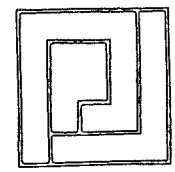
AN EVALUATION OF THE PHILIPPINE PREMARRIAGE COUNSELLING PROGRAM



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ABSTRACT

This study evaluates the effectiveness of the premarriage counselling (PMC) program and the factors affecting its effectiveness. Data on effectiveness were drawn from interviews of sampled individuals exposed to premarriage counselling vis-a-vis those who had not been exposed to PMC. An assessment of the dynamics of implementation was also made by interviews of program implementors such as counsellors, trainors, civil registrars and program coordinators. On the whole, the survey data show that the program is effective as it has improved the overall knowledge, attitude and potential practice of family planning among those exposed to PMC. Two related factors significantly affected its effectiveness, namely: the beneficiaries' level of educational attainment and the counsellors' performance.

BACKGROUND

In the Philippines, every couple applying for a marriage license is first required to receive instructions and information on family planning and responsible parenthood. Attendance to this premarriage counselling session is in compliance with Presidential Decree No. 965. Issued in July 1976, this decree is founded on the philosophy that a small family size assures a better quality of family life since it affords greater chances for satisfying the need of its members in terms of health, nutrition, high level of education and income, among others.

The implementation of the PMC program commenced in mid-1976 through the National Family Planning Office (NFPO) of the Ministry of Health (MOH) which was authorized to serve as the lead agency in program implementation. Other agencies, such as the Ministry of Social Services and Development (MSSD), Institute of Maternal and Child Health (IMCH), the Family Planning Organization of the Philippines (FPOP) and the Asian Social Institute (ASI) were likewise expected to cooperate in the endeavor (Bautista, 1982).

In 1981, a set of *ad interim guidelines* was issued by the Commission on Population (POPCOM) national office to all regional offices to guide the latter in the systematic implementation of the PMC program. In particular, these guidelines provided for a revised organizational structure of the program.

The formulation of a regional mechanism for implementing the PMC program was envisioned for the first

time in 1981. As proposed, the coordinative body at the regional level is the regional population council (RPC). The provincial/city/municipal councils become its local extensions. In areas where RPCs are non-existent, the regional population office (RPO) automatically becomes the coordinator, with the provincial population office (PPO), city population office (CPO) and the municipal population office (MPO) as the local counterparts (Bautista, 1982). More specifically, the RPC shall coordinate, monitor, oversee, evaluate and recommend policies/guidelines for the implementation of the program at the regional level. Since the MOH is the lead agency in the implementation of the program, the field staff is headed by the municipal/city health officer who serves as the action officer, under the direction of the RPO. In case a municipal health officer is absent, an action officer is to be selected from the core of premarriage counsellors to be designated by the mayor.

Under the direct supervision of the action officer are the pre-marriage counsellors who are the frontliners in providing the instruction on family planning and responsible parenthood. They may be affiliated with MSSD, ASI, IMCH, FPOP, Ministry of Agrarian Reform (MAR), Ministry of Local Government (MLG) and the Outreach project staff such as the district population officers (DPOs) and the full-time Outreach workers (FTOWs). Other private and government representatives may also be involved after undertaking training on premarriage counselling under the care of trainors duly accredited by POPCOM.

Outside of the new organizational structure, and in response to the need for upgrading the competence of PMC counsellors, POPCOM has, since 1980, spearheaded a nationwide training program using a standard training design. With POPCOM as coordinator, the training program is to be implemented through a team approach among the personnel of MOH, MSSD and POPCOM. The counsellors who have been trained to date are affiliated with such agencies as MOH, MSSD, MLG, ASI, MAR, FPOP, IMCH and the Outreach project. Under the new system, only those counsellors who have been accredited by POPCOM are authorized to conduct premarriage counselling.

In support of the training program, a set of PMC materials have been prepared by the University of the Philippines Institute of Mass Communications (UPIMC) for POPCOM. These include the *Training Manual for the Philippine Premarriage Program*, aimed at providing a functional guide in the training of premarriage counsellors who are the frontliners in the implementation of the PMC program. Also available is *A Manual On How to Provide Premarriage Information*, designed to provide the counsellors with specific guidelines in the conduct of the pre-marriage session. In addition, information / education / communication (IEC) materials have also been prepared for distribution to premarriage couples as well as for a nationwide campaign on the importance of PMC (Bistoyong, 1981).

Finally, for the first time since the

program was launched in 1976, monitoring and evaluation schemes and strategies were unified in 1981. The field staff is responsible for generating information in the field. At the lowest level of the hierarchy is the premarriage counsellor who will monitor and report on the program on a quarterly basis based on standard monitoring forms to be provided by the POPCOM regional office. These reports are to be gathered by the FTOWs which are aggregated at the different levels: the district through the DPOs, the provinces through the PPOs, and finally, the regions through the RPOs. The reports are then forwarded to POPCOM central office for consolidation.

Since these changes have been instituted, very little effort has been exerted in systematically documenting the magnitude of the problems that have been observed, as well as in assessing the effectiveness of PMC.[1] For this reason, the author has been invited to undertake this comprehensive study. The highlights of the findings of this study are herein discussed.[2]

RESEARCH DESIGN

Statement of the Problem

The study assessed the effectiveness of the PMC program and the factors affecting effectiveness, i.e., the clientele's socio-demographic characteristics, counsellor's preparedness for premarriage counselling, and the availability of IEC materials. It also discussed the dynamics involved in program implementation such as the structural arrangements, the personnel component constituted, the nature of leadership, and the availability of necessary resources. The trainors' and the counsellors' qualifications and effectiveness were also assessed.

Theoretical Framework

To put together the various concerns of the study in a more coherent manner, the following analytical framework was used.

Determining the effectiveness of a program/project is an activity that must be pursued to be able to formulate appropriate responses to problems in its implementation. Furthermore, studies on effectiveness help decision-makers ascertain the continuation of particular activities and/or their expansion in other areas.

As implied earlier, the effectiveness of the PMC program will ultimately be measured by the couples': 1) attitudes, awareness and knowledge of the subject matter; and 2) own perceptions of the effectiveness of the program which, in turn, depends on a number of factors both internal and external to it.

Certain intra-organizational factors called *program variables* may possibly influence effectiveness. These are personnel, fiscal resources, other material resources, the coordinative structure and its leadership.

The first major component is its personnel, particularly the premarriage counsellors who are the "frontliners" in the service delivery system of PMC. They serve as the primary unit of analysis in this study. They are assessed in terms of the adequacy of their training and the quality of their

service delivery as well as the manner the service delivery is affected by the counsellors' own socio-demographic characteristics.

The other physical resources (i.e., funds, IEC materials, training aids) are similarly analyzed for their adequacy and responsiveness in fulfilling the needs of the clients. "Adequacy" here means that resources are sufficient in quantity relative to the needs of the organization and its clients while "responsiveness" means that the resources are relevant to particular needs. As one scholar has said, these resources are of critical importance to the organization but they become idle and irrelevant if not mobilized in the appropriate direction (Iglesias, 1981).

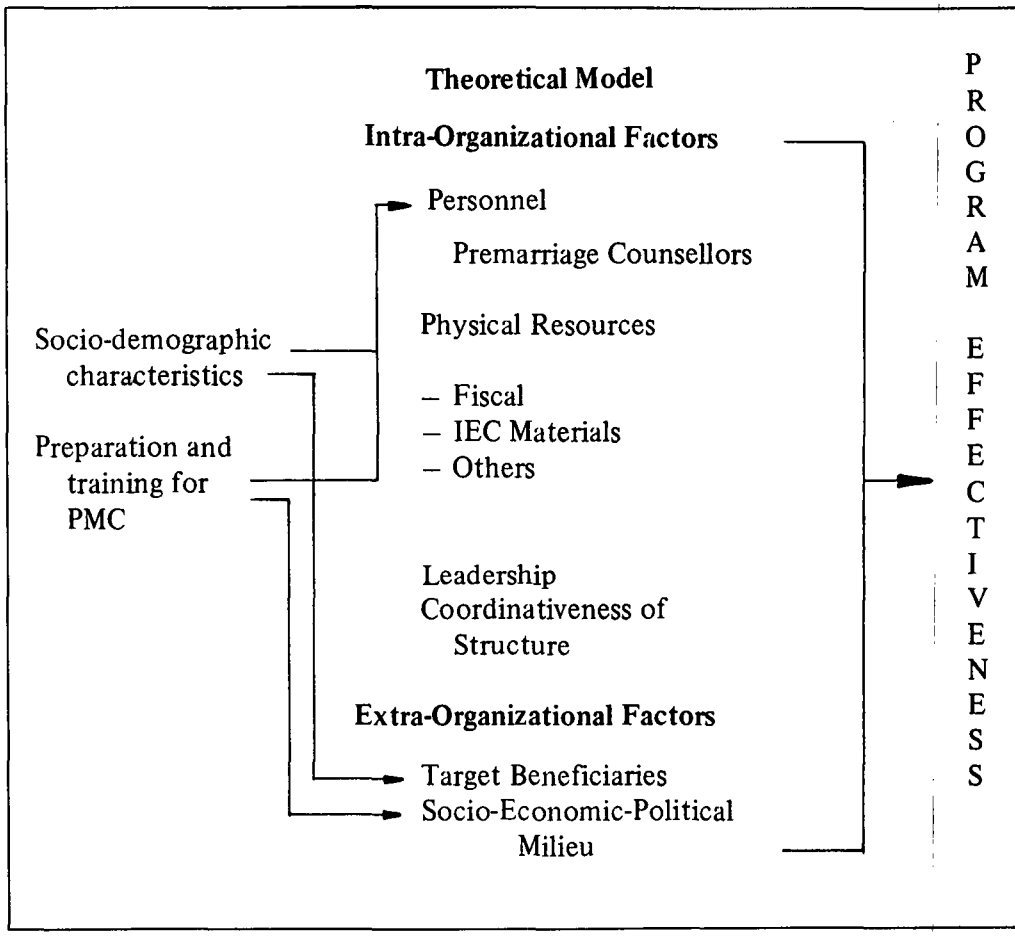
Mobilizing these resources will require the participation of key executives who shall supervise and coordinate the efforts of pre-marriage counsellors towards the goals of the program. Hence, another key element in the organization is the leadership component. The leaders are expected to 1) generate and mobilize political, administrative and clientele support; 2) facilitate, anticipate, plan, allocate and manage program resource requirements; and 3) recruit, develop, and motivate a competent working force (de Guzman et al., 1973).

This study also analyzes what particular structural mechanisms had been marshalled to be able to fulfill the program's objectives. As far as the PMC program is concerned, this has been envisioned to operate through a coordinative structure such as the RPC and its counterparts in the provinces, cities and municipalities. Structure is an important management resource since it defines "responsibility and authority relationships among individuals and units of the organization, particularly with regards to allocating, mobilizing and utilizing basic resources" (Iglesias, 1981). The coordinative structure is generally representational as related agencies participate in fulfilling stated objectives. The coordinative structure's effectiveness often depends to a large extent on who occupies the leadership position and on the cooperation of related agencies. Oftentimes, however, their efforts are dissipated by internal wrangling, lack of cooperation, and the mobility of the coordinative body to impose collective decisions upon the members, particularly when regional and departmental priorities and interests are in conflict (Iglesias, 1981).

The extra-organizational factors which may affect the effectiveness of the program include the target beneficiaries with particular socio-demographic characteristics, expectations and aspirations. These attributes more or less provide predispositions towards the acceptance/rejection of certain program goals and objectives. They cannot be taken for granted in the effort.

Other extra-organizational factors include the broad socio-economic-political milieu that may impinge on the success or failure of the program.

These interrelationships are summarized in the diagram that follows. The direction of the arrows indicate the factors affecting certain conditions.



Methodology

Type of design. This research is primarily explanatory. Specifically, a quasi-experimental-static group comparison design was used to assess the significant effect of the program among the couples who underwent the premarriage counselling vis-a-vis those who did not. With this methodology, there is also an opportunity to compare the effects of program variables and other factors on the couples (both beneficiaries and non-beneficiaries of the PMC program) and their overall knowledge, attitude and practice of family planning (the major component of the PMC program).

The research is also descriptive in nature in that it attempted to fully document the processes involved in the implementation of the program, its leadership, the coordinativeness of the structure, the preparedness of the counsellors, the capability of the trainors, the socio-demographic characteristics of the beneficiaries and the other factors that could affect the effectiveness of the program.

The study sites. The sampling of the areas selected for the study involved a multi-stage design. At the first stage, three regions of the country (one each to represent Luzon, Visa-

yas and Mindanao) were purposively selected, namely, Regions IV, VI, and XI.

At the second stage of sampling, two provinces per region were purposively chosen to determine the dynamics involved in the implementation of the PMC program in these areas.

For purposes of understanding urban and rural operations, two cities and two municipalities per region were likewise selected in the study. The choice was limited to areas where accredited counsellors operate to enable the researchers to determine whether or not the recommended IEC materials had been adopted and to find out if the counsellors perceived these materials as adequate and responsive to their needs.

Since Metro Manila is an atypical case, it was considered as another area of interest for this study, focusing on San Juan and Quezon City.

Table 1 shows a summary of the areas chosen for the study.

Respondents and data collection techniques. The respondents of the study included 132 program managers, civil registrars, counsellor-trainors and premarriage counsellors (both accredited and non-accredited) to whom questionnaires or interviews were administered (Table 2).

Two groups of clients, 1,400 in all, were randomly selected from cities and municipalities representing: 1) those who applied for a marriage license but had not undergone premarriage counselling, and 2) those premarriage and/or recently married individuals who had attended PMC lectures. They were further selected according to sex and regional background (Table 3).

In addition, existing documents regarding the PMC program were reviewed to shed light on the dynamics of its implementation.

Data gathering was undertaken in the first quarter of 1984.

Table 1. Areas Covered in the Study

Region	Municipality	City
Region IV (Regional Center: Quezon City)	Sta. Cruz, Laguna	San Pablo City
	Bacoor, Cavite	Cavite City
National Capital Region (Regional Center: Central Office)	San Juan	Quezon City
Region VI (Regional Center: Iloilo City)	Miagao, Iloilo	Iloilo City
	Binalbagan, Negros Occidental	Bacolod City
Region XI (Regional Center: Davao City)	Tagum, Davao	Davao City
	Koronadal, So. Cotabato	General Santos City

Table 2. Program Managers Interviewed, by Area

Respondents	Regional Areas NCR	IV	VI	XI	Total
Population Council Coordinators	1	7	7	7	22
Council Members	5	13	17	33	68
Civil Registrars	2	4	4	4	14
Regional ME Head	1	1	1	1	4
Trainors	←— 3 —→		3	18	24
Total	9	3 25	32	63	132

Table 3. Distribution of Respondents

	With PMC				Without PMC				Total				
	Municipality		City		Municipality		City		Municipality		City		Overall
	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female	Total
Region 4													
Cavite	25	25	25	25	25	25	25	25	50	50	50	50	200
Laguna	25	25	25	25	25	25	25	25	50	50	50	50	200
Region 6													
Iloilo	25	25	25	25	25	25	25	25	50	50	50	50	200
Negros Occidental	25	25	25	25	25	25	25	25	50	50	50	50	200
Region 11													
Davao	25	25	25	25	25	25	25	25	50	50	50	50	200
South Cotabato	25	25	25	25	25	25	25	25	50	50	50	50	200
NCR	25	25	25	25	25	25	25	25	50	50	50	50	200
TOTAL	175	175	175	175	175	175	175	175	350	350	350	350	1400

FINDINGS AND ANALYSIS

Structural Arrangements

As provided for in the ad interim guidelines of July 1981, coordinating councils were to be organized at the regional, provincial, municipal and city levels. These councils were to take an active role in coordinating, monitoring, overseeing, evaluating and recommending policies and guidelines for the implementation of the PMC program.

Coordinating councils existed in all regional areas reviewed for this research. These councils served as the umbrella organization for the family planning program of which the PMC program is a component. This conclusion may not be valid for the other subnational levels. Varying structural arrangements operated at the provincial, municipal, and city levels. In some areas, coordinative structures operated to oversee the implementation, monitoring and evaluation of the PMC program as envisioned by the population program. In other areas, one agency took an active role in performing these responsibilities.

Among the cooperating agencies with a coordinative structure, the major source of difficulty was sustaining the participation of the members who, more often than not, performed competing responsibilities.

Agencies which had a singular role in implementing the program experienced difficulties in marshalling service delivery efforts to undertake PMC.

The most active participants in the implementation of the PMC program were the Outreach and MOH personnel.

The Civil Registrars

Civil registrars also played an active role in PMCP's implementation by instructing couples to be married to attend PMC sessions before being issued a marriage license. Majority of the civil registrars interviewed reported that they learned about their participation in the program through the legal directives pertaining to the PMC

program. They did not undergo any formal training to apprise them about their role

Monitoring and Evaluation

It was noted that POPCOM had taken an active role in the performance of these functions. It initiated particularly the formulation of forms that provided a means to apprise PMC performance. However, these data were not collected regularly in the different levels. Furthermore, program managers from the local areas hardly considered them as useful information to provide corrective measures for problems encountered in the field. The data were concerned primarily with quantitative information on inputs (i.e. number of counsellors, audio-visual aids used, IEC materials distributed to couples) and the outputs (i.e., number of sessions held, number of couples trained). There was a dearth of qualitative information that elucidated on the problems of program implementation in the local areas.

The data derived primarily responded more to monitoring than to evaluation. Few information was collected on the effects of the program on the beneficiaries. Furthermore, monitoring data were consolidated in various ways thus preventing the POPCOM central office from obtaining uniform information necessary for a comparative analysis of program performance.

Training Schemes and Trainors' Background

The training of counsellors on the appropriate knowledge, skills and attitudes regarding their positions is considered an important activity in the implementation of the PMC program. Training through the team approach (the conduct of counselling sessions by a team of trained counsellors from MSSD, MOH and the Outreach project, each with an assigned content area of expertise) was envisioned.

Training structure. A review of the training structure for the different regions revealed that no uniform model operated to fulfill the requirements for upgrading the counsellors' knowledge, attitudes, and skills. The task of training counsellors at NCR and Region IV were subcontracted by POPCOM to the UPIMC. In the case of Region VI, a training program was initiated at the regional level in collaboration with Population Center Foundation (PCF). Nevertheless, Region VI still depended on the national office for trainors. It lacked enough local trainors to man their own sessions.

The most organized training scheme was observed in Region XI. Each of its five provinces and two cities had a PMC trainor-team composed of seven members. A pool of trainors were earlier trained for their role in Lucena City. Subsequently, this core trained local trainors. The region is now relatively independent in terms of conducting its own training programs for counsellors in the different municipalities and cities under it. Hence, Region XI has effectively saturated all its areas with accredited counsellors. In Regions IV and VI, some areas were not yet covered by accredited counsellors.

Trainors' characteristics. Trainor respondents were predominantly female and were mostly affiliated with MOH, MSSD, the Outreach Project and UPIMC.

Majority performed other responsibilities related to health, population, education and social work.

Trainors from NCR tended to obtain their professional training for PMC abroad. The trainors based at the subnational levels in turn depended on the central office trainors for their initial exposure to the PMC program.

Trainors assessed the adequacy of preparation for their roles as "adequate" with a mean of 4.04, in a scale of 1 to 5.

There was high readership of the *Training Manual for the Philippine Premarriage Program.* This material was found useful as a support material for training. Some of the recommendations offered by the trainors to improve its content were:

a. to include new trends in population planning and family welfare;

b. to provide more information on how skills can be developed;

c. to simplify the approach to training; and,

d. to use more case studies.

Another IEC material found to be a useful reference for training was the *Population Forum,* particularly the issue pertaining to the "Premarriage Counselling Program".

Training strategies. The length of training sessions varied from five days to two weeks.

Lecture/discussion dominated the training approaches adopted with such training aids as blackboards, flipcharts and posters.

All the topics suggested to be discussed were covered by majority of the trainors. These are: family planning, marriage and relationship, spiritual and moral values, health and nutrition, human sexuality, and home management. However, family planning was the only topic which majority of the respondents felt they could "very adequately" discuss. The adequacy of their preparation for the other topics were not considered as equally sufficient.

Majority had a favorable attitude regarding the objectives and strategies of the PMC program.

Problems. The problems that surfaced concerning training were: inadequate visual aids (i.e., projector, slides, filmstrips and IEC materials), fast turnover of trainors, existence of competing responsibilities among trainors, and lack of incentives for trainors to enthusiastically perform their duties.

Counselling

Profile of counsellors. Counselling is the most important activity to fulfill the objectives of the program. Hence, counsellors occupy a significant role in terms of imparting to couples to be married the significance of family planning and responsible parenthood.

A query into the profile of counsellors covering the areas considered for this study revealed that counselling is a female-dominated responsibility among the accredited and the non-accredited counsellors. Majority completed at least a college education

and they performed other responsibilities related to health, population, religion, social work and education.

Accredited counsellors were mostly affiliated with the Outreach project and MOH. Most of the non-accredited counsellors were connected with the church or MOH.

Preparation for PMC. The effectiveness of training counsellors may be discerned by the significant difference between the perceived level of preparation of accredited vis-a-vis non-accredited counsellors. Accredited counsellors had a higher perception than the non-accredited ones regarding the adequacy of their preparation.

A comparative assessment of the types of skills possessed by counsellors, showed that the accredited ones had an edge over the non-accredited in terms of utilization and mean level of adequacy of these skills. The seven skills assessed were: (a) the ability to explicate on what makes a successful marriage; (b) the ability to plan a counselling session; (c) the ability to communicate with couples; (d) the ability to work as a team; (e) the ability to use IEC materials; (f) the ability to propose solutions to couple's problems; and, (g) the ability to apply the management systems approach to PMC.

A slight difference also existed between the two groups regarding their knowledge of and attitude towards the program objectives. More accredited counsellors knew about and agreed with the PMC program objectives than the non-accredited.

Readership of the *Manual on How to Provide Premarriage Information* was reported by a little more than half of the accredited counsellors. A higher percentage had read the *Philippine Premarriage Information.*

Schemes for Counselling. Each counsellor (accredited and non-accredited) held about four counselling sessions per month, except for NCR (which had a mean of 7-8).

The bulk of counsellors, (both accredited and non-accredited), held sessions from one-and-a-half hours to four hours.

The group approach to counselling was the dominant approach with a team usually operating to administer premarriage counselling.

Counselling still relied on the traditional approach of lecture/discussion and dealt with the six topics recommended to be covered by counsellors.

More accredited counsellors signified utilization of a variety of training aids vis-a-vis the non-accredited ones. Like the PMC trainors, accredited counsellors also complained about inadequate audio-visual aids. The dominant aids utilized were blackboards and flipcharts.

The availability and adequacy of IEC materials for distribution to couples was a problem to about 40-45 per cent of the accredited counsellors.

The accredited counsellors also wished these IEC materials were available in the local dialects. Some also suggested improvement in the color of the materials.

Problems. The top problems that surfaced concerning counselling were the lack of interest in counselling among couples and the lack of logistic

support. The logistics problem concerned the lack of IEC materials, inadequate number of counsellors, and lack of discipline among counsellors.

Program Effectiveness

The effectiveness of the program was assessed by the outcomes of the counselling activities based on the knowledge, attitude and potential practice of family planning by the beneficiaries. Their performance on these criteria was then compared with applicants for a marriage license who had not been benefited by PMC.

Data for each criterion – level of knowledge, level of attitude and potential practice of family planning – will be discussed in the subsequent sections.

A final section will discuss the pooled KAP scores and how beneficiaries and non-beneficiaries compared in terms of these overall scores.

Knowledge of family planning objectives and methods. Two sets of questions were raised before respondents to ascertain their knowledge of family planning. The first set concerned respondents' understanding of the purposes for the practice of family planning. The second set pertained to methods for contraception.

The first set included such statements as:

1. Family planning is a preparation for responsible parenthood and promotes the general well-being of the family.

2. Family planning gives the parents the chance to choose the number of their children.

3. Family planning helps maintain the mother's health and gives her sufficient time between pregnancies to recover from the strain of childbirth.

These statements were culled from the *Training Manual on How to Provide Premarriage Information.* They were assessed using a scale of "1" to "5" where "1" signified strong disagreement and "5", strong agreement.

The data reflected in Table 4 show a difference between beneficiaries vis-a-vis non-beneficiaries regarding level of knowledge. More beneficiaries manifested a higher percentage of strong agreement to each of these items compared with the non-beneficiaries.

This trend may also be noted in Table 5 which shows the data on the

Table 4. Percentage Distribution of Responses to Each Question Re: Purposes of Family Planning

Knowledge Questions	Beneficiaries						Non-Beneficiaries					
	SA	A	NA	D	SD	No Ans	SA	A	NA	D	SD	
K Q. 1	51.9	46.9	0.7	0.3	–	0.3	46.3	51.0	2.4	0.1	0.1	
K Q. 2	46.6	50.7	2.1	0.3	–	0.3	41.7	53.9	3.7	0.7	–	
K Q. 3	48.3	47.7	3.1	0.4	–	0.4	41.7	51.3	5.9	0.7	0.4	

*SA – Strongly Agree; A – Agree; NA – Neutral; D – Disagree; SD – Strongly Disagree

Table 5. Percentage Distribution of Respondents with Correct Answer to Each Knowledge Question Re: Family Planning Methods

Knowledge Questions	Beneficiaries	Non-Beneficiaries
1. Among the six family planning methods, which can be applied without consulting the doctor? (Answer: Condom)	56.7	45.0
2. Which method requires a minor operation on the woman? (Answer: Tubal Ligation)	80.9	63.4
3. Which method is applied within the first seven days of menstruation? (Answer: IUD)	18.1	12.4
4. Which method helps regulate the woman's menstruation? (Answer: Pills)	66.6	48.0
5. Which method depends upon regular menstruation? (Answer: Rhythm)	60.7	42.4

second set of questions dealing with knowledge of family planning methods. Beneficiaries registered a better performance than the non-beneficiaries. The questions raised were as follows:

1. Among the six family planning methods cited below,[3] which could be applied without consulting the doctor?
2. Which method requires a minor operation on the woman?
3. Which method is applied within the first seven days of menstruation?
4. Which method helps regulate the woman's menstruation?
5. Which method depends upon regular menstruation?

The scores of the respondents for these two sets of questions were thereafter pooled. The highest possible score each respondent could have obtained is 25. Fifteen points is the perfect score for the first set and a maximum of 10 points could be obtained in the second set (i.e., each correct answer was given two points). A comparison of the mean level of the pooled scores for the knowledge questions of the beneficiaries and the non-beneficiaries revealed that the former had a higher level of performance. The mean score of beneficiaries was 19.04 vis-a-vis the mean of 17.35 for the non-beneficiaries. This variation is significant with a difference of mean test at α level of .001. Hence, it can be concluded that the knowledge of individuals who have undergone PMC sessions is higher than those who have yet to be counselled.

Attitude to family planning. Four statements were raised before respondents to determine their attitudes regarding certain effects of family planning (Table 6). They were asked to select the relevant points along the continuum of "1" to "5", where

Table 8. Methods Likely to be Adopted for Family Planning*

Methods to Be Adopted	Beneficiaries		Non-Beneficiaries	
	Freq	Percentage	Freq.	Percentage
Vasectomy	13	1.9	13	2.0
Tubal Ligation	43	6.4	34	5.1
Pills	227	33.5	218	32.9
I U D	57	8.4	27	4.1
Rhythm	242	35.7	270	40.8
Condom	97	14.3	119	18.0
Others	10	1.5	5	0.8
Number of Respondents	(677)		(662)	

*Multiple response

PMC program has led to a significant improvement in the overall KAP scores of the beneficiaries.

Factors Affecting KAP Scores

Selected variables were further analyzed to determine what could affect significant variability in the KAP scores of respondents, in addition to the program as a whole. The variables analyzed can be categorized into two broad types: 1) those pertaining to the socio-demographic characteristics of the respondents; and 2) those pertaining to the performance of service deliverers (the counsellors).

Elaboration data were obtained for the beneficiaries' and the non-beneficiaries' KAP scores (grouped into such categories as 21-30, 31-40 and 41-59), according to the respondents' background, such as:

1. sex;
2. social origins based on family income;
3. respondents' personal income;
4. educational attainment;
5. rural-urban origins; and,
6. current regional affiliation.

Sex and KAP scores between beneficiaries and non-beneficiaries. Table 9 reveals that when beneficiaries' and non-beneficiaries' KAP scores are compared between males and females, beneficiaries are still better than the non-beneficiaries.

The effect of sex as a factor in determining KAP scores was noticed only among the beneficiaries rather than among the non-beneficiaries. Based on a chi-square test, a slightly better performance was observed among female than male beneficiaries of PMC. A little more than 63 percent of the females registered the KAP scores of 41-50 in comparison to 57.8 percent of the males. This may be because females were more attentive during the sessions as they were the ones immediately involved in the application of birth control measures.

No significant difference was noted

KAP tests than the non-beneficiaries.

Educational attainment and KAP scores. Educational attainment was another factor which was linked with the KAP scores of beneficiaries and non-beneficiaries. It was hypothesized that a direct relationship existed between educational attainment and KAP scores, i.e., the higher the educational attainment, the higher the KAP scores since a higher educational attainment would enable the respondent to have a better understanding of a wide variety of materials, to which they may be exposed (i.e., family planning).

The elaboration results on these variable reflected in Table 12 show that this hypothesis was borne out for both beneficiaries and non-beneficiaries. A significant relationship was noted between educational attainment and KAP scores for both groups of respondents.

Rural-urban origins and KAP scores. The effect of rural-urban origins of respondents on KAP scores was also studied. Rural-urban origins were assessed by asking respondents where they resided for the most part of their lives. They were then asked to select from any one of the following three categories, namely: barrio, poblacion and city.

The data shown in Table 13 reveal that rural-urban origins only affected significantly the KAP scores of the non-beneficiaries. Higher KAP scores were noted for city-bred respondents than those raised in the poblacion and the barrios. This may be because cities provide individuals greater exposure to varied sources of information.

No statistically significant differences were noted among the beneficiaries reared in the cities, poblaciones and the barrios. In spite of rural-urban background, KAP scores were still higher among beneficiaries than those of the non-beneficiaries because of exposure to PMC .

Regional affiliation and KAP scores. The KAP scores of beneficiaries and non-beneficiaries were further examined according to their current regional affiliation. Based on the data reflected in Table 13, a significant difference was noted in KAP scores of beneficiaries as against the non-beneficiaries from the different regions. When the regions were ranked from the highest to lowest in terms of percentage of respondents reflecting KAP scores in the range of 41-50 after PMC exposure, the following ranking was obtained:

Rank	Region	% With 41-50 KAP Scores
1	Region VI	77.7
2	NCR	65.0
3	Region IV	64.6
4	Region XI	38.2

The non-beneficiaries from the different regions also varied significantly in their KAP scores. When the regions were ranked from highest to lowest in percentage of respondents reflecting KAP scores in the range of 41-50, the following were obtained:

Rank	Region	% With 41-50 KAP Scores
1	NCR	64.0
2	Region VI	61.0
3	Region IV	51.0
4	Region XI	10.5

Table 6. Percentage Distribution of Response to Each Attitude Question: Beneficiaries Vs. Non-Beneficiaries

Attitude Question	Beneficiaries						Non-Beneficiaries				
	SA	A	NA	D	SD	No Ans	SA	A	NA	D	SD
1. I personally believe that the smaller the size of the family, the greater may be the chances of satisfying the needs of the family	54.6	42.9	2.0	0.3	–	0.3	50.9	45.3	3.1	0.4	0.3
2. I believe that parents of small families tend to be happier, more emotionally stable, and better-off financially	50.1	4.1	4.0	0.4	–	0.3	46.1	48.9	4.1	0.7	0.1
3. I believe that family planning enables the father to provide only for children he can afford to support	48.4	47.7	2.9	0.7	–	0.3	47.6	48.6	2.9	1.0	–
4. I believe that family planning helps in increasing the share of each Filipino in the fruits of economic program	45.1	47.7	6.4	0.3	0.1	0.3	40.9	51.1	7.1	0.7	0.1
Mean Level	17.8						17.6				

t = 1.77. significant at $\alpha = .05$

"1" signified "strongly disagree" and "5 " "strongly agree". The four items are:

1. I personally believe that the smaller the size of the family, the greater may be the chances of satisfying the needs of the family.

2. I believe that parents of small families tend to be happier, more emotionally stable and better-off financially.

3. I believe that family planning enables the father to provide only for children he can afford to support.

4. I believe that family planning helps in increasing the share of each Filipino in the fruits of economic progress.

The data provided in Table 6 show that beneficiaries, on the whole, manifested a higher percentage of strong agreement for each of the four items as against the non-beneficiaries. Upon pooling the scores of the respondents on each of the four items (with a highest possible score of 20), the mean level for beneficiaries was 17.8 vis-a-vis 17.6 for the non-beneficiaries. While the variation is very slight, this difference is significant at α level of .05. Therefore, more PMC beneficiaries had a favorable attitude about family planning than the non-beneficiaries.

Potential practice of family planning. Respondents were finally asked whether or not they would practice family planning once married. Majority replied in the affirmative. However, beneficiaries reflected a slightly higher percentage who agreed to plan their family size as against the non-beneficiaries (Table 7). This variation which was tested by chi-square was observed to have low significance at an α of .10. This means that beneficiaries were slightly better than non-beneficiaries in expressing potential practice of family planning.

The respondents who said they were likely to practice family planning were further queried about the method they would likely adopt. Table 8 shows that beneficiaries and non-beneficiaries differed in the kinds of methods they would likely adopt. A slightly higher percentage among the beneficiaries reported possible use of more effective methods like tubal ligation, pill and IUD. Compared with the non-beneficiaries, a slightly lower percentage of the beneficiaries opted to rely on the less effective methods like rhythm and condom.

Both groups were nearly equal in terms of considering vasectomy as a method. Furthermore, it is of significance to point out that vasectomy was considered the least likely method to be chosen by both beneficiaries and non-beneficiaries. This may reflect the traditional notion that contraception is primarily undertaken more by the woman than the man.

The respondents who said that they were not likely to plan their family size gave such reasons as:

1. fear of side effects;
2. old age;
3. not yet pregnant; and,
4. family planning entails "expense".

Overall KAP scores. The scores on the three criteria were further summarized for each respondent. The highest possible score each respondent could obtain was set at 50. Twenty five points was the highest possible score for knowledge; 20, for attitude; and five points for those who indicated that they were likely to practice family planning.

The results derived show that beneficiaries had significantly higher performance with a mean of 41.74 as against the non-beneficiaries' mean of 39.69. This difference is significant with a t-test result of 8.08 at α of .001 based on a two-tailed test.

Hence, *it can be concluded that the*

Table 7. Potential Practice of Family Planning Beneficiaries Vs. Non-Beneficiaries

Practice	Beneficiaries		Non-Beneficiaries	
	Freq.	Percentage	Freq.	Percentage
Yes	677	96.9	662	94.8
No	22	3.1	36	5.2

Chi-square = 3.05945 df = 1
Significant at α = .10

Table 12. Educational Attainment and KAP Scores Between Beneficiaries and Non-Beneficiaries
(In Percent)

KAP Scores	Beneficiaries Educational Attainment					Non-Beneficiaries Educational Attainment				
	No Sch.	Elem.	H.S.	Voc.	College	No Sch.	Elem.	H.S.	Voc.	College
21 – 30	0.0	0.0	1.1	0.0	1.2	0.0	5.3	3.3	0.0	1.1
31 – 40	0.0	48.9	43.1	33.3	28.0	100.0	72.2	61.0	44.4	35.2
41 – 50	100.0	51.1	55.8	66.7	70.8	0.0	22.6	35.7	56.6	63.6
n	2	133	283	18	257	1	133	272	27	261
Test Results	Chi square = 23.33974, df = 8 Significant at α = .001					Chi square = 77.36705, df = 8 Significant at α = .001				

Table 13. Residence and KAP Scores between Beneficiaries' and Non-Beneficiaries
(In Percent)

KAP Scores	Beneficiaries			Non-Beneficiaries		
	Barrio	Poblacion	City	Barrio	Poblacion	City
21 – 30	0.6	1.4	0.9	4.0	2.9	0.8
31 – 40	41.7	39.5	33.2	57.0	58.3	45.0
41 – 50	57.6	59.2	65.9	38.9	38.8	54.2
n	321	147	229	321	139	240
Test Results	Chi square = 4.82071, df = 4 Not significant			Chi Square = 18.15059, df = 4 Significant at α = .01		

The preceding ranking is close to the ranking earlier noted for the beneficiaries' KAP scores from the different regions, except that NCR placed number one in ranking among the non-beneficiaries and Region VI ranked second. The change in position occurred because the Region VI beneficiaries substantially improved in their KAP scores in comparison to the NCR beneficiaries.

On the whole, however, the findings in this section revealed that the initial KAP scores of the couples subjected to counselling affected the level of KAP scores after exposure to PMC sessions. Those with low KAP scores prior to PMC generally obtained lower KAP scores after attending PMC sessions (i.e., Region XI).

The following ranking was obtained after the level of improvement in KAP scoring in the range of 41-50 of the different regions was examined based on the percentage increases in pre- and post-PMC:

Rank	Region	% of Increase in KAP Scores in Range of 41-50
1	Region XI	27.7
2	Region VI	16.7
3	Region IV	13.6
4	NCR	1.0

It is of interest to note that Region XI beneficiaries significantly improved over their pre-test KAP scores. NCR occupies the lowest in rank in terms of beneficiaries' rate of improvement.

The variation in the rate of improvement may be traced to the performance of counsellors. When the beneficiaries from the different regions were asked about the adequacy of counsellors' abilities,[4] the following results were obtained:

Rank	Region	Level of Adequacy of Counsellors' Skills
1	Region VI	16.3
2	Region XI	15.8
3	Region IV	15.8
4	NCR	15.5

Table 14. Regional Affiliation and KAP Scores Between Beneficiaries and Non-Beneficiaries (In Percent)

KAP Scores	Beneficiaries				Non-Beneficiaries			
	NCR	Region IV	Region VI	Region XI	NCR	Region IV	Region VI	Region XI
21 – 30	1.0	0.5	0.5	1.5	2.0	2.0	2.5	4.0
31 – 40	34.0	34.8	22.5	60.3	34.0	47.0	36.5	85.5
41 – 50	65.0	64.6	77.7	38.2	64.0	51.0	61.0	10.5
n	100	198	200	199	100	200	200	200
Test Results	Chi square = 66.89301, df = 6 Significant at $\alpha = .001$				Chi square = 135.17661, df = 6 Significant at $\alpha = .001$			

It will be observed in the preceding data that NCR beneficiaries perceived their counsellors' skills as the lowest in adequacy among the regions. Region VI counsellors had the highest rating, followed by Regions XI and IV.

Hence, program performance is also affected by the capabilities of the service deliverers in the conduct of their work.

Selected counselling characteristics and KAP scores. Further tests were made to determine the effects of selected counsellors/counselling characteristics on KAP scores. First was the effect of perception of beneficiaries regarding the preparedness of counselling sessions. It can be gleaned from Table 15 that these two factors are directly related with a significance level of .001 based on a chi-square test. Counselling sessions perceived as "very well" prepared produced beneficiaries with high KAP scores (73.8 percent in all had 41-50 scores). PMC sessions with "poor" preparation had a low percentage (50 percent) of beneficiaries with high KAP scores.

Beneficiaries were also asked about the level of adequacy of the preparation of the counsellors in the PMC sessions they attended. Based on a scale of 1 to 5 where "1" signified "very inadequate" and "5" as "very adequate," the overall assessment of beneficiaries about their skills was close to adequate, with a mean of 4.04.

The skills assessed were with regards to the following:

1. ability to put across message clearly;
2. ability to communicate;
3. ability to propose a solution to couple's problems; and,
4. ability to use visual aids.

When the assessment of the adequacy of counsellors' abilities were compared with the beneficiaries' KAP scores, a direct correlation was noted ($r = 0.1437$). This is statistically significant at $\alpha = .001$. Hence, the earlier argument concerning this relationship is further substantiated by this test. Counsellors with more adequate counselling abilities had a more favorable impact on the KAP scores of beneficiaries.

Table 15. Counselling Preparedness and KAP Scores (In Percent)

KAP Scores	Preparedness			
	Very Well	Good	Fair	Poor
21 – 30	1.3	0.5	2.5	0.0
31 – 40	24.9	45.6	40.0	50.0
41 – 50	73.8	54.0	57.5	50.0
n	225	428	40	2
Test Results	Chi square = 28.7, df = 6 Significant at $\alpha = .001$			

Beneficiaries' KAP Scores, Post PMC Exposure, By Project Sites

Beneficiaries' performances in the different project sites were also assessed. The objective of the inquiry was to determine whether the different program sites varied in terms of their overall KAP scores after PMC exposure. Based on the KAP scores of beneficiaries (See Appendix A) by project sites, the following ranking was obtained (arranged from highest to lowest areas by percentages of beneficiaries with scores in the range of 41-50, for KAP):

Rank	Site	% of Beneficiaries Scoring 41-50 after PMC
1	Binalbagan, Negros Occ.	88.0
2	Miagao, Iloilo	84.0
3	Cavite City	83.3
4	Bacolod City	76.0
6	San Juan, Metro Manila	66.0
6	Bacoor, Cavite	66.0
6	San Pablo City	66.0
8	Quezon City	64.0
9	Iloilo City	60.0
10	Koronadal, South Cotabato	44.9
11	Sta. Cruz, Laguna	44.0
12	Tagum, Davao del Norte	42.9
13	Davao City	36.0
14	General Santos City	29.4

The top three areas with beneficiaries showing the highest number of KAP scores were Binalbagan (Negros Occidental), Miagao (Iloilo) and Cavite City. The lowest three areas whose beneficiaries manifested low performances in KAP scores of 41-50 were General Santos City, Davao City and Tagum (Davao del Norte).

It might be mentioned here that the top performers (Binalbagan and Miagao) were from Region VI. Cavite City which ranked third, is from Region IV. This finding ties up with the earlier results on the KAP scores of beneficiaries from the regions. Both Regions VI and IV ranked high on overall KAP scores.

The areas which performed least in KAP scores were all from Region XI. This finding also ties up with the earlier analysis showing Region XI beneficiaries to be the lowest scorers among the regions.

An analysis of the factors affecting variation in KAP scores was further made. This was done by focusing on the demographic characteristics of beneficiaries and other program variables among the top three areas vis-a-vis the lowest three areas with respect to KAP scores.

A comparative analysis of the performance of these areas based on the aforementioned factors is reflected in Table 16. The data shown in this ta-

Table 16. Profile of Top Three Areas and Lowest Three Areas in KAP Scores Post PMC Based on Beneficiaries' Performance

Selected Variables	Top Three Areas			Lowest Three Areas		
	Binalbagan, Negros Occ.	Miagao, Iloilo	Cavite City	General Santos City	Davao City	Tagum, Davao
1. % who pursued college or more than college education	54.0	12.0	53.0	23.0	32.0	30.0
2. Perceived preparedness of counselling sessions (Mean level: Highest possible score of 4)	3.4	3.4	3.6	3.2	3.0	3.1
3. Mean Adequacy of Counselling Skills as Perceived by Beneficiaries (Highest Possible score of 20)	16.4	17.3	15.7	16.4	14.9	16.2
4. % who received *Labindalawang Kuwento ng Pag-ibig*	50.0	98.0	86.0	16.0	4.0	0.0
5. % Who Read *Labindalawa* (out of total N)	50.0	44.0	76.0	2.0	2.0	0.0
6. % Who Received *Patnubay sa Mga Ikakasal*	40.0	80.0	92.0	46.0	8.0	4.0
7. % Who Read *Patnubay* (out of total N)	40.0	72.0	82.0	36.0	8.0	4.0
8 % Who Received *Towards A Happy Family*	56.0	82.0	86.0	12.0	2.0	2.0
9. % Who Read *Towards* (out of total N)	56.0	82.0	86.0	4.0	2.0	2.0

ble substantiate the earlier conclusions made that the respondents' educational attainment is directly related to KAP scores. Except for Miagao, the other top performing areas had a high percentage of respondents who completed a college or more education. The low ranking areas in KAP scores had a generally lower percentage of respondents with college or more-than-college education.

Miagao's typical performance may be attributed to its high mean for preparedness for the counselling session as well as the high level of adequacy of counselling skills. In spite of the low level of educational attainment among the beneficiaries, high KAP scores were manifested because of the exemplary performance of counsellors.

On the whole, the top ranking areas had a higher mean level of preparedness for counselling in comparison to the low-ranking areas. Furthermore, two of the top three ranking areas (Miagao and Binalbagan) had equal or better performance than the low ranking areas in terms of adequacy of counselling skills. Hence, counselling performance as a program variable is directly related to level of KAP scores. The better the performance, the higher is the level of KAP scores.

Another important characteristic manifested by the top-ranking areas was the higher number of beneficiaries which *received* and *read* the IEC materials distributed to them (i.e., *Labindalawang Kuwento ng Pag-ibig, Patnubay sa mga Ikakasal, Towards a Happy Family*). The low ranking areas performed less well regarding this. Hence, it may also be concluded that readership of IEC materials influences the level of KAP.

Thus, three important factors stand out as important in determining level of KAP. These are: educational attainment, counselling performance and readership of IEC materials. This finding means that program effectiveness is enhanced by counsellors who perform their duties adequately.

In addition, high educational levels among the couples to be married also facilitated program performance. Those with high educational attainment also had higher KAP scores.

Rate of Improvement of Beneficiaries, By Project Site

A comparison of the percentage of improvement in KAP scores among the respondents before and after PMC exposure, revealed the ranking as shown in the next page. The data show Miagao to have manifested the most substantial improvement in the pre- and post-PMC scores. Tagum and Koronadal, both from Region XI, also dramatically changed in their KAP scores after exposure to PMC. Tagum was earlier considered as one of the areas with low KAP scores among beneficiaries after PMC exposure.

The counsellees who did not improve at all were, surprisingly, from the cities of Quezon, San Pablo and Iloilo. One group of respondents even deteriorated in performance. They were also from the city, such as Bacolod.

Several reasons were explored to determine the rationale for the varia-

Rank	Area	% of Beneficiaries Scoring 41-50		
		Pre-PMC	Post-PMC	% Improvement
1	Miagao, Iloilo	32.0	84.0	52.0
2	Tagum, Davao	6.0	42.9	36.9
3	Koronadal, South Cotabato	12.0	44.9	32.9
4	Bacoor, Cavite	42.0	66.0	24.0
5	General Santos City	6.0	29.4	23.4
6	Cavite City	60.0	83.3	23.3
7	Davao City	18.0	36.0	18.0
8	Binalbagan, Negros Occidental	72.0	88.0	16.0
9	Sta. Cruz, Laguna	36.0	44.0	8.0
10	San Juan, Metro Manila	64.0	66.0	2.0
11	Quezon City	64.0	64.0	0.0
12	San Pablo City	66.0	66.0	0.0
13	Iloilo City	60.0	60.0	0.0
14	Bacolod City	80.0	76.0	4.0

bility of the magnitude of performance of the different areas. The top three ranking areas in rate of improvement were compared vis-a-vis three areas that did not improve and one area that deteriorated (Table 17).

In spite of the fact that the counsellees from the top three municipalities had lower levels of educational attainment, remarkable improvements in their KAP scores were obtained. Table 16 shows that the top-ranking areas had a comparatively higher level of adequacy of counselling skills as perceived by beneficiaries. Miagao had a mean of 17.3; Tagum, 16.2; and, Koronadal, 15.9. The low ranking areas had mean levels below these.

A noticeable difference was also observed for the *length of counselling sessions* held in the different areas. Tagum and Koronadal's sessions ranged from 5-9 hours. Miagao had its sessions for only 1-2 hours but compensated by having the highest distribution rate for the three IEC materials (i.e., *Labindalawang Kuwento, Patnubay sa mga Ikakasal,* and *Towards a Happy Family*). Miagao's counsellors also tapped the most varied combination of training aids such as flipcharts, posters, flashcards and blackboard. Each material was used by 94-98 percent of the counsellees.

The length of the counselling sessions held by the low raters did not approximate the length of time PMC sessions were held in Tagum and Koronadal. For example, majority of Bacolod City's counsellees attended sessions ranging from 31 minutes to two hours. In Quezon City, the bulk of the beneficiaries attended PMC from one-and-a-half hours to three hours. San Pablo City and Iloilo City had the same length of about two to four hours.

These four cities failed to surpass

Table 17. Profile of Top Three Areas and Lowest Four Areas By Rate of Improvement

Selected Variables	Top Three Areas			Lowest Four Areas			
	Miagao, Iloilo	Tagum, Davao	Koronadal, S. Cotabato	Bacolod City	Quezon City	San Pablo City	Iloilo City
1. % who pursued college or more than college education	12.0%	30.0%	33.0%	59.0%	75.0%	34.0%	48.0%
2. Perceived Preparedness of Counselling Sessions (Highest Possible Score: 4)	3.4	3.1	3.1	3.4	3.2	3.6	3.1
3. Perceived Adequacy of Counselling Skills (Highest Possible Score: 20)	17.3	16.2	15.9	15.9	15.9	15.3	15.5
4. Length of Counselling Sessions Devoted By the Bulk of Counsellors	1-2 hrs. (62%)	6-9 hrs. (92%)	5-9 hrs. (95.9%)	31 mins. 2 hrs. (74%)	1-1/2 mins. 2 hrs. (66%)	2-4 hrs. (88%)	2-4 hrs (60%)
5. Received *Labindalawang Kuwento ng Pag-ibig*	98.0%	0.0%	12.0%	6.0%	8.0%	24.0%	4.0%
6. Received *Patnubay sa Mga Ikakasal*	80.0%	4.0%	14.0%	16.0%	26.0%	18.0%	16.0%
7. Received *Towards a Happy Family*	82.0%	2.0%	14.0%	40.0%	30.0%	6.0%	8.0%
8. Used Flipchart	98.0%	46.0%	81.0%	82.0%	48.0%	78.0%	30.0%
9. Used Slides	4.0%	0.0%	0.0%	2.0%	2.0%	2.0%	0.0%
10. Used Posters	98.0%	68.0%	51.0%	88.0%	50.0%	94.0%	54.0%
11. Used Blackboard	96.0%	98.0%	98.0%	16.0%	62.0%	76.0%	80.0%
12. Used Flashcards	94.0%	2.0%	0.0%	8.0%	14.0%	38.0%	22.0%
13. Used Filmstrips	2.0%	0.0%	0.0%	0.0%	2.0%	22.0%	0.0%
14. Number of Council Members Satisfied with the Management of the Coordinating Council	3/5	5/5	2/3	No coord. council	No coord. council	2/3	No coord. council

Miagao's exceptional performance in terms of level of use of training aids. Bacolod City only relied for the most part on flipcharts and posters. The bulk of the Quezon City counsellors used the blackboard and posters. San Pablo City counsellees were exposed to a combination of posters, flipcharts and blackboard. Iloilo City primarily relied on blackboard and posters.

Distribution rate of the three IEC materials by the four cities also paled in comparison with Miagao. The three types of IEC materials were disseminated to the counsellees by these areas but the highest percentage of distribution was 40 percent. In Miagao, 98 percent of the counsellees received *Labindalawa;* 80 percent received *Patnubay* and 82 percent obtained *Towards a Happy Family.*

Tagum and Davao did not have as much of IEC materials available to them for distribution, like the four cities and Miagao. The substantial improvement of their beneficiaries' KAP scores after PMC may be attributed to the adequacy of counselling skills and the long sessions held for PMC.

A further distinction was noted between the areas with high level of improvement and the low raters, in terms of the higher number of council members satisfied with the management of their respective councils among the top ranking areas. Among the low raters, three out of four did not have any coordinating council at all. Only San Pablo City had one. Hence, the leadership of the council may also have partly contributed to the PMC personnel in fulfilling program objectives. Their exemplary performance may have inspired better performance among service deliverers who, in turn, produced more knowledgeable clients.

In conclusion, therefore, the rate of improvement in KAP scores was significantly affected by the nature of counselling sessions. Some of the characteristics which were observed to significantly affect performance are: the counsellors' abilities, the length of counselling sessions, distribution of IEC materials, the level of use of training aids and satisfactory management of the program. A direct relationship was indicated between these factors and KAP scores.

The four cities may not have performed as well because of the greater pressures imposed on the counsellors. More couples apply for marriage license in the cities than in the municipalities. This is substantiated by the data in Table 18 which show the cities to have a higher number of couples subjected to PMC sessions than in the municipalities.

Furthermore, there may also be other competing responsibilities which resulted in the failure of the four city counsellors to perform better in their tasks for PMC.

PROBLEMS AND RECOMMENDATIONS

Some common problems that surfaced concerning the program are presented below. Recommendations, some culled from the respondents' perceptions and others advanced by the researcher are offered here to respond to each of these problems.

Table 18. Number of Sessions Held and Number of Couples Trained By Counsellors.

Area	Total PMC Sessions Held	Number of Couples Trained by Counsellors	Average Number of Couples Trained Per Session
NCR			
San Juan	48	1202	25
Quezon City	246	5294	21
Region IV			
Bacoor, Cavite	No data	343	Incomplete data
Sta. Cruz, Laguna	No data	391	Incomplete data
Cavite City	No data	514	Incomplete data
San Pablo City	No data	910	Incomplete data
Region VI			
Miagao, Iloilo	48	180	4
Binalbagan, Negros Occ.	70	111	2
Iloilo City	96	381	4
Bacolod City	467	1496	3
Region XI			
Koronadal, S. Cotabato	52	618	12
Tagum, Davao	52	782	15
Davao City	102	1141	11
Gen. Santos City	144	4225	29

1. Poor coordination and cooperation among the participating agencies existed in some areas from the top level of the bureaucracy to the lowest level in the hierarchy. This resulted in the failure to organize certain councils that could respond to major concerns of the program. The program was not fully effective in terms of requiring certain offices to fully participate in the attainment of PMC objectives.

The lack of coordination and cooperation may be due partly to the confusion regarding which agency should assume leadership in program implementation. In areas where MOH failed to assume the leadership, the Outreach project had taken an active role.

Furthermore, some participating agencies failed to fully participate as they were more concerned with primary responsibilities to their mother agencies.

There is, therefore, a need to clarify the importance of the program to the different levels of the hierarchy. A reorientation session may perhaps be held, starting in the regions. Respective regions may thereafter hold a similar campaign to invigorate their participation in the program.

A reassessment of the current organizational structure could be undertaken. Since POPCOM played an active role in monitoring as well as in

disseminating logistic support, it can assume a lead role in the implementation of PMC. Assuming that the monitoring system is efficient, the information consolidated can be transmitted readily to program managers for appropriate corrective measures.

2. A critical bottleneck has been the inadequacy of needed resources both for the training of counsellors and the conduct of PMC sessions.

In certain areas, the number of trainors and counsellors was not adequate to fully respond to the demand. This may be attributed partly to the lack of an organized scheme to train trainors and local counsellors.

Some of the venues for training were not sufficiently comfortable to attract regular PMC counsellors to the areas.

Likewise, the distribution of IEC materials was not wide enough so as to cover fully the target beneficiaries. Related to this, some IEC materials were not fully relevant to the sociocultural background of the beneficiaries (i.e., they were not written in the local dialect).

To respond to these inadequacies, the following recommendations are offered. Cooperating agencies, including the local governments, can allocate in their budget a certain amount for PMC. The use of audio-visual aids such as filmstrips or VTRs may be considered for counselling particularly in certain areas where there is a lack of counsellors.

An organized scheme for training trainors and counsellors is necessary to ensure equal opportunities for training in the different parts of the country. The central office may train a core of trainors from the region who may thereafter form a team to develop more local trainors. A set of criteria may be formulated to determine the basis for selecting trainors.

Local government support may be tapped to be assured of a regular and a comfortable venue for counselling.

Since educational attainment is an important attribute in determining KAP scores, IEC materials may be selectively distributed to counsellees, particularly to those who are socially deprived.

3. Lack of discipline/skills among counsellors in performing their responsibilities was notably observed. Some arrived late to administer the PMC sessions while others failed to discuss all the topics stipulated by the program.

Some counsellors lacked the appropriate skills to motivate the counsellees to participate in discussions.

It is, therefore, recommended that to instill discipline among counsellors and to be assured that they discuss all the topics expected to be covered in the program, evaluation instruments that can obtain immediate feedback from the counsellees can be formulated and implemented.

Follow-up training on accredited counsellors should also be undertaken to provide them with recent developments and trends related to the conduct of their work.

4. Lack of interest among the counsellees was manifested through tardiness, non-participation in discussions, inattentiveness, and disturbance of fellow counsellees during ses-

sions. The disinterest of some couples may be due to the fact that they were already familiar with the topics discussed in PMC sessions in view of their professional training (i.e., medical professionals). Some do not appreciate the significance of the PMC program.

Non-participation may, in turn, be attributed to the conduct of PMC sessions to a large group, thus inhibiting discussion. Moreover, the varying socio-economic background of participants deter "meaningful exchange" of ideas among them.

Given these problems, a mass education campaign may be held to inform the public about the PMC program. Exemptions from PMC may be permitted, especially for those who have obtained adequate training in related PMC topics, such as the medical professionals.

If possible, couples should be grouped together in accordance with their educational backgrounds.

The number of couples attending PMC sessions should be controlled to prevent it from becoming unwieldy.

Disciplinary measures should be imposed upon couples who fail to come on time for the session (i.e., advising them to attend a subsequent meeting).

5. Inadequate data base for monitoring and evaluation was another problem noted. Monitoring data were obtained but were not consolidated promptly since it was not perceived that they could provide managers the opportunity to effect corrective measures. Another possible cause could be that the monitoring forms merely elicited quantifying information. No qualitative data were obtained to identify problems in the process of implementation. Furthermore, the beneficiaries' perspective regarding the program was not among the concerns inquired about.

The monitoring forms can, therefore, be further improved by including questions that can elicit responses providing for stop-gaps to certain problems.

More questions with qualitative responses can be included to draw out the different kinds of problems encountered in implementation.

Occasional evaluation should be undertaken to determine the effects of the program on the beneficiaries.

6. Another problem was the reliance by some counsellees on a "padrino" to be exempted from going through the PMC sessions.

To avoid this, peer pressure may be employed to prevent some counsellors from granting certificates to couples who have not attended PMC sessions.

Administrative control should be implemented to check on erring officials.

7. The content of PMC counselling primarily focused on family planning and marriage and relationships. The four other topics were not given equal time for discussion.

The program heads may reassess the subject matter to be covered in PMC sessions. Considering that the program stipulated a minimum of two hours per counselling session, such time may not be sufficient to discuss all topics satisfactorily. Hence, limiting the subject matter coverage to family planning and marriage and relationships may

provide assurance of a more thorough discussion of these topics.

8. Sex differences were noted among those exposed to counselling. In particular, females were more receptive than males to PMC.

There should thus be more efforts to dispel the notion that family planning is the lone responsibility of the woman. A more aggressive campaign to correct male attitude against direct involvement in family planning should be undertaken.

CONCLUSION

The findings in this study substantiate the theoretical model presented at the beginning of this paper. In particular, three factors significantly stand out in terms of affecting program performance. These are: 1) the beneficiaries' socio-demographic characteristics (i.e., educational attainment); 2) the counsellors' performance (i.e., adequacy of preparation, length of counselling session, distribution rate of IEC materials, reliance on more visual aids); and 3) the satisfactory leadership among council coordinators. Direct relationships were observed between these factors and KAP scores. This means that beneficiaries with high educational attainment, those exposed to better prepared counsellors, those who read IEC materials, and those who were exposed to more visual aids in PMC had higher KAP scores. Another contributory factor is the exemplary leadership of council coordinators.

The nature of other program inputs (e.g., coordinativeness of the structure, fiscal and other logistic support) was also qualitatively analyzed. However, the design of the research was not sufficient to determine whether a variation in the quantity or quality of these inputs could significantly affect performance.

This study also showed that qualitative differences existed between the characteristics of accredited vis-a-vis non-accredited counsellors. More accredited counsellors perceived their preparation to be more adequate than the non-accredited counsellors. Likewise, more accredited counsellors reported the availability and utilization of more training aids than the non-accredited counsellors while in the conduct of counselling work. Both possessed similar socio-demographic characteristic.

On the whole, the program was noted to have had a significant effect, since a higher level of KAP scores was observed among PMCP beneficiaries vis-a-vis the non-beneficiaries.

NOTES

[1]UPIMC has conducted another study entitled "An Evaluation of the Premarriage Counselling Program in POPCOM Region IV." Although this study identified several "areas of concern", it was based on a rather small sample of respondents and did not specifically look into the "impact" of the PMC program.

[2]This is an abridged version of a report entitled *An Evaluation of PMPC: Integration Report*, submitted by this author to the Population Center Foundation and the Commission on Population, July 1984.

[3]The respondents were made to select one from six alternatives provided.

[4]Beneficiaries were asked about their assessment of the adequacy of counsellor's skills in four areas. These are: ability to put across message

clearly, ability to communicate, ability to propose solutions to couples' problems and ability to use visual aids. The highest possible score on this measure is 20.

REFERENCES

Bautista, Paulina F. 1980. *Training Manual for the Philippine Premarriage Program.* U.P. Institute of Mass Communications.

Bistoyong, Rosalina. 1981. "Status Report: PMC Program." *Population Forum.* 7(2).

De Guzman, Raul P. et al. 1973. "Increasing the Administrative Capacity of Provincial Governments for Development: A Study of the Provincial Development Assistance Project in the Philippines." *Philippine Journal of Public Administration.* 17(3).

Iglesias, Gabriel U. 1981. "Assessing Administrative Capability." *Institutional Dimensions of Regional Development.* G. Shabbit Cheema (ed.). Japan: Maruzen Asia.

Appendix A. KAP Scores of Beneficiaries By Project Sites

KAP Scores	San Juan	Quezon City	Sta. Cruz, Laguna	Bacoor, Cavite	San Pablo City	Cavite City	Miagao, Iloilo	Binalbagan, Negros. Occ.	Iloilo City	Bacolod City	Tagum, Davao	Koronadal S. Cotabato	Davao City	Gen. Santos City
	Beneficiaries													
21–30	0.0	2.0	2.0	0.0	0.0	0.0	0.0	0.0	0.0	2.0	2.0	0.0	2.0	2.0
31–40	34.0	34.0	54.0	34.0	34.0	16.7	16.0	12.0	40.0	22.0	55.1	55.1	62.0	68.6
41–50	66.0	64.0	44.0	66.0	66.0	83.3	84.0	88.0	60.0	76.0	42.9	44.9	36.0	29.4
n =	50	50	50	50	50	48	50	50	50	50	49	49	50	50

Chi-square = 101.11819 with 26 degrees of freedom
Significant at $\alpha = .001$

Appendix B. KAP Scores of Non-Beneficiaries by Project Sites

KAP Scores	San Juan	Quezon City	Sta. Cruz, Laguna	Bacoor Cavite	San Pablo City	Cavite City	Miagao, Iloilo	Binalbagan Negros Occ.	Iloilo City	Bacolod City	Tagum, Davao	Koronadal S. Cotabato	Davao City	Gen. Santos City
	Non-Beneficiaries													
21–30	4.0	0.0	2.0	4.0	2.0	0.0	6.0	4.0	0.0	0.0	0.0	8.0	2.0	6.0
31–40	32.0	36.0	62.0	54.0	32.0	40.0	62.0	24.0	40.0	20.0	94.0	80.0	80.0	88.0
41–50	64.0	64.0	36.0	42.0	66.0	60.0	32.0	72.0	60.0	80.0	6.0	12.0	18.0	6.0
n =	50	50	50	50	50	50	50	50	50	50	50	50	50	50

Chi-square = 190.31984 with 26 degrees of freedom
Significant at $\alpha = .001$