42.1	1.8	100.0	285/4.8
Bgy. Nangka, Marikina	33.3	0.0	0.0	16.7	16.7	33.3	0.0	0.0	100.0	180/3.0
All Areas	38.0	2.1	2.0	11.6	15.6	23.3	5.2	2.2	100.0	
Mean (Minutes)	94.2	5.2	5.0	28.8	38.7	57.8	12.9	5.4		248/4.1

[1] *Includes time spent in "Free Clinic" activities.*

PFO activities at the clinic (Table 6). These were spent mostly in coordinating with family planning clinic personnel, home-visiting, and conducting prospective acceptors to the clinic. Strikingly, there is a wide variation in the hours spent in dispensing clinic duties, from a low of one hour to a high of eight hours. Not only were PFO work hours shorter than expected, there appeared to be an underutilization by half of the total hours they actually spent in the clinic arising perhaps from low client load or, as often the case, shorter than expected number of hours of stay in the clinic or both.

Similarly, during a "typical field day" only 4.1 hours were spent in actual fieldwork, and about half of the day was spent doing nothing while at assigned post or elsewhere (Table 7). It was learned from the observational fieldwork that MCRAs in Metro Manila can be contacted with relative ease than in rural areas due to the geographic compactness of the dwelling units. Moreover, observational data indicated that the PFO-MCRA interaction was rather cursory and impersonal.

Several questions were included in the PFO and BSPO questionnaires bearing on the manner and amount of time spent in the performance of their duties. From a list of 13 tasks, PFOs were asked the three on which they spent most of their working time on

and the three on which they spent the least time. Results have shown that PFOs spent most of their time in motivating couples to become new acceptors, maintaining continuing users and establishing BSPs. The activities on which they reported to have spent the least time on were helping the mayor in preparing the municipal development plan, coordinating with workers of other agencies, and assisting in activities other than family planning.

When asked about the number of work days in a week and work hours in a day PFOs spent during the past week, the PFOs reported an average of five work days a week and eight work hours a day.

Similar questions were asked of the BSPOs about their working days/hours. Majority (16 out of 20) of them worked from one to three days with two who said they worked for seven days. The mean number of days spent per week working as a BSPO was 2.8 days. The BSPO typically spent 10.6 hours in family planning activities during the week before the survey. The BSPOs are voluntary workers who apparently work for half the number of days and nearly a fourth of the number of hours of a regular employee working for five days or for 40 hours per week.

Supervision and Training

The PFOs were asked a set of selected questions bearing on the need for more guidance and support from the PPM. Seven out of 10 PFOs said they felt no need for more guidance from the PPM than what they were getting. Majority (55 percent) of PFOs reported that the PPM's visits to the BSP areas were not often and long enough: 85 percent said the PPM's last visit was more than a month ago and lasted for 2.2 hours compared to 2.7 hours which the PFOs thought it should be.

Similarly, more than half (55 percent) of BSPOs reported their PFO's last visit was more than a week ago. BSPOs claimed these visits were not long enough (2.5 hours) and wanted these visits to be 3.6 hours on average.

All PFOs had an office and this was often located in the same building as the PPM. However, only 60 percent of PFOs said they report to their office daily. The other 40 percent said they report to their office for only once a week.

About two-thirds (65 percent) of PFOs reported that the BSP areas are within less than 25 minutes of travel from their office. It would seem, thus, that supervision by the PPM over the PFOs, and the PFOs over the BSPOs could be done with relative ease. However, the above observations seem to point out that supervision was not frequent or long enough.

Only a fifth of PFOs considered their pay as adequate. However, 70 percent claimed they were paid on time. Four out of five (80 percent) PFOs complained that their travel allowance was inadequate and half of them reported that their travel reimbursements were delayed. Almost all BSPOs (95 percent) reported they were "very much" or "moderately"

satisifed with their jobs. Ninety percent reported having received incentives and all of them were found to be members of the association of BSPOs.

Majority of the BSPOs (85 percent) received the 3-5 days formal training by the POPCOM while the remaining 15 percent were informally trained. However, more than half of the BSPOs felt they needed more training in human reproduction, community organization, supplying pills and condoms, filling up BSP client forms, BSP survey and spotmapping, and motivating couples to become new acceptors. BSPOs were more likely to report having followed up users of other methods than of resupplying pill and condom users. They were also more likely to have conducted meetings or home visits than to have given out IEC materials.

Information, Education and Communication

Eighty-five percent of PFOs reported they conducted home visits during the week before the survey. These visits were likely made to conduct BSP surveys, to follow-up users and to motivate new acceptors. About two-thirds (65 percent) of them kept a written record of these visits, although in only 77 percent of these recorded visits were the records available. On average, a PFO conducted 42 home visits over the last three months or 14 home visits per month.

More BSPOs (90 percent) reported they conducted home visits last month. The mean number of visits per month was 23.1. These were most likely follow-up visits to users of methods other than pills and condoms, for condom and pill resupply, and for motivating acceptance. Only one-eigth of the BSPO's time was spent for motivating MCRAs to shift to more effective methods.

Majority of PFOs (80 percent) reported BSPOs were in possession of extra IEC materials to give away. However, based on self-reports, 53.3 percent of BSPOs said they had none of these materials. In fact, 20 percent of BSPOs said they did not have printed materials even for themselves. It is not surprising that 35 percent of BSPOs reported they did not distribute any IEC materials to MCRAs in the month prior to the survey. When asked about the additional copies needed for the coming month, BSPOs cited a number 2-3 times larger than the copies they had on hand. PFOs tended to reflect a more conservative estimate of the demand for IEC materials than BSPOs.

Barangay level organizations were a weak source of support for reaching MCRAs. Only 30 percent of PFOs and BSPOs said they have used barangay assemblies and family planning clubs to reach MCRAs.

Family planning clinics were reported to be non-existent in four out of five BSP areas. Furthermore, no hospitals were found in any of the BSP areas. This is understandable due to the fact that BSP areas are often located in the depressed areas of Metro Manila. In terms of family planning supplies, BSPOs reported to be in pos-

session of 24 pill cycles and 36 pieces of condoms available for distribution. The average number required to meet a month's demand was 52 cycles for pills and 67 pieces of condoms. BSPOs are obviously understocked.

THE OUTREACH PROJECT OUTPUTS

Measuring the NCR Outreach project inputs and outputs is particularly difficult for the following reasons: the growing diversity and complexity of the Philippine family planning program structure, organization and operation, the increasing integration of programs with development as well as with health projects; the decentralization of administrative control with increasing involvement of community-level leaders; and the blurring of the distinction between private and public sectors in the provision of family planning services. The design of this study (static group comparison) was selected to reduce these measurement problems.

Contraceptive prevalence was considered to be the key measure in gauging the effectiveness of family planning Outreach workers since it is the intermediate output (as opposed to the final output of fertility reduction) of the highest order and since it can be more meaningfully linked with other intermediate programmatic outputs such as the levels of knowledge and favorable attitudes towards family planning and small family size.

The sub-sections below will deal on a comparison between Outreach and non-Outreach wives with respect to: 1) knowledge of contraceptive methods, 2) attitudes towards family size and contraceptive methods, and 3) contraceptive practice. Correlates of knowledge (K), attitudes (A) and practices (P) of Outreach and non-Outreach wives will be discussed next. Information on KAP of PFOs, BSPOs and wives will be compared last to assess the appropriateness of PFOs and BSPOs as change agents influencing the perceptions, attitudes and behavior of wives. For the comparisons to be valid, Outreach and non-Outreach clinic personnel's (OICs, midwives and IEC personnel) KAP will be compared with the wives they serve. This will establish the effectiveness of Outreach workers and of family planning clinic personnel in promoting contraceptive KAP.

The data presented below come from survey responses of wives, PFOs, BSPOs, OICs, midwives and IEC personnel.

Knowledge of Contraceptive Methods

Knowledge of *at least one* or any contraceptive method was universal among Outreach and Non-Outreach wives (Table 8). Nineteen out of 20 wives *named* at least one contraceptive method and only one out of 20 *recognized* at least one after hearing a description of the method. Of the six program methods (pills, IUD, ligation, vasectomy, rhythm and condom), pills, IUD, condoms and ligation were the best known to wives in Outreach and non-Outreach areas, and vasectomy and rhythm were fair-

ly well known in both areas. In general, the level of awareness (percent of those who named or heard) of program methods among Outreach wives did not differ significantly from those of non-Outreach wives. However, non-Outreach wives tended to show better knowledge than Outreach wives in three out of the six program methods as shown by the higher percentages

Table 8: Percentage Distribution of Married Women 15-44 in Outreach and Non-Outreach Areas by Knowledge of Specific Contraceptive Methods, Metro Manila, 1983.

Method	Area	Percent of Married Women 15-44 Who...			Total	
		Named[1]	Heard[2]	Not Heard	%	N
More Effective Methods						
Pills	Outreach	85.3	13.5	1.2	100.0	400
	Non-Outreach	87.8	12.0	0.2	100.0	400
IUD	Outreach	68.1	28.7	3.2	100.0	400
	Non-Outreach	66.0	31.0	3.0	100.0	400
Ligation	Outreach	59.0	33.5	7.5	100.0	400
	Non-Outreach	58.8	33.7	7.5	100.0	400
Vasectomy	Outreach	19.3	58.2	22.5	100.0	400
	Non-Outreach	22.0	54.8	23.2	100.0	400
Less Effective Methods						
Rhythm	Outreach	45.8	30.0	24.2	100.0	400
	Non-Outreach	46.3	32.7	21.0	100.0	400
Condom	Outreach	65.5	31.3	3.2	100.0	400
	Non-Outreach	60.5	35.5	4.0	100.0	400
Withdrawal	Outreach	50.8	35.7	13.5	100.0	400
	Non-Outreach	40.6	40.2	19.2	100.0	400
Abstinence	Outreach	17.7	18.8	63.5	100.0	400
	Non-Outreach	13.0	17.5	69.5	100.0	400
Foam	Outreach	6.5	28.0	65.5	100.0	400
	Non-Outreach	12.5	24.0	63.5	100.0	400
Injection	Outreach	8.8	42.2	49.0	100.0	400
	Non-Outreach	13.8	32.0	54.2	100.0	400
Any Method						
	Outreach	95.0	5.0	0.0	100.0	400
	Non-Outreach	94.5	5.5	0.0	100.0	400

[1] *Method mentioned by R.*

[2] *Method R recognized after hearing a complete description of how it was used.*

among them who named these methods. Only the condoms and vasectomy were better known among Outreach than among non-Outreach wives.

Of the four less effective methods, the level of awareness of withdrawal was highest while that for abstinence was lowest and those for foam and injection in between. The latter two methods were better known among non-Outreach wives, while the first two were better known among the Outreach wives.

Four correlates of contraceptive knowledge were examined.[2] The results of these analyses are excerpted below.

Perceived Relative Effectiveness of Contraceptive Methods

One way to test contraceptive knowledge is to find out how well a respondent descriminates between two contraceptive methods. Wives were asked to compare three pairs of methods (pills vs. IUD; rhythm vs. condoms; IUD vs. condoms) with regard to their effectiveness in preventing pregnancy when used by couples in their community. The results indicate that the relative effectiveness of these methods was not well understood. Only about one in 10 wives were able to correctly identify the IUD as a little more effective than the pills, with Outreach wives' ability to make the correct identification not statistically different from non-Outreach wives (11.1 percent vs. 10.9 percent). With regard to rhythm and condoms, only 6.7 percent of Outreach wives were able to correctly identify no difference in effectiveness between these two methods compared to 7.5 percent for non-Outreach wives. The highest percentage of correct response was on the comparison of the effectiveness between IUD and condoms. Although not statistically significant, slightly more Outreach (47.4 percent) than non-Outreach (44.3 percent) wives gave correct responses to this question. In general, wives in Outreach and non-Outreach areas were similar in their perception of the relative effectiveness of the three selected pairs of program methods. This finding is contrary to the expectation that compared with those in non-Outreach areas, Outreach wives would have more knowledge and possess better ability to discern between any two methods due to the more individualized instruction received from Outreach workers.

An attempt is made to compare the ability of wives to discern the effectiveness of program methods with that of the Outreach workers who serve them. The level of correct and acceptable responses of Outreach workers was generally higher than those of wives. However, a disturbingly high proportion of the former (70 percent for PFOs and 60 percent for BSPOs) could not make the correct distinction of the effectiveness between pills and the IUD, and between rhythm and condoms (45 percent for PFOs and 50 percent for BSPOs). Moreover, the percentages of correct responses were higher for BSPOs than for PFOs in the

two more difficult of the three questions asked. It seems reasonable to conclude that the relative effectiveness of the various program methods were not very well imparted to the Outreach wives, that this matter was probably not sufficiently covered in the training of Outreach workers, and that probably the PFOs paid less attention to this aspect of their training than did the BSPOs.

The striking similarity between Outreach and non-Outreach wives in their ability to discern the relative effectiveness of two methods may gain some explanation from the fact that more non-Outreach clinic workers than those in Outreach clinics gave correct and acceptable responses. It would seem, thus, that the similarity in wives' perception of relative effectiveness in both areas lies in the fact that clinic workers in non-Outreach areas possess better knowledge than their Outreach clinic counterparts, but are comparable to the knowledge of the PFOs and BSPOs who are in closer contact with Outreach wives.

Perceived Best Time for Initiating Contraceptive Practice

Another area of contraceptive knowledge that was tested concerned the best time for initiating contraceptive practice following a live birth. Immediate use of contraception results in a long period of overlap with postpartum amenorrhea (of about 6-8 months, on the average) during which protection from pregnancy with a contraceptive is unnecessary. Some women can be expected to discontinue contraception even before they resume ovulation. Those who delay contraceptive use until after the resumption of menstruation run the risk of getting pregnant since ovulation may occur before the first postpartum menses. The best time to start contraceptive practice thus appears to be a few months after childbirth but before the time menstruation is likely to return. Majority of wives in both areas seemed to want to wait for the resumption of menstruation before initiating contraceptive use, with Outreach wives showing a significantly higher proportion (56.3 percent) than non-Outreach wives (51.3 percent). Only about one in 10 wives gave the "correct" response (i.e., a few months after childbirth but before the time menstruation is likely to return) with Outreach wives showing similar tendency (12.5 percent) as non-Outreach wives (11.5 percent). Significantly more non-Outreach (36.5 percent) than Outreach (30.5 percent) wives erred on the safe side. by indicating that a woman should start contraception "right away."

Although PFOs were as likely as wives to cite the "correct" response (15 percent vs. 12.5 percent), both the PFOs and BSPOs (55 percent) tended to err on the safe side more often than the sampled Outreach wives. Significantly more wives (56.3 percent) than PFOs (30 percent) or BSPOs (40 percent) said a woman ought to wait after the resumption of menstruation before initiating contra-

ceptive use. Clearly, the PFOs and BSPOs need to do more to correct this perception among wives. Moreover, more training of PFOs and BSPOs on this aspect seems to be highly indicated. Data showed that non-Outreach clinic workers (OICs, midwives and IEC workers) perceived more correctly the best time to initiate contraceptive practice after birth than Outreach clinic workers since more of them gave the "correct" response or erred on the safe side.

Wives' Exposure to FP Program Communication

Mass media and program information materials can be considered to be the best means of spreading family planning messages. In general, less than half of the interviewed wives have heard, seen or read messages about family planning from these various sources. Of the eight sources asked about, the newspaper was cited most frequently by significantly more wives in Outreach (53.5 percent) than in non-Outreach (46.2 percent) areas. The radio was cited second highest (44.7 percent) by wives in both areas. Television was cited third highest (38.2 percent in Outreach and 42.7 percent in non-Outreach areas). The fourth highest source cited was from printed materials (31.3 percent for Outreach and 22 percent for non-Outreach wives). Family planning messages from movies were cited as frequently as printed materials distributed by family planning and other workers. Significantly more Outreach (31.3 percent) than non-Outreach (22 percent) wives reported having received family planning leaflets from family planning clinic or field workers in the past 12 months before the survey. Other materials, lectures or meetings, and stage presentations were cited less frequently to have been the source of family planning messages by wives in both areas.

Although significantly more Outreach than non-Outreach wives were exposed to non-mass media sources, the level of exposure to these sources may be considered to be disappointingly low and resulted undoubtedly from the previously cited low level of materials at the disposal of PFOs and BSPOs.

The wives were questioned further about various types of printed materials produced by the family planning program. Wives in Outreach and non-Outreach areas were asked whether in the last 12 months they had seen, received and wanted to see specified family planning printed materials produced by the Commission on Population (POPCOM). Of the nine printed materials, the most popular were comic books about advantages of small families and on family planning methods. While the least popular were brochures on rhythm and vasectomy. Although all nine brochures were more popular among Outreach wives, significantly more Outreach than non-Outreach wives have seen only four of them: comic books about advantages of small families, and brochures on IUD, rhythm and condoms.

Wives were asked whether within the last 12 months specified types of

field workers had discussed family planning with them, whether they were using a method at that time, and for how many times these discussions had taken place. Only about one in six (15.8 percent) Outreach wives said that the PFO discussed family planning with her during the last 12 months. Significantly more Outreach wives (21.3 percent) had been talked to by BSPOs than by PFOs due undoubtedly to the fact that BSPOs resided in the same barangay as the wives. The data also showed that of the wives with whom the PFOs (15.8 percent) and BSPOs (21.3 percent) had discussed family planning, 38.6 percent and 32.8 percent, respectively, were not using a family planning method at that time. This finding suggests that the motivational efforts of the PFOs were limited to only 6.1 percent of MCRAs (.386 x .158) during the past year while those for BSPOs to 7.0 percent (.328 x .213). Assuming that the wives spoken to by PFOs and BSPOs were not the same, we can thus expect a liberal estimate of their joint motivational efforts to consist of 13.1 percent of MCRAs. Considering the current (1984) national targets for family planning acceptors of 9.3 percent of MCRAs per year, motivational efforts need to at least be doubled to ensure attainment of POPCOM's acceptor targets each year.

The wives were asked whether, during the year before the survey, specified types of fieldworkers had discussed family planning with them. Four of the five types specified were non-medical workers of partner agencies who were expected to include family planning promotion among their activities, namely: the livelihood workers of the Ministry of Human Settlements (MHS), the social workers of MSSD, the barangay nutrition scholars (BNS) of the national nutrition program, and the field workers of Project Tulungan who aside from their nutritional and social work also motivate wives to practice family planning. Doctors, nurses and midwives were grouped together into a single category representing the partner agencies that operate clinics. Of the five types of workers specified, doctors, nurses or midwives were most frequently claimed to have discussed family planning with wives in both Outreach (21.2 percent) and non-Outreach (20.2 percent) areas.

For Outreach areas, wives were equally likely to have been talked to about family planning by doctors, nurses or midwives as by BSPOs (21.3 percent) but were less likely to have been talked to by PFOs (previously cited as 15.8 percent). This suggests that static clinic personnel did as much motivational work as the BSPOs who sought out MCRAs in their homes. Moreover, more non-users were in contact with static clinic personnel than with either the PFO or the BSPO.

Awareness and Membership in Clubs Promoting Family Planning

The interviewed wives were asked whether they knew of "any club or

association in their barangay that has been established for the purpose of promoting family planning" and if so, whether they had been members of such clubs or were currently members. The results showed that only a very small proportion of Outreach wives (12.8 percent) and far fewer wives in non-Outreach areas (5.8 percent) knew of any such club. Current membership to such clubs was limited to a handful of wives (1.2 percent of Outreach and 0.5 percent of non-Outreach wives). These wives (who were current members to these clubs) were more likely to cite "helping the needy," "sharing knowledge with other people," and "helping prepare and cook for students" as the activities of these clubs than "learning more about family planning" and "motivating other wives to practise family planning."

Attitudes Towards Family Size and Modern Contraceptive Methods

Wives in Outreach and non-Outreach areas as well as family planning workers were asked about their *ideal* number of children and the *expected* number they would want to have considering the number of living children they now have. The response distributions of the two measures of family size for wives did not differ significantly (shown in Appendix Tables 8 and 9). The distributions followed a normal curve with modal frequencies observed at three or four children. The mean ideal number of children was, however, slightly higher for Outreach (3.5) than for Non-Outreach (3.3) wives. The mean ideal number of children that PFOs and BSPOs held for themselves and for wives in the BSP areas they serve also did not differ significantly from each other (3.4 vs. 3.3). Similarly, the mean expected number of children between Outreach and non-Outreach wives did not differ significantly (3.7 vs. 3.8). However, the reported number of expected children was significantly lower (2.8) for PFOs than for BSPOs (4.2, calculated for BSPOs with ages between 15 and 44 years only). It appears that PFOs expected a number *lower* for themselves than for the wives in the communities they serve, while BSPOs expected to have *more* children than they would expect wives in their BSP areas to have. BSPOs are much older than PFOs or wives (mean ages: 41.6, 29.2 and 29.2 years, respectively). This accounts for the larger number of expected children they cited than PFOs or wives.

When asked whether or not they would want to become pregnant in the future, wives in Outreach and non-Outreach areas responded similarly. About half of the wives said they do not want to become pregnant (again) in the future (49.5 percent for Outreach and 51.8 percent for non-Outreach). The other half was split into those who want to be pregnant (again) in the future (43.8 percent for Outreach and 42.2 percent for non-Outreach) and those who said "it depends" (6.7 percent for Outreach and six percent for non-Outreach).

Wives were asked whether they

approve or disapprove of the use of modern contraceptive methods such as the pills, the IUD or sterilization. Nearly nine in 10 wives in Outreach (89.4 percent) and non-Outreach (88.7 percent) areas said they approved of use of these methods. However, a significantly *lower* proportion of Outreach wives (3.2 percent) held no opinion on the subject compared with non-Outreach wives (7.3 percent) and a significantly *higher* proportion of Outreach wives moderately disapproved of modern contraception than non-Outreach wives (5.2 percent vs. 1.8 percent). It appears that the differences in wives' attitudes lie not on more approval but on lesser disapproval which was surprisingly found among non-Outreach wives.

Wives tended to view their husband's attitude towards modern contraceptive methods as more dispproving than their own. This was true of wives in both Outreach and non-Outreach areas. One out of five wives in Outreach and non-Outreach areas reported that their husbands either disapproved or held no opinion on the use of modern contraceptive methods. Four out of five wives reported their husbands as approving use of these methods.

All Outreach and clinic personnel who were interviewed said they approved of the use of modern contraceptive methods except for the OICs and midwives in Outreach areas one in 10 of whom said they disapproved. Eighty percent of PFOs strongly approved use of these methods compared with 90 percent of BSPOs. Seven out of 10 clinic OICs and midwives, and five out of 10 IECs in Outreach areas strongly approved use of these methods. The corresponding figures in non-Outreach areas were six out of 10 OICs, and eight out of 10 midwives and IECs. The significantly higher disapproval of Outreach relative to non-Outreach wives to the use of modern methods may have been a reflection of the disapproving attitudes held by some Outreach clinic personnel.

Wives were asked a series of questions on attitudes about specific contraceptive methods: their past and current use, and their willingness to try these methods. Significantly more Outreach wives (51.3 percent) were currently using a contraceptive method than non-Outreach wives (46.9 percent). Fewer non-users in Outreach than in non-Outreach areas were willing to try in the future (32.5 percent vs. 35 percent), but the difference was not statistically significant. Of the methods of contraception available, the methods most wives were likely to try in the future were ligation and pills (20-25 percent), rhythm second highest (12 percent), withdrawal, the IUD, abstinence and condoms third highest (6-10 percent), and injections, vasectomy and foam least (below five percent).

Contraceptive Practice

Table 9 presents the percentages of wives who ever-tried each of the specified contraceptive methods in Outreach and non-Outreach areas, as well as those for PFOs and BSPOs. The·

Table 9: Percentages of Married Women 15-44 in Outreach and Non-Outreach Areas, PFOs and BSPOs Who Said They had Ever-tried Each Method, Metro Manila, 1983.

Method	Outreach		Non-Outreach		PFO	BSPO
	N	%	N	%	%	%
More Effective Method						
Pills	155	38.7	159	39.7	64.3	35.0
IUD	78	19.5*	59	14.7*	35.7	25.0
Ligation	73	18.2*	55	13.7*	7.1	25.0
Vasectomy	1	0.2	2	0.5	7.1	0.0
Less Effective Method						
Rhythm	91	22.7*	71	17.7*	57.2	20.0
Condoms	93	23.2*	66	16.4*	42.9	30.0
Withdrawal	169	42.2*	99	24.7*	21.5	35.5
Abstinence	64	15.9*	24	5.9*	14.3	5.0
Foam	7	1.7	8	1.9	7.1	0.0
Injection	11	2.7	8	1.9	14.3	0.0
Any Method	263	65.7	248	62.0	92.9	70.0

**Differences between proportions in Outreach and non-Outreach areas are significant at $p < .05$ level.*

data show that the percentages of wives in Outreach areas who ever-tried the IUD, ligation, rhythm, condoms, withdrawal and abstinence were significantly higher than those in non-Outreach areas. Particularly for the pills, the percentage of wives in Outreach areas who ever-tried this method was not significantly different from those in non-Outreach areas. This was true also of vasectomy, foam and injection. For any married woman, the percentage of those who had ever-tried at least one method in Outreach areas did not differ significantly from those in non-Outreach areas (65.7 percent vs. 62 percent).

More Outreach workers than wives ever-tried each contraceptive method. Significantly more PFOs than wives ever-tried the reversible methods (like pills, the IUD, rhythm, condoms, foam and injectibles), while significantly more BSPOs than wives or PFOs ever-tried ligation. Almost all PFOs (92.9 percent) ever-tried at least one contraceptive method, and significantly more BSPOs (70 percent) than wives in both areas ever-tried any method. In view of their wider experience, PFOs may be better motivators than BSPOs in convincing MCRAs to try a contraceptive method. That more couples in Outreach than non-Outreach areas ever-tried a method may reflect the better motivation they received from Outreach workers as a result of their experiences. Furthermore, more Outreach than non-Outreach OICs, midwives and IECs ever-tried each contraceptive method (data not shown).

Table 10: Percentage Distribution of Married Women 15-44 Sampled in Outreach and Non-Outreach Areas by Method of Family Planning Currently Used, Metro Manila, 1983.

Method	Outreach			Non-Outreach		
	N	Percent of MWRA	% of Fecund Women	N	Percent of MWRA	% of Fecund Women
Total	**400**	**100.0**	**100.0**	**400**	**100.0**	**100.0**
Not Currently Using	124	31.0	37.6*	155	38.8	45.2*
Using Any Method	206	51.3	62.4*	188	46.9	54.8*
More Effective Methods:	**123**	**30.7**	**37.3**	**126**	**31.6**	**36.7**
Pills	30	7.5	9.1*	51	12.8	14.9*
IUD	19	4.8	5.8	18	4.5	5.2
Ligation	73	18.2	22.1*	55	13.8	16.1*
Vasectomy	1	0.2	0.3	2	0.5	0.5
Less Effective Methods:	**83**	**20.6**	**25.1**	**62**	**15.3**	**18.1**
Condoms	0	0.0	0.0	1	0.2	0.3
Rhythm	13	3.2	3.9	17	4.2	4.9
Withdrawal	41	10.2	12.4	27	6.8	8.0
Rhythm + Withdrawal	8	2.0	2.4	4	1.0	1.2
Rhythm + Condom	1	0.2	0.3	1	0.2	0.3
Withdrawal + Condom	0	0.0	0.0	1	0.2	0.3
Abstinence	17	4.2	5.2	9	2.2	2.6
Other	3	0.8	0.9	2	0.5	0.5
Hysterectomy	2	0.5	–	2	0.5	–
Pregnant	68	17.0	–	55	13.8	–

**Differences between Outreach and non-Outreach figures significant at $p < .05$.*

Contraceptive prevalence can be expressed in at least two ways: 1) as a proportion of married women of reproductive age (MWRAs), which is a crude measure since currently pregnant, sterile and amenorrheic women are included in the denominator even if they are not exposed to pregnancy risks, and (2) as a proportion of fecund MWRAs, which is a *refined* measure since it excludes currently pregnant sterile and infecundable women. Table 10 expresses contraceptive prevalence in both ways. Regardless of fecundity status, about half of MWRAs in Outreach and non-Outreach areas were found currently using a contraceptive method. Slightly more wives in Outreach areas were found currently using a contraceptive method. Slightly more wives in Outreach areas were pregnant than in non-Outreach areas. For purposes of comparing method-specific prevalence, it is preferable to use the refined measure (expressed as a percent of fecund wo-

men) in order that disparities in the proportion of fecund MWRAs will not affect the comparisons.

Based on the refined measure, significantly more Outreach than non-Outreach fecund wives were currently using a method at the time of the survey. Of the more effective methods, ligation showed the highest prevalence with significantly more Outreach than non-Outreach wives having undergone ligation. Pills came a poor second with significantly lesser Outreach than non-Outreach wives currently using the method. IUD was third highest with Outreach wives showing similar levels as non-Outreach wives. Current use of the less effective methods in Outreach and non-Outreach areas did not differ significantly. Of the less effective methods, withdrawal was the most popularly used, with rhythm (alone or in combination) second, and abstinence third highest. It is surprising to note that virtually none of the MCRAs were using the condoms. This may have resulted from the low level of condom supplies of BSPOs as earlier reported.

It appears that the higher contraceptive prevalence level in Outreach than in non-Outreach areas was due mainly to more wives who were ligated, and minimally to IUD insertions and to users of abstinence and other methods. Pill use was significantly lower in Outreach than in non-Outreach areas perhaps as a result of low level of pill supply among Outreach workers.

Two major correlates of contraceptive practice are discussed below. These are acceptability of methods and accessibility to the source of current methods used.

Acceptability of a Method

Acceptability of a contraceptive method may be indicated by the proportion of current users to those who ever-tried a specific method. These ratios indicate qualitatively the methods that are likely to be used in the long run. Table 11 shows these ratios only for reversible methods since irreversible methods like sterilization are likely to be continued in the long run. Abstinence was the most likely to be continued; the IUD, rhythm, withdrawal and pills more likely; and condom least likely. It can also be observed that acceptability ratios were significantly higher for non-Outreach than for Outreach wives. It is worth noting that of these methods, abstinence was by far the most acceptable. However, this method was tried among very few MCRAs. The low acceptability of pills and especially of the condoms in Outreach areas probably reflected the unavailability of supplies with PFOs and BSPOs. Surprisingly, the acceptability of rhythm and withdrawal was comparable to that of the IUD which is a semi-permanent method. This may arise from the fact that these are non-supply related methods, and the fact that the use of rhythm is permitted by the Catholic religion.

Another indicator of acceptability is the reason for non-use of the method. Wives who were currently using

Table 11: Percent Currently Using of Those Who Ever-tried Specified Contraceptive Methods in Outreach and Non-Outreach Areas, Metro Manila, 1983.

Method	Outreach		Non-Outreach	
	Ratio	N	Ratio	N
More Effective Method:				
Pills	19.4*	155	32.1*	159
IUD	24.4*	78	30.5*	59
Less Effective Method:				
Rhythm	24.2*	91	31.0*	71
Condoms	0.0	93	1.5	66
Withdrawal	24.2	169	27.3	99
Abstinence	26.6*	64	37.5*	24

**Differences between Outreach and non-Outreach ratios significant at $p < .05$.*

methods other than the pills, the IUD or sterilization were asked why they preferred using a less effective method (LEM). At least five out of six LEM users cited fears of pain or side effects as the reason for not preferring to use pills or the IUD. Slightly more wives in Outreach (85.4 percent) than in non-Outreach (83.8 percent) areas cited this reason for not using the pills. This pattern was reversed with the IUD where slightly less Outreach (89.0 percent) than non-Outreach (91.9 percent) LEM users cited this same reason. The differences between areas in the proportions citing this reason were, however, not statistically significant. On the other hand, significantly more non-Outreach (69.3 percent) than Outreach (52.4 percent) LEM users gave fears of pain or side effects as the reason for not using sterilization. Obviously, Outreach wives were more informed about sterilization than non-Outreach wives. Significantly more LEM users cited husband's objection and wanting more children as a reason for non-use of sterilization than of pills or IUD. This is obviously a result of the irreversibility of sterilization as compared with pills or the IUD. It is interesting to note that significantly more Outreach LEM users cited husband's objection as a reason for non-use of the IUD and sterilization than non-Outreach wives. Perhaps the motivational approaches used by Outreach workers failed to include the husbands. When one considers these first three reasons for non-use as factors affecting the acceptability of clinical methods, it is readily apparent that more should be done both in the Outreach and non-Outreach areas to improve these methods' acceptability since an overwhelming majority of non-users of more effective methods (MEM) cited these reasons for not preferring to use them.

Acceptability of Current Source

Before discussing the acceptability of methods currently used, a consideration of the source of current methods and the persons from whom wives obtained or learned about them will first be made. Sterilization users were asked who performed the operations, IUD users were asked who inserted the device, users of methods requiring re-supply were asked who gave their last supply, and users of methods that require only information were asked who instructed them.

Three-fourths of MEM users such as pills, the IUD and sterilization in Outreach and non-Outreach areas cited doctors, nurses and midwives. One-sixth of current users of MEMs in Outreach areas cited the PFOs and BSPOs while salespersons were cited by significantly more users in non-Outreach than in Outreach areas. It appears that salespersons have substituted for the services of PFOs and BSPOs in non-Outreach areas. (For details, see Appendix Table 10.)

On the other hand, far fewer current LEM users such as condoms, rhythm, withdrawal, abstinence and other methods cited doctors, nurses and midwives. By far, the spouse was the most important source of information and supplies of LEMs, with significantly more non-Outreach than Outreach wives citing him. Outreach users cited friends, relatives and neighbors as an important source significantly more than did non-Outreach users. It appears that the diffusion of knowledge about contraceptive supplies and services was wider in Outreach than in non-Outreach areas. A larger proportion of current LEM users in non-Outreach than in Outreach areas cited "other" sources (often reported as something they have learned from school or a book).

The distribution of current users of methods requiring services and supplies by place where supplies were last obtained showed that three-fourths of MEM users in Outreach and non-Outreach areas got their last supply from or were served at the clinic or hospital. (For details, see Appendix Table 11.) Significantly more MEM users in non-Outreach areas got their supplies from the pharmacy or other stores than MEM users in Outreach areas. It is also observed that only 7.3 percent of MEM users in Outreach areas cited the BSP, 4.1 percent "at home" and 1.6 percent at "neighbor's house" which seem to point to Outreach workers as their likely sources. It is interesting to note that Outreach users tended to cite private doctor's office as their most recent source more than did non-Outreach users. It must be recalled that Outreach wives were slightly of higher socio-economic status than non-Outreach wives. Only two LEM users in Outreach and four LEM users in non-Outreach areas cited a place where they got their most recent supply. These constituted mainly users of condoms (alone or in combinations), foam and injectibles. These users were equally likely to obtain their supplies at clinics/hospitals and at pharmacies or other stores.

When asked how they learned about their current source of contraceptive supplies or information, 44.6 percent of users in Outreach areas relying in medical, Outreach or commercial sources cited a doctor, nurse or midwife, compared to 49.2 percent of users in non-Outreach areas. About a fifth of users in Outreach areas cited the PFOs and BSPOs as their source of information on where to get their current contraceptive supplies and services. Wives in Outreach and non-Outreach areas were equally likely to cite other field workers as an informational source. Significantly more non-Outreach than Outreach wives cited friends as a source of information. The results (shown in detail in Appendix Table 12) point out that even in Outreach areas, the medical and paramedical workers were most often cited by users as the persons who have referred them to the sources of contraceptive supplies and services, and that wives in non-Outreach areas who otherwise might have learned from the PFOs and BSPOs have learned of these sources from friends and others.

Current users in Outreach areas reported a mean travel time to the source of family planning service as 32.0 minutes compared to 35.1 minutes in non-Outreach areas. (See Appendix Table 13). Although the mean travel times are quite similar, their distributions differed reflecting more users in non-Outreach areas who claimed to have spent 0-5 minutes of travel compared with users in Outreach areas. Significantly more Outreach users got to the source of family planning services using taxis and public jeepneys, while significantly more non-Outreach users got to the source on foot, and to a lesser extent through public vehicles or tricycles. (For details, refer to Appendix Table 14).

On the average, Outreach users spent one peso and fifty centavos more than non-Outreach users (₱8.30 for Outreach and ₱6.80 for non-Outreach users) for return fares. Significantly less Outreach than non-Outreach users spent ₱1.00-15.00 for fare, while significantly more Outreach than non-Outreach users spent ₱16.00 or more for reaching the source. (For details, see Appendix Table 15).

The average Outreach users paid ₱2.00 more than did the average non-Outreach user (₱9.30 vs. ₱7.30) for family planning services. Significantly more Outreach users paid less than ₱1.00 for services than non-Outreach users (42.2 percent vs. 26.1 percent). Fewer Outreach users paid from P1.00 to P15.00 than non-Outreach users, but fewer non-Outreach than Outreach users (42.2 percent vs. 36.1 percent). Fewer Outreach users paid from P1.00 to P15.00 than non-Outreach users, but fewer non-Outreach than Outreach users paid from P16.00 to P18.00 or more. (For details, see Appendix Table 16). This is due to the fact that more Outreach than non-Outreach users had undergone sterilization several of whom may have paid for services or spent some amount for medicines in connection with their post-operative care.

SUMMARY, CONCLUSION AND RECOMMENDATIONS

The NCR FP Outreach structure is similar in many ways to the national Outreach project – the number of clients covered, the lines of authority followed, and the external organizations with which it relates. Some characteristics in the metropolitan environment can potentially contribute to better performance of Outreach workers. For example, the compactness of depressed residential sites, and the greater availability of transport facilities imply that the clientele can be contacted with relative ease. However, the relatively high concentration of family planning services creates organizational problems in Metro Manila. This is reflected in the lack of a clear-cut delineation in the areas of responsibility between clinical and Outreach family planning workers. Functional responsibilities overlap and functional coordination, where it exists, is limited only between family planning and health workers, and occasionally with local officials.

PFOs in Metro Manila are highly qualified for their major roles – that of motivating couples to practice family planning and of augmenting the family planning services provided by static clinics. Being nurses or midwives, PFOs can be expected to be more effective in their motivational role since they are likely to be more credible sources of family planning information. As college graduates, PFOs can be expected to be more effective in coordinating family planning IEC activities of other development workers from various agencies thus widening the sphere of acceptance of the concept of family planning. The study findings, however, showed that their role in service-provision has, to a large extent, encroached on their motivational activities as well as supervisory and other roles. For instance:

- San Juan PFOs spent three days in clinic activities and only two days are devoted to field motivation and other tasks.
- BSPOs claimed the PFO's visits were not often and long enough.
- More than half (53.3 percent) of BSPOs claimed they had no IEC materials, 35 percent said they did not distribute IEC materials in the month before the survey, and 20 percent claimed they did not have these materials even for themselves.
- Doctors, nurses and midwives rather than PFOs were most often cited by wives to have been the major sources of family planning information, supplies and services.
- Significantly more Outreach wives had been talked to about family planning in the year before the survey by BSPOs (21.3 percent) than by PFOs (15.8 percent). Of the 15.8 percent of wives with whom PFOs talked to, majority (61.4 percent) were already using a method at that time, thus limiting the motivational activities of PFOs to only 6.1 percent of MCRAs during the past 12 months.

It seems reasonable to conclude that PFOs were not as active as they

should be in their motivational activities. Field observational notes pointed out that only half of the total PFO work hours were spent in service contacts. This finding reinforces the above observation in a way as to justify the recommendation to rechannel PFO slack hours to the intensification of motivational activities. Outreach workers have, however, undoubtedly contributed to the promotion of contraceptive practice.

Contraceptive prevalence was significantly higher in Outreach (62.4 percent) than in non-Outreach (54.9 percent) areas. Most of the difference arise from the higher percentages of ligation and withdrawal users in Outreach areas. This difference could have been larger had it not been for the fact that significantly more non-Outreach wives were using the pills.

Effective demand for contraception can be gauged from the proportion of MCRAs who were found not currently using a method but said they were willing to try in the future. If indeed one of the main functions of Outreach workers is to motivate non-users to practice contraception, the study results showed that the presence of Outreach workers did not materially increase the level of effective demand. Outreach and non-Outreach areas did not differ significantly in the proportion of MCRAs not currently using and who said they were willing to try a method in the future (32.5 percent vs. 35 percent).

Furthermore, the results also showed that the presence of the Outreach project did not improve or augment certain aspects of family planning services provided in areas where only family planning clinics existed. For instance, wives in Outreach and non-Outreach areas held similar knowledge of and favorable attitudes towards modern contraceptive methods. Wives' perception of the relative effectiveness of program methods in both areas was very poor. The proportion of wives in both areas who ever-tried a method did not differ significantly.

Although contraceptive prevalence was significantly higher in Outreach than in non-Outreach areas, several aspects of the project still need improvement. The following is a list of identified weaknesses implied by the findings and suggestions towards improved organization, management and support services.

1. There appears to be a lack of a clear-cut delineation in the areas of responsibility between Outreach and clinic workers. There is a need to delineate the responsibility of each worker and to set up firm guidelines specifying the functional relationship of each. Metro Manila is a densely populated area and the high concentration of family planning services does not guarantee reaching those who most need these services. More attention should be placed on functional rather than on territorial delineation.
2. There is need to improve the coordination of the activities of POPCOM's partner and participating agencies at local levels. Such improvements include the esta-

blishment of more formal coordinating committees and the active involvement of all concerned.

3. Stricter field supervision of PFOs and BSPOs is indicated. This can be attained through more frequent and longer field visits of PPMs and PFOs.
4. BSPOs need to be re-trained. More emphasis should be given to the six of the 10 training subjects where they felt they were deficient.
5. Motivational efforts of PFOs and BSPOs need to be strengthened. This can be realized through more frequent home visits and through increasing the amount of time spent with MCRAs.
6. More efforts should be made to include the husbands in the motivation for use of modern contraceptive methods since a substantial proportion held unfavorable attitudes towards them.
7. PFOs and BSPOs need to be provided with enough IEC materials to ensure a steady supply for their motivational activities.
8. IEC materials should include advice on the best time to start contraceptive use since PFOs and BSPOs held inaccurate information about it.
9. Barangay-level organizations need to be strengthened in their family planning related activities. Particularly for family planning clubs, efforts should be made to establish more of them, to increase their membership, to enlist wives's active participation in them and to align the club's activities toward sustaining the member's interest on family planning and of motivating non-users to practice contraception.
10. Efforts should be made to increase the acceptability of the IUD, condoms and rhythm in Outreach areas. Results showed that although significantly more Outreach MCRAs have tried these methods, the prevalence levels of these methods were not significantly different from those observed in non-Outreach areas.
11. Efforts to promote the use of pills in Outreach areas appear to be highly indicated. Fewer Outreach wives ever-tried or were found practicing this method. One step in this direction is the provision of adequate supplies of pills. Another step is the improvement in the motivational approaches for use of this method and of the IUD since majority of non-users cited fears of pain and side effects as reasons for not using these methods.

In conclusion, the major findings of this study seem to suggest that the augmentation of family planning clinic services by Outreach structures did not present a substantial advantage over areas that had no such structures. However, it must be recognized that Metro Manila cities and municipalities that opted not to participate in the project are more affluent ones with more vigorous family planning programs. In Makati, for instance, the

absence of Outreach did not prevent the municipal government from employing "field census assistants" who do full-time motivational activities in family planning and other related concerns. Thus, the trivial advantage in terms of contraceptive prevalence of Outreach over non-Outreach areas may have been due to such equalizing factors. The major weakness identified by the study is the lack of a clear-cut delineation between clinic and Outreach responsibilities which leads to overlapping functions. This major weakness could perhaps be remedied by a few organizational rearrangements. Even in a metropolitan environment such as Metro Manila, specialized delivery mechanisms for family planning may still be considered essential.

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NOTES

[1]The latest MCRA survey was conducted in August 1983 by the PFOs with assistance from the BSPOs.

[2]For a more detailed analysis, see the Project Final Report bearing the same title. This was submitted to the Population Center Foundation, Makati, Metro Manila in June 1984.

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Appendix Table 1

List of the 20 Outreach and 20 Non-Outreach Areas of the Study, Metro Manila, 1983

Area	Outreach BSPs	Area	Non-Outreach Puroks
1. Quezon City	1. Bukid Kainging, Apolonio Samson	1. Caloocan	1. Bgy. 93, Zone 8 9th St. 11th Avenue, Caloocan
Dist. I	2. Dagot, Makaturing		2. Bgy. 576, Balik-Balik
	3. Sto. Domingo, Balinggasa		3. Bgy. 138, Bagong Barrio
Dist. II	4. Capri Relocation, Novaliches	Caloocan	4. Bgy. 70 Statsenburg
	5. Mendez, Baesa		5. Bgy. 157, East Bagong Barrio
Dist. III	6. Escopa III	Pasig	6. Kaniogan
Dist. IV	7. San Isidro	Manila	7. Bgy. 561, Balik-Balik
	8. Sto. Nino		8. Bgy. 562, Balik-Balik
2. Malabon	9. Potrero (Atis Road)	2. Caloocan	9. Bgy. 143, Bagong Barrio
	10. Ibaba (Camus Ext.)	Navotas	10. San Jose, Little Samar
	11. Concepcion (E. Jacinto St.)	Navotas	11. Tangos, Apogan
3. Mandaluyong	12. Hulo	3. Makati	12. Bgy. Singkamas
	13. Barangka Drive		13. Bgy. La Paz, Mola
	14. Mabini (Abella Cpd.)		14. Bgy. La Paz, Eureka
4. Marikina	15. Parang (Herbosa Cpd.)	4. Pasig	15. Palatiw, Villa Rosario
	16. Calumpang		16. San Miguel, Bagong Liwayway
	17. Barangka (Tuazon)		17. Kapasigan, Blumentritt St.
5. San Juan	18. Corazon de Jesus	5. Pasig	18. Bgy. Pinagbuhatan Purok Ilang-Ilang
	19. Little Baguio	Makati	19. Bgy. Pitogo
	20. Bgy. Halo-Halo		20. Bgy. Bangkal

Appendix Table 2a

Distribution of Outreach Program Workers, Family Planning Clinic Facilities and Barangays Covered by Outreach Workers, Metro Manila, 1983

Municipality/City/District	Number of Outreach Workers			Number of Health Center of FP	Number of Barangays		
	PPM	PFO	BSPO		Total	Covered	
						N	% of Total
Total	**9**	**74**	**383**	**94**	**220**	**182**	**82.7**
Quezon City:	4[1]	47	162	40	138	117	84.8
District I	1	9	38	11		31	
District II	1	17	54	16		39	
District III	1	6	29	6		23	
District IV	1	15	41	7		24	
Malabon	1	6	53	11	21	17	81.0
Mandaluyong	1	8	46	17	27	16	59.2
Marikina	1	7	50	20	13	13	100.0
San Juan	1	6	72	7	21	19	90.4

[1] *Excludes one PPM II who is the overall supervisor of the PPMs.*

Appendix Table 2b

Distribution of Outreach and Non-Outreach MCRAs, Metro Manila, 1983

Municipality/City/District	Estimated Number of MCRAs	Estimated Number of MCRAs in Depressed Areas[2]	Number of MCRAs Surveyed by Outreach Workers As of 1984
Outreach Areas	**268,565**	**56,211**	**144,115**
Quezon City:	157,191	33,543	40,754
District I	40,556		
District II	50,226		
District III	27,880		
District IV	38,529		
Malabon	29,836	5,067	26,616
Mandaluyong	30,469	7,816	28,333
Marikina	32,933	3,190	31,022
San Juan	18,136	6,595	17,390
Non-Outreach Areas	**409,005**	**82,025**	–
Caloocan	71,830	24,969	–
Manila	222,662	33,409	–
Makati	53,140	4,161	–
Navotas	19,679	10,475	–
Pasig	41,694	9,011	–

[1] *As of the 1980 Census.*

[2] *Depressed area classification list of the National Housing Authority, Elliptical Road, Quezon City, 1977.*

Appendix Table 3

Percentage of Sampled Outreach and Non-Outreach Areas With a Family Planning Clinic Facility, Metro Manila, 1983

Outreach Area	With FP Clinic N	With FP Clinic %	Total	Non-Outreach Area	With FP Clinic N	With FP Clinic %	Total
Quezon City	3	37.5	8	Caloocan	2	40.0	5
Malabon	0	0.0	3	Manila	0	0.0	3
Mandaluyong	0	0.0	3	Navotas	0	0.0	2
Marikina	1	33.3	3	Makati	0	0.0	5
San Juan	0	0.0	3	Pasig	2	40.0	5
All	4	25.0	20		4	25.0	20

Appendix Table 4

Percentage Distribution of Households of Sampled MCRAs in Outreach and Non-Outreach Areas by Selected Housing Characteristics, Metro Manila, 1983

Housing Characteristics	Outreach N	Outreach %	Non-Outreach N	Non-Outreach %
1. Number of Rooms in the House	**400**	**100.0**	**400**	**100.0**
One	262	66.1*	307	76.9*
Two	97	24.4	78	19.5
Three	24	7.3	13	3.2
Four	5	1.2	1	0.2
Five	4	1.0	0	0.0
NS	3	–	1	–
Mean	1.5		1.3	
2. Location of Toilet	**400**	**100.0**	**400**	**100.0**
Inside the house	100	25.0	116	29.0
Outside the house	299	75.0	283	71.0
3. Materials of Which the Walls are made	**400**	**100.0**	**400**	**100.0**
Concrete	114	28.6	123	30.7
Non-concrete	285	71.2	277	69.3
NS	1	–	–	–
4. Materials of Which the Floors are Made	**400**	**100.0**	**400**	**100.0**
Concrete	42	10.6	54	13.5
Non-concrete	357	89.3	346	85.6
NS	1	–	–	–
5. Piped Water Inside the House	**400**	**100.0**	**400**	**100.0**
Yes	40	10.1	15	3.7
No	356	89.9*	385	96.2*
NS	4	–	–	–

**Differences between percentages in Outreach and Non-Outreach areas significant at $p < .05$.*

Appendix Table 5

Percentage Distributions of Married Women 15-44 by Selected Demographic and Background Characteristics in Outreach and Non-Outreach Areas, Metro Manila, 1983

Characteristic/Category	Outreach		Non-Outreach	
	N	%	N	%
1. Current Age (yrs)	**400**	**100.0**	**400**	**100.0**
15-19	17	4.2	18	4.5
20-24	98	24.5	91	22.8
25-29	103	25.8	117	29.2
30-34	92	23.0	84	21.0
35-39	58	14.5	57	14.2
40-44	32	8.0	33	8.2
Mean	29.2		29.1	
2. Number of Living Children	**400**	**100.0**	**400**	**100.0**
0	3	0.7	3	0.8
1	79	19.7	72	18.0
2	82	20.5	85	21.2
3	78	19.5	74	18.5
4	60	15.0	59	14.8
5	35	8.7	33	8.2
6	16	4.0	23	5.8
7	9	2.2	11	2.8
8	4	1.0	5	1.2
9+	2	0.5	5	1.2
No live born	32	8.0	30	7.5
Mean	2.8		2.9	
3. Number of Child Ever-Born	**400**	**100.0**	**400**	**100.0**
No live born	32	8.0	30	7.5
1	71	17.7	67	16.7
2	75	18.8	77	19.2
3	75	18.8	72	18.0
4	59	14.7	60	15.0
5	33	8.2	33	8.2
6	26	6.5	26	6.5
7	14	3.5	16	4.0
8	6	1.5	7	1.7
9	5	1.2	4	1.0
10	1	0.2	5	1.2
11	1	0.2	1	0.2
12 and above	2	0.5	2	0.5
Mean	3.1		3.2	
4. Duration of Marriage (Yrs)	**400**	**100.0**	**400**	**100.0**
0	8	2.0	4	1.0
1-4	104	26.0	101	25.0
5-9	128	32.1	128	32.0
10-14	81	20.3	84	21.2
15-19	50	12.5	55	13.7
20-24	22	5.5	22	5.5
25-29	6	1.5	5	1.2
Mean	9.3		9.2	

Appendix Table 6

Percentage of Married Women 15-44 by Selected Cultural and Background Characteristics in Outreach and Non-Outreach Areas, Metro Manila, 1983

Characteristic/Category	Outreach		Non-Outreach	
	N	%	N	%
1. Language Spoken in Home	**400**	**100.0**	**400**	**100.0**
Tagalog	186	46.5	178	44.5
Cebuano	36	9.0	42	10.5
Ilocano	22	5.5	26	6.5
Hiligaynon	29	7.2	26	6.5
Bicol	36	9.0	39	9.8
Waray	64	16.0	67	16.8
Pangasinan	15	3.8	3	0.7
Pampango	5	1.2	8	2.0
Other	7	1.8	11	2.7
2. Region of Wife	**400**	**100.0**	**400**	**100.0**
None	2	0.5	0	0.0
Catholic	371	92.7	362	90.5
Iglesia ni Cristo	16	4.0	24	6.0
Other Christian	10	2.5	13	3.2
Muslim	1	0.2	0	0.0
No Information	0	0.0	1	0.2
3. Length of Stay in Metro Manila (Yrs)	**400**	**100.0**	**400**	**100.0**
Less than 1 year	10	2.5	8	2.0
1	9	2.2	8	2.0
2	10	2.5	7	1.8
3	11	2.8	9	2.2
4	10	2.5	9	2.2
5-9	68	17.0	66	16.5
10-14	66	16.5	73	18.2
15+	119	29.8	106	26.5
Since Birth	97	24.2	114	28.5
Mean	30.5		33.1	
4. Length of Stay in Barangay (Yrs)	**400**	**100.0**	**400**	**100.0**
Less than 1 year	43	10.8	36	9.0
1	32	8.0	33	8.2
2	26	6.5	31	7.8
3	30	7.5	33	8.2
4	36	9.0	35	8.8
5-9	91	22.8	83	20.8
10-14	60	15.0	46	11.5
15+	52	13.0	65	16.2
Since Birth	30	7.5	38	9.5
Mean	13.4		15.0	

Appendix Table 7

Percentage of Married Women 15-44 By Selected Socio-Economic Characteristics in Outreach and Non-Outreach Areas, Metro Manila, 1983

Characteristic/Category	Outreach		Non-Outreach	
	N	%	N	%
Wife's Education	**400**	**100.0**	**400**	**100.0**
None	2	0.5	1	0.2
Grade 1-4	25	6.3	25	6.3
Grade 5-7	155	38.7	148	37.0
High School	172	43.0	194	48.5
College	46	11.5	32	8.0
Husband's Education	**400**	**100.0**	**400**	**100.0**
None	2	0.5	4	1.0
Grade 1-4	20	5.0	17	4.2
Grade 5-7	122	30.5	133	33.2
High School	198	49.5	203	50.8
College	57	14.2	43	10.8
No Information	1	0.2	0	0.0
Wife's Occupation	**400**	**100.0**	**400**	**100.0**
None	319	79.8	322	80.5
Admin/Professional	5	1.2	1	0.2
Clerical	4	1.0	1	0.2
Sales	30	7.5	36	9.0
Other Non-Manual	1	0.2	1	0.2
Other Manual	41	10.2	39	9.8
Husband's Occupation	**400**	**100.0**	**400**	**100.0**
None	8	2.0	17	4.2
Admin/Professional	8	2.0	6	1.5
Clerical	7	1.8	5	1.2
Sales	34	8.5	32	8.0
Other Non-Manual	11	2.8	6	1.5
Farming, Fishing	5	1.2	17	4.2
Other Manual	325	81.2	317	79.2
No Information	2	0.5	0	0.0

Appendix Table 8

Percentage Distribution of Married Women 15-44 In Outreach and Non-Outreach Areas by Ideal Number of Children for Couples in the BSP Area, Metro Manila, 1983

Ideal Number of Children	Outreach		Non-Outreach	
	N	%	N	%
1	3	0.7	0	0.0
2	51	12.7	76	19.0
3	151	37.7	155	38.7
4	139	34.7	135	33.7
5	32	8.0	24	6.0
6	18	4.5	7	1.7
7	3	0.7	2	0.5
8 or more	0	0.0	1	0.2
DK	1	0.2	0	0.0
NI	2	0.5	0	0.0
Total	400	100.0	400	100.0
Mean	3.5		3.3	

Appendix Table 9

Percentage Distribution of Married Women 15-44 In Outreach and Non-Outreach Areas by Expected Number of Children, Metro Manila, 1983

Expected Number of Children	Outreach		Non-Outreach	
	N	%	N	%
0	1	0.2	2	0.5
1	6	1.5	6	1.5
2	76	19.1	90	22.6
3	123	30.8	106	26.6
4	98	24.6	85	21.2
5	48	12.0	48	12.0
6	23	5.7	34	8.5
7	13	3.2	16	4.0
8	8	2.0	5	1.2
9	3	0.7	4	1.0
10	0	0.0	3	0.7
11	0	0.0	0	0.0
12	1	0.2	1	0.2
Total	400	100.0	400	100.0
Mean	3.7		3.8	

Appendix Table 10

Percentage Distribution of Current Users in Outreach and Non-Outreach Areas by Method Currently Used and by Source of Information, Supplies and Services on Current Method, Metro Manila, 1983

Source of Information/Supplies	Outreach				Non-Outreach			
	More Effective Method		Less Effective Method		More Effective Method		Less Effective Method	
	N	%	N	%	N	%	N	%
Doctors, Nurse, Midwife	94	76.4	15	18.1	95	75.4	11	17.7
PFO	10	8.1	2	2.4	0	0.0	0	0.0
BSPO	10	8.1	1	1.2	0	0.0	0	0.0
Other Non-Medical Field Workers	1	0.8	0	0.0	1	0.8	0	0.0
Salespersons	6	4.9	1	1.2	27	21.4	2	3.2
Spouse	0	0.0	28	33.7	1	0.8	30	48.4
Friends, Relatives Neighbors	2	1.6	28	33.7	1	0.8	10	16.1
Other	0	0.0	7	8.4	0	0.0	9	14.5
No Information	0	0.0	1	1.2	1	0.8	0	0.0
Total	123	100.0	83	100.0	126	100.0	62	100.0

Appendix Table 11

Percentage Distribution of Current Users in Outreach and Non-Outreach Areas by Method Currently Used and by Where Supply or Service Was Last Obtained, Metro Manila, 1983

Place Where Services and Supplies Last Obtained	Outreach				Non-Outreach			
	More Effective Method		Less Effective Method		More Effective Method		Less Effective Method	
	N	%	N	%	N	%	N	%
At clinic or hospital	97	78.9	1	50.0	95	75.4	2	50.0
At doctor's office (not clinic)	3	2.4	0	0.0	1	0.8	0	0.0
At pharmacy or other store	7	5.7	1	50.0	26	20.6	2	50.0
At BSP	9	7.3	0	0.0	0	0.0	0	0.0
At neighbor's house	2	1.6	0	0.0	1	0.8	0	0.0
At home	5	4.1	0	0.0	1	0.8	0	0.0
Elsewhere	0	0.0	0	0.0	1	0.8	0	0.0
No Information					1	0.8		
Total	123	100.0	2	100.0	126	100.0	4	100.0

Appendix Table 12

Percentage Distribution of MW15-44 In Outreach and Non-Outreach Areas by Person From Whom R Learned About FP Source (For MWRA who are Currently Using a Method that is Obtained from Clinic, Hospital, Pharmacy, Store or BSP) Metro Manila, 1983

Informant	Outreach		Non-Outreach	
	N	%	N	%
PFO	12	9.9	0	0.0
BSPO	13	10.7	0	0.0
Doctor	30	24.8	32	25.0
Nurse or midwife	24	19.8	31	24.2
Other field workers	6	5.0	7	5.5
Friend	30	24.8	47	36.7
Others	6	5.0	11	8.6
Total	121	100.0	128	100.0

Appendix Table 13

Percentage Distribution of MW15-44 in Outreach and Non-Outreach Areas by Minutes to Reach FP Source From Home (For MWRA who are Currently Using a Method that is Obtained from Clinic/Hospital Doctor's Office, Pharmacy, Store or BSP), Metro Manila, 1983

Minutes to Reach FP Source	Outreach		Non-Outreach	
	N	%	N	%
0-5	22	18.2	33	25.4
6-20	30	24.8	33	25.4
21-40	30	24.8	19	14.6
41-60	27	22.3	13	10.0
61-80	1	0.8	0	0.0
81-86	10	8.3	29	22.3
Did not go directly	0	0.0	2	1.5
No Information	1	0.8	1	0.7
Total	121	100.0	130	100.0
Mean (for conclusive responses only)	32.0		35.1	

Appendix Table 14

Percentage Distribution of MW15-44 In Outreach and Non-Outreach Areas by Means of Travel to FP Source (for MWRA who are Currently Using a Method that is Obtained From Clinic/Hospital, Pharmacy, Store, or BSP), Metro Manila, 1983

Means of Travel	Outreach		Non-Outreach	
	N	%	N	%
Taxi	27	22.3	16	12.5
Public jeepney	62	51.2	40	31.2
Tricycle	5	4.1	17	13.3
Private vehicle	6	5.0	14	10.9
Foot	20	16.5	38	29.7
Others	1	0.8	2	1.6
No Information	0	0.0	1	0.8
Travel	121	100.0	128	100.0

Appendix Table 15

Percentage Distribution of MW15-44 in Outreach and Non-Outreach Areas by Round Trip Fare to FP Source (for MWRA who are Currently Using a Method that is Obtained from Clinic/Hospital, Pharmacy, Store or BSP and Who Used Direct Routes to FP Source) Metro Manila, 1983

Round Trip Fare (Pesos)	Outreach		Non-Outreach	
	N	%	N	%
1	1	1.1	0	0.0
1-5	53	56.4	46	62.2
6-10	8	8.5	14	18.9
11-15	3	3.2	6	8.1
16-20	8	8.5	3	4.1
21-40	9	9.6	1	1.3
41-60	0	0.0	1	1.3
61-76	1	1.1	1	1.3
No pay	9	9.6	1	1.3
No Information	2	2.1	1	1.3
Total	94	100.0	74	100.0
Mean (for conclusive responses only)	8.3		6.8	

Appendix Table 16

Percentage Distribution of MW15-44 In Outreach and Non-Outreach Areas by Payment for FP Services (for MWRA Who are Currently Using a Method That is Obtained from Clinic/Hospital, Pharmacy, Store or (BSP), Metro Manila, 1983

Payment for Services (Pesos)	Outreach		Non-Outreach	
	N	%	N	%
1	51	42.2	47	36.1
1-5	37	30.7	43	33.1
6-10	11	9.1	21	16.2
11-15	1	0.8	8	6.2
16-20	4	3;3	2	1;5
21-40	2	1.6	2	1.5
41-60	2	1.6	2	1.5
61-80	0	0.0	0	0.0
81 or more	7	5.8	4	3.1
Payment in kind	1	0.8	0.8	0.0
No information	5	4.1	1	0.8
Total	121	100.0	130	100.0
Mean (for conclusive responses only)	9.3		7.3	

INFORMATION FOR CONTRIBUTORS

1. Editorial Policy	The **Philippine Population Journal** publishes original papers, reviews, documents, lectures and major book reviews that may be of scientific interest to students of population of the Philippines and of practical value to population planners and policy-makers. Preference will be given to materials with clear program and policy implications. Papers which are accepted for publication will be subject to minor editorial change for reasons of style, format and expressions.
2. Review of Manuscripts	Articles submitted will be reviewed initially for appropriateness by the editors and, when judged appropriate, will be sent to referees who are knowledgeable about the subject area. Papers that are provisionally accepted with revisions will be sent back to the author for revision and/or concurrence within two weeks. The final judgment will be that of the editors, but they will be influenced heavily by the recommendations of the editorial staff and the referees.
3. Preparation of Manuscripts	To be submitted are two copies of the article clearly typewritten on one side of the paper (standard 8½ by 11 inches) only, doubled-space, with margins of at least 1½ inches on both sides. The article should be between 20-40 pages.
4. Abstract	An abstract of not more than 100 words must be prepared together with the article.
5. Acknowledgments	This must be done in a separate section.
6. Cover Page	Cover page should contain title, author, institutional affiliation and complete address of author to whom proofs and correspondence should be sent.
7. Illustrations and Tables	Tables and charts should be numbered with arabic numerals and should carry brief descriptive titles. Illustrations should preferably be submitted in a form suitable for direct reproduction.
8. Notes	Explanatory and supplementary material may be placed in NOTES on a separate page. However, notes should be kept to a minimum.
9. References	References must be listed using the format in the Reference sections of Vol. I, No. I. issue, March 1985.