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Process Evaluation of the Department of Health Human Resources for Health Deployment Program

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Abstract

The Philippine national government, through the Department of Health (DOH), has a long tradition of augmenting the supply of health care workers in underserved areas. Even with the adoption of the Local Government Code in 1991, which shifts the mandate of DOH from being sole provider of health services to provider of technical services for health, the DOH continues to deploy health care professionals throughout the country. Over the last decade, the national health resources for health (HRH) deployment program has expanded from a relatively small program with a budgetary support of less than PhP200 million that deployed less than 500 health professionals in 2010 to a massive program of about PhP10 billion that deployed almost 30,000 health care workers in 2020. This process evaluation aims to assess the DOH-HRH deployment program design and logic, and document its implementation vis-à-vis its stated design. We find that while the program has many advantages over individual local governments in reallocating HRH across geographic boundaries, there are both design and implementation challenges that may negatively impact on the experiences of deployed health care workers, which, in turn, may reflect negatively on the program. We provide some actionable recommendations specific to these issues to improve the program.

Keywords: Health resources for health, Deployment program, Process evaluation

Disclaimer: This article/report reflects the points of view and thoughts of the authors', and the information, conclusions, and recommendations presented are not to be misconstrued as those of the Department of Health (DOH). Furthermore, this article or report has not yet been accepted by the DOH at the time of writing. The material presented here, however, is done in the spirit of promoting open access and meaningful dialogue for policy/plan/program improvement, and the responsibility for its interpretation and use lies with the reader.

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Process evaluation of the Department of Health Human Resources for Health Deployment Program

Michael R.M. Abrigo, Gina A. Opiniano, and Zhandra C. Tam[1]

1. Introduction

The supply of human resources for health (HRH) is critical in the delivery of health care goods and services. In the Philippines, while the supply of HRH appears to be sufficient at the national scale, recent analysis by Abrigo and Ortiz (2019) of more finely disaggregated data shows that less than a quarter of cities and municipalities in the country have HRH densities above the 41 physicians, nurses, and midwives per 10,000 population recommended by the World Health Organization [WHO] (2016), leaving at least three-quarters of cities and municipalities with potentially insufficient number of health care workers to provide health care services.

The Philippines has a long history of recruiting health care workers from areas with relatively more abundant supply in order to be deployed and augment the supply of health care workers in underserved areas. Despite this tradition, very few studies have documented and assessed its implementation. This study aims to contribute to the literature by providing a process evaluation of the current Department of Health (DOH) national health care worker deployment program. As such, it aims to provide context and study background on future assessments of the impact of this program.

The DOH-HRH deployment program may have particular advantages over individual local governments to reallocate HRH across geographic boundaries mainly through the provision of program benefits. However, as pointed out by Araujo and Maeda (2013), the challenge is not only to identify effective interventions to entice health care workers to practice their profession in underserved areas, but to choose the combination of interventions that may realistically be implemented. This involves recognizing that health professionals may have different preferences, and should not be treated as one homogenous population.

1.1. Background

The Department of Health has been recruiting health professionals to augment the supply of health care workers in underserved areas for over four decades. In 1974, the DOH introduced the Rural Health Practice Program that requires physicians and nurses to practice in rural areas as prerequisite for the issuance of professional licenses. This was then changed into a voluntary program in 1986, and was the precursor of the current Rural Health Team Placement Program. Alongside this was the development of the Medical Pool Placement Program that allows hiring of physicians on a temporary basis to augment the HRH in hospitals.

With the enactment of the Local Government Code in 1991 and the subsequent adoption of Executive Order 102 in 1999, the DOH was effectively transformed from being the sole provider of health services in the public sector to being a provider of specific health services

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and of technical services for health. In the early years of decentralization, DOH introduced the Doctors to the Barrios (DTTB) Program, a national physician deployment program that aims to address the shortage of medical doctors in rural areas.

A DOH survey in 1992 found that 271 municipalities in the Philippines had no physicians, which became the impetus for the creation of the DTTB program (Leonardia, et. al., 2012). Despite this innovation, however, a recent estimate by Abrigo and Ortiz (2019) shows that in 2015 less than a quarter of cities and municipalities in the country have HRH densities higher than the recommended threshold by the WHO. They further noted that while the country produces a substantial number of health professionals – with HRH to population densities exceeding internationally set thresholds at the national level – different push and pull factors that affect the locational decision of health professionals have resulted in increasing spatial concentration of health care workers, primarily in more developed regions.[2]

The DOH-HRH deployment program aims to address this market failure by recruiting health care workers in regions with relatively abundant supply to be deployed in areas with "missing markets" for health care workers. The DOH-HRH program also addresses informational challenges by exposing deployed health care workers to working conditions in communities, thereby bridging information gaps between potential workers, i.e., health professionals, and the realities in places of work, i.e., in community health settings.

Since the introduction of the DTTB program, the DOH has expanded its HRH deployment program to include midwifery and nursing professionals, and to practically all health and allied health professions in more recent years. From being a relatively small program with a budget of less than PhP200 million in 2010, the DOH deployment program has grown to a PhP10 billion-worth program in 2020.

1.2. Objectives

This study aims to evaluate the design and implementation of the DOH Human Resource for Health (HRH) Deployment Program. More specifically, this process evaluation seeks to (1) assess the program design and logic of the DOH-HRH deployment program, (2) document its actual implementation, including perceptions of stakeholders, bottlenecks in implementation, and deviations from program design, and (3) provide actionable recommendations to improve its design and implementation. This process evaluation is intended to provide context and study background for an impact evaluation of the DOH-HRH deployment program.

1.3. Limitations

While we aim to fully document the implementation of the DOH-HRH deployment program, we focus our attention on the three largest subprograms by number of professionals deployed, namely, midwives, nurses, and physicians. Further, we limit our analysis to the implementation of the program within five years after DOH Administrative Order (AO) 2014-0025, which is the latest in a series of DOH-AOs that provide guidelines on the implementation of the DOH-HRH deployment program.

[2] See Abrigo and Ortiz (2019) for a more extensive discussion on the demographic distribution, and more recent stock and flow estimates of health care workers in the Philippines.

2. Review of Literature

The spatial imbalance of health professionals between and within countries is a "worldwide, longstanding and serious problem" (Dussault and Franceschini, 2006). Despite this recognition and the critical role that health workers play in the delivery of health services, little is known about their geographic availability and accessibility (Guagliardo, 2004).

Several "pull" and "push" factors, including individual and community characteristics, work environment, financial incentives, and education system, have been identified in the literature to influence the locational decision of health professionals (Dussault and Franceschini, 2006; Lehmann, et. al., 2008; Wilson, et. al., 2009; Barnighausen and Bloom, 2009; Araujo and Maeda, 2013; McPake, et. al., 2014). However, much of the literature are focused on English-speaking industrialized economies and largely on only a subset of the available HRH cadres, particularly on physicians (Dolea, et. al., 2010; Mandeville, et. al., 2014).

The World Health Organization (2010) reviewed several interventions and their likely impacts to improve retention of health workers in remote and rural areas based on experiences around the world (see Table 1 for summary). Many of the studies that were included in their review were observational and did not use a control group, and were therefore considered of "low" quality. The recommendations were rated as "strong" if the intervention is likely to be successful in a wide variety of settings, and otherwise as "conditional" if the intervention requires "careful consideration of contextual issues and prerequisites" for implementation to be successful. Interventions that provide personal and professional support, targeted admission for students with rural backgrounds, and include rural health topics in curricula were rated as "strong" recommendations.

In the Philippines, while there have been a number of studies that document profiles of health workers in the country (e.g., Reyes and Picazo, 1990; WHO, 2013), research on factors that affect their location decision remains scant. Much of the studies in this area focus on factors relating to decisions to migrate (e.g., Astor, et. al., 2005; Lorenzo, et. al., 2007; Alonso-Garbayo and Maben, 2009), and rarely on intentions to locate domestically. Some exceptions include Abrigo and Ortiz (2019) and Leonardia, et. al. (2012) that both studied local location choice decisions among health workers in the country.

Abrigo and Ortiz (2019) estimated propensity models of location choice decision among physician, nurses and midwives using observed counts of health workers by municipality and city. Their revealed preference approach captures the contribution of locational factors on the decision of health workers on where to practice their professions. They found that physicians, nurses and midwives are more likely to locate in areas where their earnings potential may be highest. Unlike in other studies, however, they found that health workers from ethnolinguistic minorities are less likely than other health workers in the same profession to work in areas with high ethnolinguistic concentration. Leonardia, et. al. (2012), on the other hand, uses a revealed preferences approach, wherein they directly asked physicians their motivations to participate in the country's national rural physician deployment program. They found that physicians who joined the Doctors to the Barrios program were largely driven by return service obligations (53.5%), opportunity to serve rural populations (23.9%), and interest in public health and community medicine (18.3%).

Table 1. Summary of WHO evidence-based recommendations

Category	Recommendation	Evidence quality	Recommendation strength
Education	Use targeted admission policies to enroll students with a rural background in education programs for various health disciplines, in order to increase the likelihood of graduates choosing to practice in rural areas.	Moderate	Strong
	Locate health professional schools, campuses and family medicine residency programs outside of capitals and other major cities, as graduates of these schools and programs are more likely to work in rural areas.	Low	Conditional
	Expose undergraduate students of various health disciplines to rural community experiences and clinical rotations as these can have a positive influence on attracting and recruiting health workers to rural areas	Very low	Conditional
	Revise undergraduate and postgraduate curricula to include rural health topics so as to enhance the competencies of health professionals working in rural areas, and thereby increase their job satisfaction and retention.	Low	Strong
	Design continuing education and professional development programs that meet the needs of rural health workers and that are accessible from where they live and work, so as to support their retention.	Low	Conditional
Regulatory interventions	Introduce and regulate enhanced scopes of practice in rural and remote areas to increase the potential for job satisfaction, thereby assisting recruitment and retention.	Very low	Conditional
	Introduce different types of health workers with appropriate training and regulation for rural practice in order to increase the number of health workers practicing in rural and remote areas.	Low	Conditional
	Ensure compulsory service requirements in rural and remote areas are accompanied with appropriate support and incentives so as to increase recruitment and subsequent retention of health professionals in these areas.	Low	Conditional
	Provide scholarships, bursaries or other education subsidies with enforceable agreements of return of service in rural or remote areas to increase recruitment of health workers in these areas.	Low	Conditional

Table 1. Summary of WHO evidence-based recommendations (continued)

Category	Recommendation	Evidence quality	Recommendation strength
Financial incentives	Use a combination of fiscally sustainable financial incentives such as hardship allowances, grants for housing, free transportation, paid vacations, etc., sufficient enough to outweigh the opportunity costs associated with working in rural areas, as perceived by health workers, to improve rural retention	Low	Conditional
Personal and professional support	Improve living conditions for health workers and their families and invest in infrastructure and services (sanitation, electricity, telecommunications, schools etc.) as these factors have a significant influence on a health worker's decision to locate to and remain in rural areas.	Low	Strong
	Provide a good and safe working environment, including appropriate equipment and supplies, supportive supervision and mentoring, in order to make these posts professionally attractive, and thereby increase the recruitment and retention of health workers in remote and rural areas.	Low	Strong
	Identify and implement appropriate outreach activities to facilitate cooperation between health workers from better served areas and those in underserved areas, and, where feasible, use telehealth to provide additional support to health workers in remote and rural areas.	Low	Strong
	Develop and support career development programs and provide senior posts in rural areas so that health workers can move up the career path as a result of experience, education and training, without necessarily leaving rural areas.	Low	Strong
	Support the development of professional networks, rural health professional associations, rural health journals etc. in order to improve the morale and status of rural providers and reduce feelings of professional isolation.	Low	Strong
	Adopt public recognition measures such as rural health days, awards and titles at local, national and international levels to lift the profile of working in rural areas as these create the conditions to improve intrinsic motivation and thereby contribute to the retention of rural health workers.	Low	Strong

Source: WHO (2010)

3. Overview of DOH-HRH deployment program

3.1. Key policies

Prior to the 1991 Local Government Code (Republic Act [RA] 7160), the Department of Health (DOH) is the sole provider of health services in the Philippines. During this period, the DOH has already been deploying health care workers to underserved areas on a temporary basis. In 1974, the DOH introduced the Rural Health Practice Program which requires rural health practice as pre-requisite for the issuance of medical and nursing license. This was then changed in 1986 into a voluntary program that focused on community health and development. The Medical Pool Placement Program, on the other hand, allows the hiring of physicians on a temporary basis to augment the human resources in hospitals, including provincial and district hospitals that send their resident physicians to training.

Since 1991, however, much of health services, including primary health care service and the operation of health facilities except apex hospitals, were delegated to local governments under RA 7160. The DOH's new roles were reaffirmed in 1999, by virtue of Executive Order 102, which mandates the DOH to be provider of specific health services and of technical services for health, including to local governments.

In the early years of decentralization, local governments in rural areas faced tight budgets and had difficulties recruiting local health personnel (Dussault and Franceschini, 2006). A survey in 1992 found that 271 municipalities had no physicians, which prompted the DOH to implement the Doctors to the Barrios (DTTB) program in the succeeding year (Leonardia, et. al., 2012). The DTTB program aims to provide quality health care service in depressed, marginalized, and underserved areas across the country. Since the introduction of the DTTB program, several other health worker deployment programs were added, including those for midwives, nurses, dentists, medical technologists, nutrition-dieticians, and physical therapists.

In 2018, the Philippine government enacted the Universal Health Care (UHC) Act (R.A. 11223) that automatically enrolls every Filipino citizen in the National Health Insurance Program. Under the UHC Act, the Commission on Higher Education and the DOH are mandated to expand scholarship grants for allied and health-related undergraduate and graduate programs. Recipients of these government-funded scholarship programs are then required to provide return service in priority areas for at least three years, with compensation, under the DOH. The UHCT Act also mandates the creation of a National Health Workforce System (NHWS) to help local public health systems address their human resource need. Similar to prior national health worker deployment programs, the DOH is mandated to deploy health workers in the NHWS.

3.2. Program design

While the thrust of the DOH human resource for health (HRH) deployment program has generally remained the same over the past three decades, the design of the program has undergone several iterations with the issuance of updated DOH guidelines governing its implementation. In this section, we present the current design of the program as provided for in DOH Administrative Order (AO) No. 2014-0025, and the latest applicable DOH issuance. We limit our discussion to those relating to deployment in local governments.

3.2.1. Organization

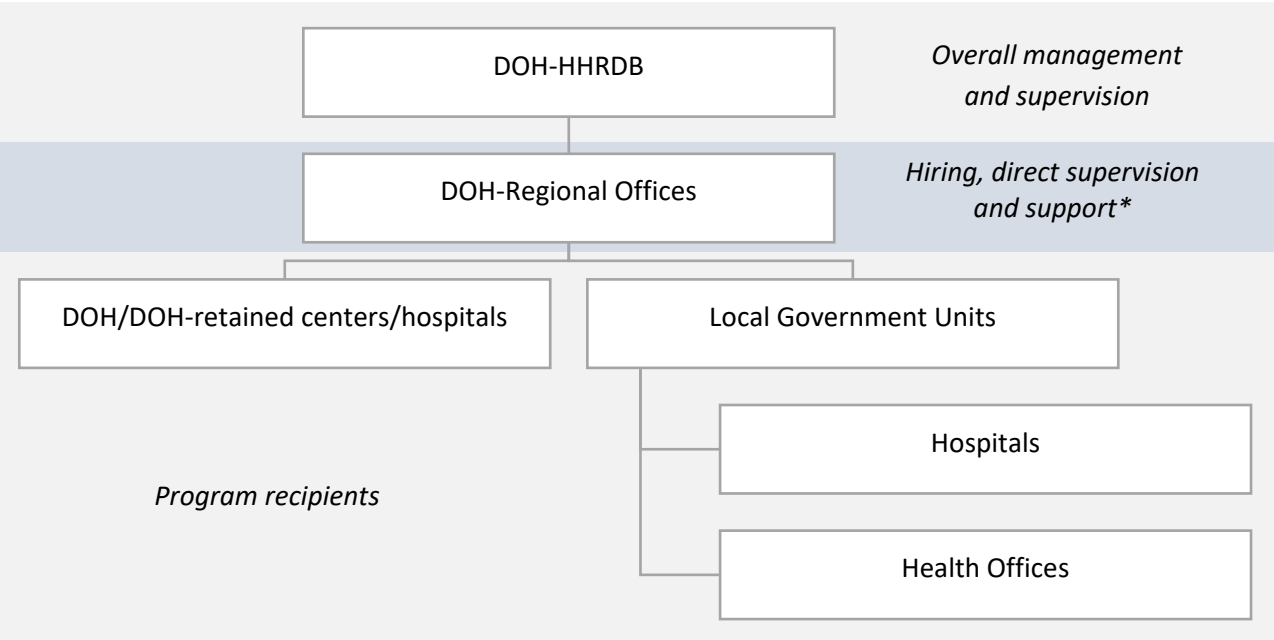
The DOH-HRH deployment program is managed by the Health Human Resource Development Bureau (HHRDB), which directly supervises its implementation by DOH Regional Offices (DOH-ROs). The DOH-HHRDB provides overall administration, including policy formulation, slot allocation, coordination, and monitoring, of the HRH deployment programs. The DOH-ROs, on the other hand, serves as a conduit between the central administration of the DOH-HRH deployment program and the recipient local governments and health facilities. The DOH-ROs coordinate, endorse, and facilitate the deployment of HRH to their areas of assignment. They also conduct pre-deployment orientation of the HRH. Except for physicians deployed under the DTTB program, all deployed HRH are hired through the DOH-ROs. Figure 1 summarizes the implementing structure of the DOH-HRH deployment program.

3.2.2. Site selection

Following DOH-AO 2014-025, the selection of priority areas and the number and type of health workers for deployment is determined by DOH based on the following criteria:

1. Population of recipient or catchment area of the health facility
2. Geographic location and socio-economic classification of area
3. Gaps in current HRH vis-à-vis recommended HRH to population ratio
4. Accreditation status of health facility
5. National priority health facilities for upgrading of infrastructure and services to support achievement of health-related Millennium Development Goals
6. Need for specialized care or services as mandated by law

Figure 1. DOH-HRH deployment program implementing structure



*Excluding DTTB program.

Source: Adapted from DOH Administrative Order No. 2014-0025.

For the DTTB program, the HHRDB requires requesting local governments to submit a matrix of health personnel and a resolution justifying the need for DTTB deployment. The request of local governments needs to be recommended by the provincial DOH office and the DOH-RO.

Operationalization of the priority areas have evolved over the years. In 2015, the priority areas include doctorless cities and municipalities, 5th and 6th class municipalities, and national priority areas under several initiatives, such as municipalities included in the 44 Focus Geographical Areas (FGAs), Accelerated Sustainable Anti-Poverty Program, Whole of Nation Initiative, and Bottom-up Budgeting. In 2018, the focus was to provide one health worker per barangay, geographically isolated and disadvantaged areas, identified municipalities with indigenous people, 4th to 6th class municipalities, and other national priority areas, including those in the 44 FGAs, 36 focus areas of the 2017-2022 Philippine Plan of Action for Nutrition, and areas with DOH pharmaceutical programs.

3.2.3. HRH selection

The selection of HRH follows the usual hiring and selection process in government. The HHRDB and DOH-ROs post call for hiring, which include the requirements, core competencies and benefits, as well as information on the application process, for each program. Applicants accomplish the requirements and submit it to DOH-ROs or to its extension offices.

Except for applications to the DTTB program that is processed by HHRDB, the selection and recruitment for the HRH deployment programs are through the DOH-ROs. The DOH-ROs endorse selected applicants to HHRDB, where either the HHRDB or DOH-ROs process the appointment documents of selected HRHs as appropriate.

Applicants are generally required to be board-certified for their respective profession. Table 2 summarizes the quality standard, offered compensation, and brief description of possible tasks of recruited HRH for a selection of the DOH deployment programs.

3.2.4. Deployment process

The on-boarding of health workers in the DOH-HRH deployment programs start with a pre-deployment orientation seminar by the DOH-ROs. DTTB physicians across the country have additional centralized orientation conducted by the HHRDB. These pre-deployment orientations are then followed by a location-specific orientation conducted by the PDOHO.

Deployment of health workers commences with the issuance of the HHRDB or the DOH-RO of a Department Personnel Order or a Regional Personnel Order, respectively, and endorsement to the deployed workers' place of assignment. The deployed health worker may then report to his/her place of assignment to perform the tasks required of him/her.

Table 2. Quality standard, compensation and functions by deployment program

Position	Quality standard	Salary Grade (PhP/month)	Brief functions
Medical Officer IV	Doctor of Medicine; R.A. 1080 (Board) eligibility	23 (PhP75,359)	Provide direct medical services
Rural Health Physician	Doctor of Medicine; R.A. 1080 (Board) eligibility	24 (PhP85,074)	Provide direct medical services
Dentist II	Doctor of Dental Medicine or Dental Surgery; Board eligibility; Relevant experience and training	17 (PhP38,464)	Provide preventive dental health services
Nurse II	Bachelor of Science (B.S.) in Nursing; Board eligibility; Relevant experience and training	15 (PhP32,053)	Conduct health education, provide nursing services, and serve as navigator in facility
Nurse II*	B.S. in Nursing; Board eligibility; Relevant experience and training	15 (PhP32,053)	Manage health-related information systems and logistics (Public Health Associates [PHA]); Provide program support based on needs (non-PHA)
Medical Tech-nologist II	B.S. in Medical Technology or in Public Health; Board eligibility; Relevant experience and training	15 (PhP32,053)	Provide laboratory services
Pharmacist II	B.S. in Pharmacy; Board eligibility; Relevant experience and training	15 (PhP32,053)	Manage the pharmaceutical supply chain of primary healthcare services
Nutritionist-Dietician II	B.S. in Nutrition and Dietetics; Board eligibility; Relevant experience and training	15 (PhP32,053)	Implement nutrition program
Midwife II	Completion of midwifery course; Board eligibility; Relevant experience and training	11 (PhP22,316)	Conduct health education, home visits, and provide midwifery services

Notes: Monthly basic compensations are as of 2020 based on the 2019 Salary Standardization Law (R.A. 11466). Values are gross of taxes and other contributions, and net of statutory benefits or premium payment. Experience and training requirement include one year of relevant experience and four hours of relevant training, unless otherwise stated. NS – not specified. *Charged under Maintenance and Other Operating Expense.

Sources: 2019 DOH-HHRDB Memorandum and DOH Department Memorandum 2018-034.

3.2.5. Benefits

The monthly compensation by HRH employed under the DOH-HRH deployment programs are summarized in Table 2. Prior to June 2019, except for DTTB physicians, all deployed health workers under the DOH-HRH deployment program were hired under contracts of service, and therefore no employer-employee relationship existed between the hired health workers and the DOH. Beginning in 2019, all health workers, except for those hired as Public Health Associates, are hired as contractual employees under personnel services, and are therefore eligible for statutory benefits, including basic pay, personnel economic relief allowance, representation allowance, subsistence allowance, and hazard pay, if applicable. Those under contract of service, on the other hand, are provided a five percent premium to their basic pay.

In addition to specified monthly compensation, under DOH Department Order 2018-0009, the provincial DOH office (PDOHO) or the integrated provincial health office are tasked to lobby for supplementary incentives to support deployed health workers, including the following:

1. Funds, logistics and materials for health-related programs or projects
2. Monthly allowance or honorarium
3. Meal or meal allowance during their tour of duty
4. Transportation or transportation allowance to cover field assignments and travels on official business
5. Communication allowance
6. Modest board and lodging, whenever necessary
7. Learning and development opportunities

Further, under DOH-AO 2014-0025, the DOH, through the HHRDB and DOH-ROs, are tasked to provide learning and development interventions to deployed health workers based on their learning needs. The recipient local governments, on the other hand, are tasked to cover the transportation and living allowances of deployed health workers who are attending capacity building activities.

DTTB physicians may also earn a master's degree in Public Management major in Health Systems and Development (MPM-HSD) from the Development Academy of the Philippines (DAP). The DAP MPM-HSD is a 38-unit inter-disciplinary program designed for the DTTB program. Classes are held for two weeks every six months over the duration of physicians' DTTB assignment.

3.2.6. Retention and absorption

In DOH-AO 2014-0025, recipient local governments of the DOH-HRH deployment program are tasked to "support and endeavor to retain", and to "implement ways and means to hire" deployed health workers.

3.3. Program statistics

Over the last decade, the DOH-HRH deployment program has ballooned from a relatively small program with a budgetary support of less than PhP200 million in 2010 to about PhP10 billion in 2020. This represents a substantial increase from less than one percent of new DOH appropriations in 2010 to about 10 percent in 2020.

This increase in budgetary support has allowed the DOH-HRH deployment program to expand substantially, sending 439 individuals, composed of 248 physicians and 191 midwives, in 2010 to almost 30,000 individuals, composed of physicians, dentists, nurses, pharmacists, medical technologists, nutritionist-dieticians, midwives, physical therapists, and public health associates, in 2020. Table 3 summarizes the number of deployed cadres by type and year between 2010 and 2020.

Focusing on the most recent available data (see Table 4), when disaggregated by region of deployment assignment, Bicol Region (9.1%), Eastern Visayas (8.6%) and Central Visayas (8.0%) were the greatest recipients by share of all deployed health workers in 2020. There are however important differences across deployed health professions. CALABARZON, for example, received the highest number (12.7%) of all deployed physicians, while Eastern Visayas was the deployment site of the largest number of nurses (13.7%) in 2020.

3.4. Previous evaluations

Despite almost three decades of program implementation, the evidence based on the DOH-HRH deployment program remains thin. A few exceptions include Leonardia, et. al. (2012), Andaya (2011) and Politico (2011), and Lawas, et. al. (2016) that evaluated the implementation of the DTTB program and the Medical Pool Placement and Utilization Program (MPPUP), respectively, and Avancena, et. al. (2019) that conducted a cost-benefit analysis of the DTTB program.

Avancena, et. al. (2019) developed a mathematical model that they calibrated using parameters from the literature and expert opinion applied to hypothetical cohort of children in two provinces and in a representative rural municipality. Based on the analysis of two health conditions, namely, pediatric pneumonia and diarrhea, they concluded that the DTTB is cost-effective, and that their estimates likely underestimate the benefits from the program.

Table 3. Number of DOH-deployed health workers, 2010-2020

	2010	2012	2014	2016	2018	2020
Physician	248	393	458	537	456	724
DTTB	67	235	320	407	311	371
MPPUP	181	158	138	35	37	30
Others	…	…	…	95	108	323
Dentist	…	…	…	267	278	201
Nurse	…	10,000	11,292	16,703	17,856	18,628
Pharmacist	…	…	…	…	276	303
Medical Technologist	…	…	…	441	655	589
Nutritionist-Dietician	…	…	…	…	153	189
Midwife	191	2,391	2,700	4,205	5,022	4,519
Physical Therapist	…	…	…	…	…	65
Public Health Associate*	…	…	…	1,681	3,821	3,286
All cadres	439	12,784	14,450	23,834	28,517	28,504

Notes: DTTB – Doctors to the Barrios; MPPUP – Medical Pool Placement and Utilization program; *Includes unclassified health workers under the Universal Health Care-Implementers Deployment Program.
Source: DOH-HHRDB.

Table 4. Number of deployed health workers by region and profession, May 2020

	Physician	Dentist	Nurse	Pharmacist	Medical Techno-logist	Nutritionist-Dietician	Midwife	Physical Therapist	Public Health Associate	All cadres
National Capital Region	23	5	328	21	11	2	85	0	466	941
Caraga	46	4	509	11	22	8	130	6	212	948
Ilocos Region	36	23	1,083	21	49	2	213	1	206	1,634
Cagayan Valley	43	7	1,183	17	24	2	260	3	189	1,728
Central Luzon	57	17	1,150	21	22	3	97	7	453	1,827
CALABARZON	92	15	1,619	17	51	6	142	4	198	2,144
MIMAROPA	51	10	462	11	22	6	183	4	100	849
Bicol Region	32	17	1,666	9	5	17	600	1	206	2,553
Western Visayas	59	16	634	18	42	10	272	16	276	1,343
Central Visayas	36	23	1,565	12	78	21	390	2	126	2,253
Eastern Visayas	50	29	1,712	16	39	4	398	5	166	2,419
Zamboanga Peninsula	30	5	916	15	49	16	320	3	115	1,469
Northern Mindanao	57	4	1,154	16	26	15	338	5	75	1,690
Davao Region	44	6	770	14	43	2	259	2	138	1,278
Soccsksargen	17	6	1,027	58	49	47	467	3	146	1,820
Caraga	22	4	920	14	35	5	210	4	123	1,337
Bangsamoro ARMM	30	20	1,413	5	19	25	157	5	276	1,950
Philippines	725	211	18,111	296	586	191	4,521	71	3,471	28,183

Note: Aggregate values may be slightly different to those in Table 3 because of difference in recording period.

Source: DOH-HHRDB.

Leonardia, et. al. (2012), using self-administered questionnaire and face-to-face interviews, found that physicians who joined the DTTB program as part of a return service obligation reported having less satisfaction, while those who were motivated by interests in public health care reported being more satisfied with their deployment experience. Further, they documented that physicians who received their medical training from institutions in the National Capital Region perceived that there were fewer options for them in their place of assignment, and were more critical of the compensation that they received. Leonardia, et. al. (2012) report that among the 452 deployed DTTB physicians between 1993 and 2011 only 18% were absorbed by the local government where they had been deployed. They concluded that inadequate local government support and local politics were the most critical factor that determine the retention among deployed DTTB physicians.

Andaya (2011) surveyed 73 deployed DTTB physicians in 2011 to assess the fidelity of DTTB program implementation to its operational guidelines, particularly with respect to issues faced by deployed physicians. She found that a substantial proportion of deployed physicians had little (13%) to no familiarity (16%) with the rationale behind and the objectives of the DTTB program. Her study noted several deviations from the DTTB program operational guidelines, including on the provision of additional incentives by the local governments (e.g., honoraria, subsidized board and lodging, etc.), place of residence during deployment by DTTB physicians, social preparation and orientation conducted by DOH, and monitoring and evaluation by DOH-ROs.

Politico (2011) employed a mixed design approach to assess the implementation and sustainability of the DTTB program. She found that deployed DTTB physicians have low awareness of the DTTB program's goals. Further, she found that retention rate is relatively low only at 18% among deployed DTTB physicians between 1993 and 2009. Among the 65 currently deployed physicians who were surveyed, only 23% had stated intentions to continue working in their host LGU, while a predominant 53% were planning to enter medical residency programs. About a quarter of those surveyed mentioned staying in government health service (14%) or having other career plans (10%). Politico (2011) concludes that the low retention may be related to overall job satisfaction, stress at work, LGU support, and support and supervision from DOH. She also highlighted other issues with the program, including (1) inequitable geographic distribution of DTTB physicians, (2) non-adherence to deployment and allocation process, (3) non-documentation of program impacts.

Lawas, et. al. (2016), also using self-administered questionnaires and face-to-face interviews, evaluated the MPPUP. They found that hospitals request for additional health workers either to address the need of health facilities with expanded capacity but without increased plantilla positions, or of rural and remote facilities that have difficulties attracting and retaining health workers. They documented that while deployed physicians expected to provide only patient care services, they were, however, given administrative responsibilities, training functions, and research and other outreach activities. The concluded that the MPPUP was beneficial to hospitals, and that MPPUP physicians have high degree of satisfaction.

4. Methodology

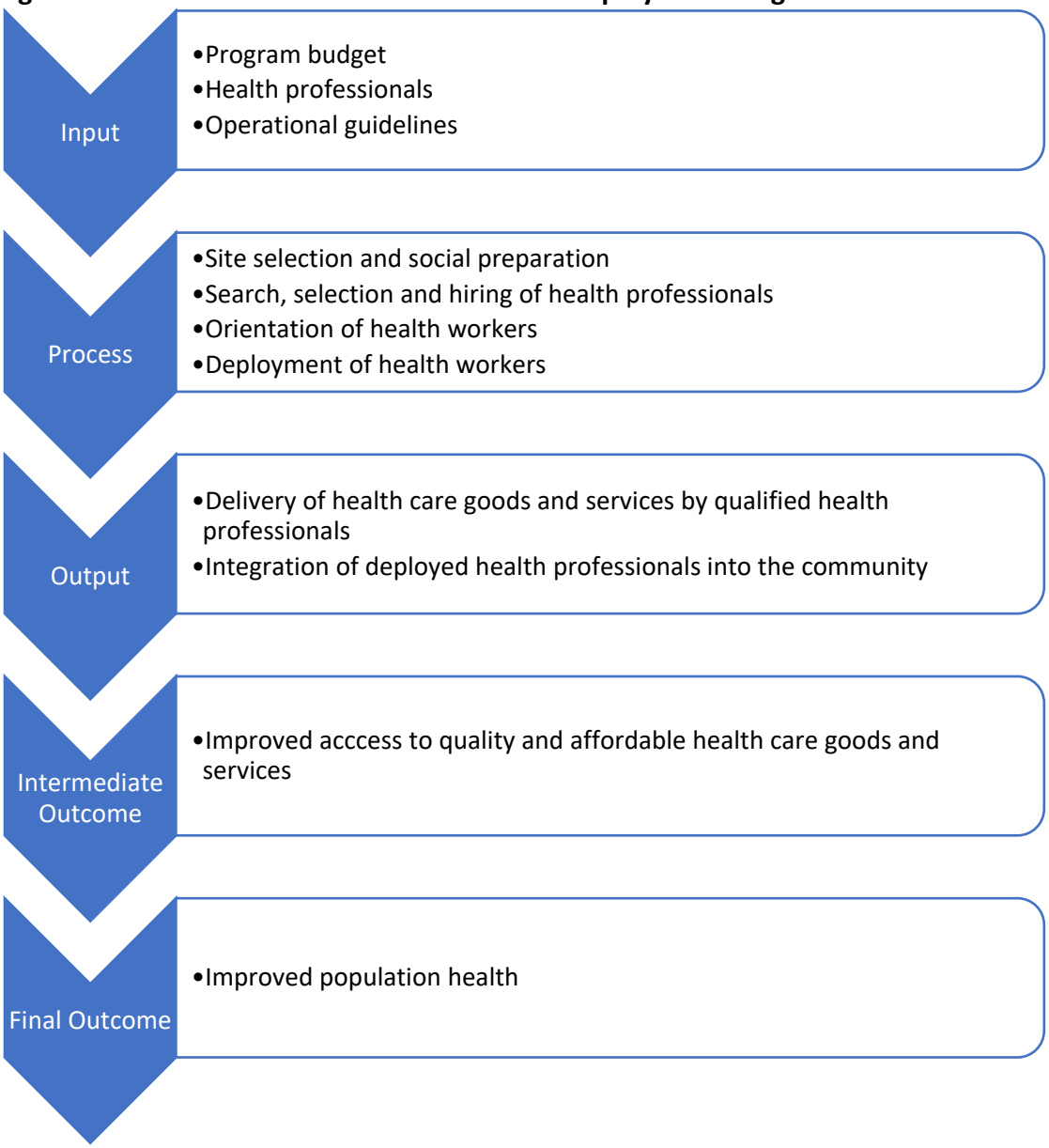
This study is a process evaluation of the DOH-HRH deployment program, where we document the actual implementation of the program, and assess its conformity with its original design.

We also assessed the plausibility of some of the key assumptions required by the program's results framework.

4.1. Results Framework

This process evaluation is anchored on the results framework of the program. A results framework summarizes the logical causal pathways from inputs and processes employed by the program to produce outputs, which, in turn, result in the program goals. It describes how the intervention, in this case the DOH-HRH deployment program, is conceptualized to deliver its intended results. Figure 2 presents the DOH-HRH deployment program results framework which was developed based on DOH-AO 2014-0025 and RA 11223. This results framework is effectively the analytic framework followed in this study.

Figure 2. Results Framework of the DOH-HRH Deployment Program



Source: Authors' elaboration based on DOH Administrative Order No. 2014-0025.

The overarching goal of the DOH-HRH deployment program is to improve health outcomes among the population. This may be attained through the program by deploying and integrating qualified health personnel, especially in underserved areas, which, in turn, will result in the improved delivery of health care goods and services. The deployment of health care workers requires financial, human resource, and policy support to be able to conduct the many different processes involved to successfully deploy health care workers, including selection of sites for deployment and their social preparation; search, selection and hiring of qualified health personnel; orientation of selected HRH prior to deployment; and eventual deployment in selected sites.

These individual steps have implied assumptions. For example, program budgets need to be sufficient to cover program costs and made available in a timely manner. Hiring of HRH for deployment requires a pool of available and willing health workers. Local governments, on the other hand, are assumed to have resources, e.g., health facilities, and medical equipment and supplies, to allow the deployed HRH to perform their duties. Local governments are also assumed to be willing and have the capacity to absorb deployed HRH when their contracts under the DOH-HRH deployment program expires to ensure continuous delivery of health care services to the community.

4.2. Data collection methods

This study employs a mixed-method approach that includes the review and analysis of secondary data (e.g., program documents, and official statistics), and of primary data collected through key informant interviews (KIIs) and focus group discussions (FGDs), and through an online survey of program alumni and of medical, nursing and midwifery students.

We conducted a desk review of DOH-HRH deployment program documents, including policies and guidelines, budgetary allocations, and monitoring statistics, to (a) document the official design and intentions of the program, (b) map out the roles and responsibilities of key stakeholders as provided for in government policies, and (c) assess potential challenges and bottlenecks as may be identified from monitoring statistics. Insights from the desk review are then used to inform the guide questions used in KIIs and FGDs, and the online alumni and student surveys.

The KIIs and FGDs were designed to provide an in-depth discussion with program managers, deployed HRH, and recipient-government local executives to capture their views and experiences with regard the deployment program. Discussions with recipient-government local executives focus on their view of the program design and logic, their experience of the deployment process, and their recommendations to improve the program. Discussions with currently and previously deployed HRH, on the other hand, also touched on program benefits, while those with program managers included topics on administration and financing, and sustainability in addition to those previously mentioned. A copy of the KII and FGD guide questions are provide as appendices to this report.

The KIIs and FGDs were conducted either through face-to-face or online meetings with respondents. In addition to FGDs with program managers in DOH-CO in the National Capital Region, discussions and interviews were conducted with program managers, deployed health care workers, and local government representatives in Cagayan Valley, Central Visayas, and Davao Region. Each session usually ran for around 1.5 to 2 hours, depending on the number of respondents. The KIIs and FGDs were audio-recorded with the consent of the participants.

Finally, we also conducted an online survey of HRH deployment program alumni to capture the experiences of a broader set of respondents, as well as to assess their willingness to accept absorption by their host local governments. We adopted the questionnaire by Leonardia, et. al. (2012) to capture the experience of program alumni during their deployment. An online student survey, on the other hand, was conducted to capture the willingness of future potential HRH pool to be deployed in underserved areas. The questionnaires are provided as appendices.

5. Results and Discussion

This section presents the results of the analysis conducted from data collected in the different activities outlined in the previous section. The discussion is separated into two subsections. The first subsection discusses the assessment on program design and logic, which focuses on the reasonableness of the different program components based on a design standpoint. Attention was given to whether the implied assumptions in each of the steps are plausible in actuality based on information in the literature and available statistics. The second subsection, on the other hand, discusses the implementation of the program as experienced by program managers, deployed healthcare workers, and local government representatives. The analyses in this subsection are drawn mainly from the KII, FGDs, and online surveys conducted.

5.1. Program design and logic

This subsection looks at the plausibility of the program based on a design standpoint. The different program components are assessed based on whether implicit assumptions are likely to be met in reality based on indications from available data and the literature on the topic.

5.1.1. Organization

The DOH-HHRDB provides overall management of the DOH-HRH deployment program, while the DOH-ROs provide direct supervision and support to the program. This set-up may be optimal for the program given that information on public sector HRH gaps and on HRH supply availability, and budgetary support are more abundant at this level of organization. Further, central and regional government offices may have more extensive reach to disseminate information. These together allow the DOH-HHRDB and DOH-ROs to advertise job postings more widely, receive greater number of applications, and re-allocate health workers from areas with relatively more abundant supply to areas where supply may be more limited. In Abrigo and Ortiz (2019), for example, they noted that majority of physicians (59.9%), dentists (67.3%), pharmacists (53.7%), and nutritionist-dieticians (56.5%) reside in the National Capital Region, Central Luzon or CALABARZON. Because of the informational and financial resources available to the national and regional organizations of the DOH, they may have comparative advantage relative to local governments that have more limited financial resource and network to perform the same requirements.

5.1.2. Site selection

The DOH-HRH deployment program was envisioned to augment the supply of healthcare workers in underserved areas with the priority areas identified by the DOH, which may change from year to year. Based on the 2018 DOH-HRH deployment guidelines, the prioritization criteria may be too broad, thereby potentially diluting the potential benefits of the program by allowing deployment in areas where there may be sufficient supply of health care workers. For example, under the 2018 guidelines, the DOH-HRH deployment program may deploy in any one of the following: in 687 fourth to sixth class municipalities; in 1,045 municipalities included in the 44 Focus Group Areas of the DOH; in 57 cities and 804 municipalities in the 2017-2022 Philippine Plan of Action for Nutrition; and in 87 cities and 1,167 municipalities with geographically isolated and disadvantaged areas. For reference, the country has 146 cities and 1,488 municipalities.

Table 5. Share of program recipient-local governments (%): Philippines, 2016-2018

	Physician				Nurse	Midwife
	Any	DTTB	MPPUP	Others		
All local governments	35.1	25.0	1.0	12.0	100.0	94.2
A. By local government income class						
First Class	30.5	19.5	1.8	12.2	100.0	92.7
Second Class	34.0	22.0	0.5	14.0	100.0	95.5
Third Class	36.0	24.7	1.0	14.3	100.0	93.7
Fourth Class	34.4	24.3	0.5	11.7	100.0	95.7
Fifth Class	38.5	32.5	1.1	8.5	100.0	94.7
Sixth Class	63.0	59.3	0.0	3.7	100.0	85.2
B. By 2015 poverty incidence						
< 10%	19.5	4.5	2.5	16.0	100.0	90.5
10% to < 20%	34.7	20.0	1.0	16.2	100.0	95.3
20% to < 30%	42.9	32.6	1.6	13.9	100.0	96.8
30% to < 40%	36.5	31.4	0.0	7.5	100.0	97.3
40% to < 50%	35.2	30.0	0.9	7.0	100.0	97.8
> 50%	37.0	29.5	0.0	8.5	100.0	84.0
C. By 2010 HRH-to-population ratio						
> 1:5,000	30.7	14.4	2.5	16.9	100.0	94.8
1:10,000 to < 1:5,000	28.5	19.5	0.0	12.5	100.0	100.0
< 1:10,000	37.8	29.7	0.7	10.3	100.0	92.8

Notes: DTTB – Doctors to the Barrios; MPPUP – Medical Pool Placement and Utilization Program.
Sources: Values are based on DOH-HHRDB program monitoring data. Municipal- and city-level poverty incidence are based on Philippine Statistics Authority (2019a) small area estimates. HRH-to-population ratio are based on the composite of physicians, nurses, and midwives calculated from the 2010 Census of Population and Housing (National Statistics Office, 2012).

Indeed, examination of the place of deployment of physicians, nurses and midwives between 2016 and 2018 show that the DOH-HRH deployment program has deployed in first to third income class local governments, in areas with relatively low poverty incidence, and in areas with relatively high HRH-to-population ratio (see Table 5).

5.1.3. Health worker selection

Requiring applicants to the DOH-HRH deployment to have professional board certification ensures that health workers who will be hired have the requisite training and skills to perform their duties in the community. Additional benefits may be had by selecting and hiring from a large pool of applicants whereby board-certified candidates may be further screened and ranked based on their qualifications, including additional training, and the duration and quality of their relevant experiences. A high recruitment-success rate may suggest high demand for slots among the DOH-HRH deployment programs.

Table 6. Recruitment success rate (%) by region and selected cadre: Philippines, May 2020

	Dentist	Nurse	Pharmacist	Medical Technologist	Nutritionist-Dietician	Midwife
National Capital Region	100	100	100	100	100	100
CAR	100	94	65	100	100	88
Ilocos Region	96	85	100	100	100	96
Cagayan Valley	54	98	100	100	100	99
Central Luzon	100	100	100	100	100	100
CALABARZON	83	84	113	121	200	93
MIMAROPA	100	95	100	100	100	96
Bicol Region	94	96	75	63	74	99
Western Visayas	94	79	100	98	91	97
Central Visayas	110	100	100	100	100	100
Eastern Visayas	193	92	100	93	100	97
Zamboanga Peninsula	71	90	100	100	100	100
Northern Mindanao	57	87	89	104	83	97
Davao Region	67	83	117	100	100	97
SOCCSKSARGEN	67	91	100	73	100	100
Caraga	50	92	100	100	71	100
Bangsamoro ARMM	100	95	100	100	100	199
Philippines	95	92	98	98	96	100

Notes: Values are based on DOH-HHRDB program monitoring data. CAR – Cordillera Autonomous Region; CALABARZON – Cavite, Laguna, Batangas, Rizal and Quezon (Region IV-A); MIMAROPA – Mindoro, Marinduque, Romblon and Palawan (Region IV-B); SOCCSKSARGEN – South Cotabato, Cotabato, Sultan Kudarat, Sarangani and General Santos (Region XII); ARMM – Autonomous Region in Muslim Mindanao. Recruitment success rate is calculated as the ratio of filled relative to available slots.

Table 6 shows the recruitment success rate, calculated as the share of filled relative to available slots, by region and selected deployment programs as of May 2020. It shows that demand for slots by health care workers in the DOH-HRH deployment are relatively robust, with national recruitment success rate ranging from 92% for nurses and 100% for midwives. When

disaggregated by region, the National Capital Region, Central Luzon, and Central Visayas have recruitment success rates of at least 100%, suggesting that the slots are either fully or over-subscribed. In some regions and professions, however, the recruitment success rates are relatively low, such as for dentists in Cagayan Valley, Caraga, and Northern Mindanao, where the recruitment success rate is below 60%, suggesting that there may be low demand for slots in those areas. This may be correlated with the spatial distribution of dentists in the country. Based on data from the 2015 Census of Population (PSA, 2016), only five percent of all dentists reside in these three regions.

5.1.4. Benefits

The DOH-HRH deployment program generally uses financial incentives to counterbalance the perceived and actual opportunity costs associated with working in underserved areas. As classified by WHO (2010), however, financial incentives may not necessarily work in all contexts. While the opportunity costs from working in underserved areas may not be readily calculated from available data, comparison of offered basic pay by the DOH-HRH deployment program and national average wages may provide indications of benefits associated with employment options for health care workers.

As shown in Table 7, health workers employed under the DOH-HRH deployment program receive a premium of at least 35% (for dentists) and up to 140% (for rural health, i.e., DTTB, physicians) of median wages for each profession. In all of these selected programs, the offered basic wages by the different DOH-HRH deployment programs are above the 75th percentile of basic wage rates of health workers in the same profession.

Table 7. Basic daily pay: Deployed DOH-HRH and comparable quality standard (QS), 2018

	Offered basic pay		Daily basic pay (Comparable QS)		
	Salary Grade	Daily basic pay	25-th percentile	50-th percentile	75-th percentile
Rural Health Physician	24	3,332	920	1,363	1,923
Medical Officer IV	23	2,982	920	1,363	1,923
Dentist II	17	1,581	769	1,166	1,363
Nurse II	15	1,319	491	600	818
Medical Technologist II	15	1,319	500	700	850
Nutritionist-Dietician II	15	1,319	500	636	954
Pharmacist II	15	1,319	350	636	962
Midwife II	11	917	500	600	800

Notes and Sources: Daily basic pay is based on 2018 values. DOH-HRH deployment program basic pay are based on DOH Department Memorandum 2018-034 and Executive Order 201, series of 2016, modifying the salary schedule for government personnel. Daily basic pay for comparable quality standards are based on estimates from the October 2018 round of the Labor Force Survey by the PSA (2019b).

Despite this apparent premium provided by the DOH-HRH deployment program, the recruitment success rates presented in Table 8 suggests that there may be other factors that are important for health workers in deciding to work in underserved areas.

In order to identify potential program levers to entice health care workers to be deployed in underserved areas, we conducted an online willingness to accept experiment with Medicine,

Nursing and Midwifery students. Each student is presented a set of five alternative employment options which they are asked to rank. Four of the options provide different benefits for accepting deployment in an underserved rural community. These benefits are based on those already provided in some of the DOH-HRH deployment programs. The last of the options is an outside-value option wherein they will not accept to be employed in an HRH deployment program, and instead work elsewhere. Each survey participant is provided three sets of such options to be ranked. The sets are randomly assigned, and each of the options within sets are randomized for each respondent. Table 8 presents the results of the willingness-to-accept experiment with parameters estimated using ranked-ordered logistic regression.

The results of the willingness-to-accept experiment show differences in the preferences among students, who are presumably the future pool of healthcare workers in the DOH-HRH deployment program, across fields. Future physicians are more likely to accept deployment with at least 150% premium in wages, and have some control over their place of assignment. Nurses, on other hand, are more likely to accept deployment with at least 100% premium on wages, housing and travel allowance, control over their place of assignment, and training aligned with their continuing professional development (CPD). Midwives, on the other hand, are more likely to respond to provision of CPD-related trainings.

Table 8. Student willingness-to-accept deployment by professional field

	Medicine	Nursing	Midwifery
Monthly compensation: Base is national average wage rate			
50% higher than national average (=1)	-0.383	0.013	-1.634
	(1.231)	(0.065)	(0.842)
100% higher than national average (=1)	0.287	0.510***	0.102
	(0.830)	(3.093)	(0.061)
150% higher than national average (=1)	1.098***	0.615***	0.964
	(2.878)	(3.707)	(1.063)
200% higher than national average (=1)	1.086**	0.745***	0.740
	(2.338)	(4.343)	(0.546)
Allowance			
With housing and travel allowance (=1)	0.212	0.212*	0.738
	(1.228)	(1.672)	(1.044)
Deployment site selection: Base is no choice on selection			
Limited choice of site (=1)	0.637***	0.220*	-0.312
	(2.653)	(1.746)	(0.428)
Choice to be indicated in application (=1)	0.965***	0.714***	-0.054
	(2.851)	(5.190)	(0.077)
Training: Base is no free training			
Training aligned with CPD (=1)	0.257	0.505***	0.962***
	(0.998)	(3.727)	(7.163)
Number of Observations	195	795	60
Bayesian Information Criterion	369	1437	113

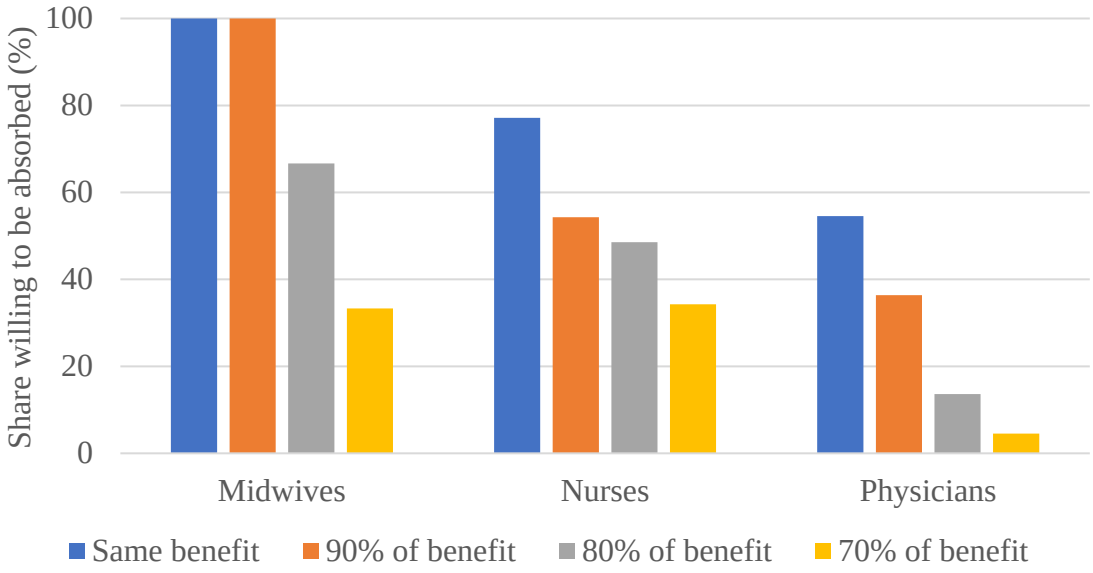
Notes: Values in parentheses are standard errors clustered by respondent-experiment set pair. *, **, and *** indicate statistical significance at the 10-, 5- and 1-% alpha-levels, respectively. CPD – Continuing Professional Development. Source: Authors' calculations.

5.1.5. Retention and absorption

Interviews with program managers indicate that the longer-term goal of the DOH-HRH deployment program is for local governments to be able to employ and retain their own team of health care workers to provide health care services in the community. The DOH-HRH deployment program is seen only as a stopgap measure to allow the continuous provision of services in underserved areas in the near-term. However, the policy on the deployment program is relatively weak in enticing local governments to absorb the deployed health care workers. To wit, DOH-AO 2014-0025 only requires local governments to "support and endeavor to retain", and to "implement ways and means to hire" deployed health workers. A more pointed option may include deploying health care workers contingent on local government plans and actions to hire their own or to absorb deployed health care workers.

Absorption of DOH-HRH deployed health care workers presupposes that local governments are willing and have the capacity to absorb the deployed workers. In terms of capacity, fiscal data from the Bureau of Local Government Finance show that local governments remain highly dependent on block grants, i.e., Internal Revenue Allotment (IRA), from the national government to finance their expenditures. In 2019, IRA constitute 78-, 41-, and 76% of total incomes of province, city, and municipality governments, respectively. In terms of willingness, while it has been documented that expenditures on population, health and nutrition services is positively correlated with local government incomes (e.g., Abrigo and Tam, 2019), exogenous expansion of local government incomes does not readily result in increased expenditures on population, health and nutrition services (Abrigo and Ortiz, 2018).

Figure 3.Willingness to be absorbed by local governments by profession



Source: Authors' calculations. Benefit levels are relative to the schedule of benefits received by respondents during their tour of duty in the DOH-HRH deployment program. Sample sizes are as follows: Midwives (3), Nurses (35), and Physicians (66).

Absorption post-DOH-HRH deployment program also assumes that deployed health care workers are willing to be absorbed if offered a position. Results from the online survey of DOH-HRH deployment program alumni, however, suggest that even with the current level of

deployment program benefits only 77% of nurses and 55% of physicians are willing to be absorbed by their host local government if offered a position. These propensities, together with those of midwives, decrease as wage premia are decreased, which may be expected when the deployed health care workers are employed by local governments instead of the national government through the DOH-HRH deployment program. This observation underscores both the saliency of financial incentives to retain health care workers, as well as the need to understand other factors that affect health care worker decisions regarding where to practice their profession.

5.2. Program implementation

This section documents the actual implementation of the DOH-HRH deployment program and compares it with stated intent or procedures of the program. This draws heavily from the online survey of DOH-HRH deployed health workers, and from FGDs and KIIs with program managers, deployed personnel, and local government representatives.

5.2.1. Organization

Program managers, deployed health care workers, and local government representatives appear to be similarly aware of the goal of the DOH-HRH deployment program to ensure the delivery of health care services in communities by augmenting the local supply of health care workers in the public sector based on discussions during FGDs and KIIs. The participants generally agree that the program has been able to meet this objective. However, while program managers and deployed health care workers understand that the program is a stop-gap measure, many of the local government representatives interviewed had expressed their desire to make the program permanent if possible. This common sentiment, also expressed by some deployed HRH and some program managers, seems to suggest a discrepancy in their understanding of the implications of the HRH deployment program as an augmentation program.

When asked whether their motivation in joining the deployment programs have changed when in their actual deployment after having experienced serving the community, majority of the HRH participants in the FGD sessions responded to the affirmative. Interestingly, those who have previous hospital experiences have similarly expressed their desire to continue serving in the community as the deployment program allowed them to compare and contrast certain aspects of their hospital and community experiences. This resonates the result of the study of Leonardia, et. al. (2012) on the motivation of the respondents to participate in the rural health deployment program, particularly the opportunity to serve rural populations.

5.2.2. Site selection

In addition to awareness of its objectives, program managers are also aware of the overall target beneficiary of the DOH-HRH deployment program, i.e., underserved areas. In practice, however, this may not necessarily be the case as shown in Table 5, which suggests possibilities of inclusion error wherein health workers had been deployed in areas with high-income, high HRH-to-population ratio, and low poverty incidence. While many of the program managers, particularly those from DOH-ROs, expressed that the deployment of health care workers is programmatic and are not likely to be influenced by particular requests from local governments, they stated that they respond to requests based on availability of program slots.

Based on the experience of program managers, local governments that request for health care personnel augmentation are likely beneficiaries based on need rather than because of the request. In cases where HRH augmentation is requested, the same is not always approved. Accordingly, there are instances when requests are not granted primarily due to lack of budget or the unavailability of slots. Further, some program managers expressed their concern that the target of having one health care worker per barangay may not be appropriate in some cases, especially when a barangay is particularly large or covers geographically isolated areas.

The responses of some HRH concur with this apprehension particularly those who are assigned to municipalities with a large number of barangays, barangays with large population, or health facilities with large catchment areas. Some HRH detailed the challenges of reaching the geographically isolated sites that hinder their supposed smooth delivery of health service to the community.

5.2.3. Health worker selection

Based on discussion with program managers, selection and hiring of health care workers to be deployed follows the hiring process for government personnel. The DOH offices post calls for application, and applicants send the requirements to the DOH-CO, ROs, or PDOHO. The applicants are pre-assessed based on their submitted documents. Shortlisted applicants are invited for an interview.

An online survey with DOH-HRH deployment program alumni shows that knowledge about the program comes largely from personal networks, including friends (69.2%), social media (30.8%), and school (29.8%) (see Table 9). The DOH website and offices are also an important source of information based on responses by program alumni (31.7%), although it appears to be only secondary to personal networks. These observations appear to be largely consistent across profession, sex, and marital status of health care workers.

In the DTTB program, physicians select where they wish to be deployed during their orientation workshop in DTTB during which they are already hired. Preference over a site is given to the health worker who has prior ties, e.g., current or previous resident, birthplace of parents, etc., to their choice of site. Multiple claims to a deployment site are resolved by bargaining among those with the same preference for sites. Health workers in other deployment programs, on the other hand, self-select into their choice of deployment site when they apply for the program. The deployment sites are made known to health workers during application, who are then free to not continue with the application process when they are not amenable to working in any of the available beneficiary sites.

5.2.4. Deployment

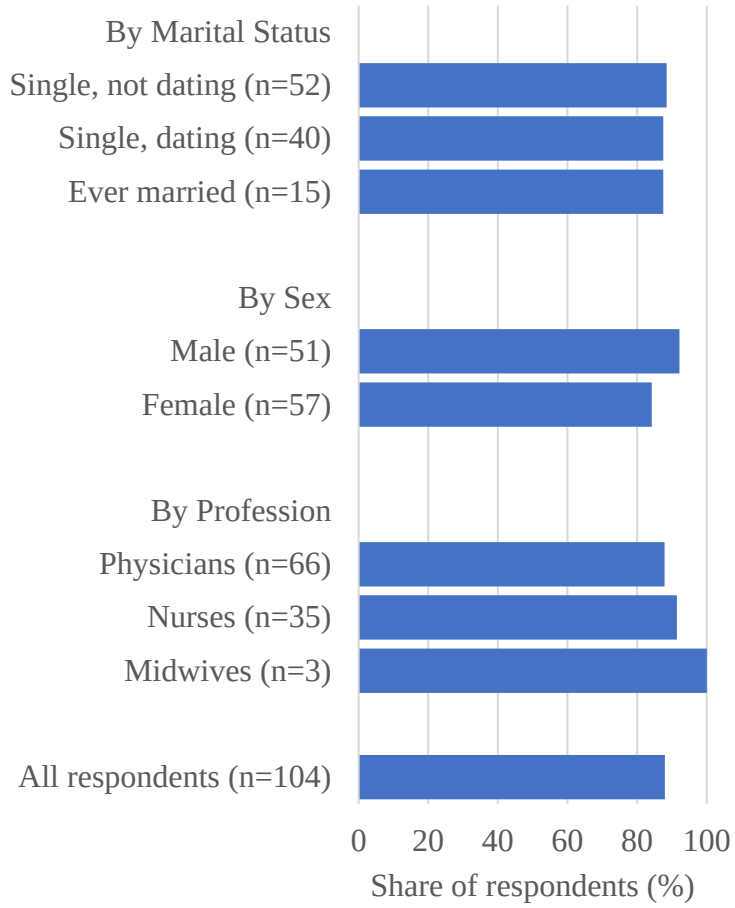
Prior to deployment, hired health care workers under the DOH-HRH deployment program are expected to attend a pre-deployment orientation seminar (PDOS) at the DOH-CO, in the case of DTTB program physicians, and in the DOH-ROs. Based on results of the online survey, presented in Figure 4, almost 90% percent of respondents stated that they attended a PDOS, with males more slightly more likely to respond in the affirmative relative to females.

Table 9. Source of information on the DOH-HRH deployment program by selected characteristics

	All respondents (n=104)	By profession			By Sex		By Marital Status		
		Midwives (n=3)	Nurses (n=35)	Physicians (n=66)	Female (n=57)	Male (n=51)	Ever married (n=15)	Single, dating (n=40)	Single, not dating (n=52)
Radio	2.9	0.0	2.9	3.0	1.8	3.9	0.0	7.5	0.0
TV	6.7	0.0	8.6	6.1	1.8	11.8	6.3	10.0	3.8
Print	4.8	0.0	2.9	6.1	0.0	9.8	6.3	5.0	3.8
Social media	30.8	33.3	37.1	27.3	31.6	33.3	25.0	42.5	26.9
DOH	31.7	33.3	42.9	25.8	31.6	33.3	31.3	35.0	30.8
School	29.8	33.3	0.0	45.5	24.6	35.3	12.5	30.0	34.6
Family	11.5	0.0	17.1	9.1	14.0	7.8	25.0	10.0	7.7
Friends	69.2	100.0	80.0	62.1	70.2	68.6	56.3	75.0	69.2
Others	8.7	0.0	0.0	13.6	12.3	5.9	25.0	2.5	9.6

Notes: Authors' calculations based on online survey with DOH-HRH deployment program alumni. Caution must be exercised when interpreting results from subpopulations with small sample sizes. Values for "All respondents" exclude 4 responses with no profession stated.

Figure 4. Share (%) of alumni who attended PDOS by selected characteristics



Note: Authors' calculations based on online survey with DOH-HRH deployment program alumni. Caution must be exercised when interpreting results from subpopulations with small sample sizes. Values for "All respondents" exclude 4 responses with no profession stated. PDOS – pre-deployment orientation seminar.

The PDOS conducted by DOH provides an important avenue for health care workers to set and manage expectations about the latter's areas of assignment, roles and responsibilities, and program benefits, among others. Based on discussions during FGDs and KIIs, some of the deployed health care workers opined that the orientation was sufficient while some of them expressed the opposite. On one hand, some HRH are generally aware of the potential scenarios in an underserved area, hence their expectations are usually commensurate to what they actually experience at work. On the other hand, some of the FGD and KII participants find the orientation to be insufficient to prepare them for their actual deployment.

While the orientation may be described as a "starter pack" according to some health care worker-participants, some respondents expressed that the orientation that they received does not fully provide details of what deployed workers need to expect or know prior to deployment, including (1) other potential roles and responsibilities that they may be assigned to, (2) means of communication available in deployment sites, (3) safety protocols in case of emergency situations, and (4) medical equipment and other resources available for them to practice their profession, among others.

It is to be noted that the orientation on the HRH's job description, content of contract, program benefits and reportorial obligations were appreciated, however, a counterbalance response can be summed up by the statement of one HRH that the "actual situation is different from what is provided in the orientation." Suggestion to provide a more detailed and cadre-focused orientation seem common among all cadres represented in the study.

Discussions during FGDs and KIIs with deployed workers, and results of the online survey suggest that health care workers may be overworked during deployment. In one of the FGDs, a participant mentioned having experienced being assigned multiple assignments and responsibilities, including (1) administrator at the rural health unit, (2) health educator and health care practitioner in communities, (3) health advocate in the local government, (4) member in various local government committees, and (5) on-call clinician in birthing facilities. The participant also expressed "frustration" over seeing many colleagues working beyond regular working hours because of limited human resource in their deployment site. This is substantiated by the responses of majority of the health care worker participants who claim that "work continues even during weekends." While their actual experiences vary in terms for example on the number of patients they have to attend to every week, they are all in agreement that they do administrative work apart from their basic roles and responsibilities.

Table 10. Average working hours by activity type, and number of patients per week

	Hours per week on activities			Average number of patients per day
	Clinical practice	Community visits	Adminis-trative work	
All respondents (n=104)	22.8	18.6	12.4	43.9
By Profession				
Midwives (n=3)	8.0	28.7	2.7	21.7
Nurses (n=35)	18.8	22.7	8.8	39.4
Physicians (n=66)	25.6	16.1	14.6	47.3
By Sex				
Female (n=57)	21.0	19.3	12.0	44.2
Male (n=51)	24.7	17.6	13.0	43.7
By Marital Status				
Ever married (n=15)	21.8	19.7	14.1	52.9
Single, dating (n=40)	25.7	16.0	11.4	46.0
Single, not dating (n=52)	21.0	20.1	12.8	39.7

Note: Authors' calculations based on online survey with DOH-HRH deployment program alumni. Caution must be exercised when interpreting results from subpopulations with small sample sizes. Values for "All respondents" exclude 4 responses with no profession stated.

This experience may not be unique to the focus group. As shown in Table 10, survey respondents reported working for more than 50 hours per week on average. This is spent largely on clinical practice (22.8 hours), and on community visits (18.6 hours), although a substantial portion is also spent on administrative work (12.4 hours). When disaggregated by health care

worker characteristics, important differences in working hours may be observed across profession, sex, and marital status. Physician work weeks, for instance, are the longest, averaging 56.3 hours with about a quarter (14.6 hours) of that spent on administrative work.

It is worth noting, however, that there are also health care worker participants who shared that in their areas of assignment, under normal circumstances, they are assured family time during weekends. This means that they only work within the prescribed number of hours which may be associated with the distant location of the health facility from the households. Being able to work only within the required number of hours is also a choice HRH must make, as one respondent conveyed. This does not remove the fact, nonetheless, that all HRH are aware that they are on call during emergencies and calamities.

In order to further assess the experience of health care workers on their deployment experience, we adopted the questionnaire by Leonardia, et. al. (2012) based on Bancroft (2006) that asks deployed workers on their agreement on statements covering personal and job satisfaction, career advancement, working environment, living conditions, and compensation. Table 11 presents net agreement, calculated as the difference in the proportion that sates either "Strongly agree" or "agree" and either "Strongly disagree" and "disagree", on each statement.

The results presented in Table 11 suggest that survey respondents have relatively high personal satisfaction in their work as more respondents agree that they "find fulfillment" in serving the community (+94.2 net agreement), "have good friends at work" (+92.3), "know what is expected" of them at work (+91.3), find their work "meaningful and stimulating" (+90.4), and feel appreciated in the community (+89.4). However, survey responses also suggest that many deployed health care workers have issues in accessing equipment (+37.5), medical supplies (+33.7), and essential drugs and medications (+32.7) that they need to perform their job safely and efficiently. Further, the survey reveals that many deployed health care workers feel that their work is not appreciated by their primary employer, i.e., DOH (+28.4), and that they are not satisfied with the support that they receive from the latter (+26.0).

5.2.5. Benefits

Delays in the receipt of monthly compensation appear to be prevalent especially during the first few months of hiring based on reports during FGDs and KIIs with both program managers and deployed health care workers. According to program managers these delays, ranging from one to three months, may be due to a number of factors, including (1) the length of time in processing hiring documents, (2) delays in the sub-allotments to DOH-ROs, and (3) late submission of daily time records or other pertinent documents of deployed health care workers.

Table 11 presents the frequency of receipt and satisfaction among deployed health care workers on the DOH-HRH deployment program benefits. Among all respondents, 7.7% cited that they receive their monthly compensation less frequently than once a month, with nurses reporting higher prevalence of delayed receipts of monthly compensation (11.4%) compared to physicians (6.1%).

The receipt of benefits other than monthly compensation appear to vary across health care workers. For instance, only around half of nurses ever received monthly allowance/honorarium, while more than nine in ten deployed physicians were provided monthly allowance. Receipt of other benefits among nurses also appear to be less prevalent,

such as those for meals (5.7%), transportation (8.6%), communication (2.9%), and board and lodging (2.9%), compared to deployed physicians.

In some of the FGDs with deployed health care workers, participants raised the issue that they have at times challenges in reaching communities, which may require traveling long distances by foot. While the deployed health care workers admitted being aware of such tasks prior to deployment, they intimated that they usually use their own resources (e.g., own salary to pay for transportation fare or gas, if owning a vehicle) to be able to reach communities. Some FGD participants mentioned that the transportation costs related to delivering health care services are allegedly deducted from their salaries.

Table 11. Deployment experience

Statement	Net agreement
I find fulfillment in serving my community.	+94.2
I have good friends at work.	+92.3
I know what is expected of me when I come to work.	+91.3
The work I am doing is meaningful and stimulating.	+90.4
The community where I am assigned generally appreciates my work.	+89.4
The job matches my skill and expertise.	+85.6
Considering everything, I am satisfied with my job.	+80.8
I feel safe working in the community where I am deployed.	+79.8
My family supports my decision to be part of the DOH deployment program.	+78.8
The government officials in the community where I am assigned appreciates my work.	+77.9
I feel safe living in the community where I am deployed.	+76.0
I can take time to eat lunch and snacks every day.	+75.0
I have the flexibility to balance workplace demands and my personal life.	+73.1
I feel that my views are respected at work.	+72.1
I have clean running water at my workplace.	+70.2
The workload is manageable.	+67.3
I am fairly evaluated on my work.	+66.3
I have sufficient training to perform the task expected of me.	+59.6
I receive recognition for doing good work.	+59.2
I have regular electricity at my workplace.	+58.7
I work with a competent local government.	+56.3
I feel that there are sufficient opportunities to develop my career.	+55.8
I am satisfied with the quality of care that my health facility can provide.	+54.4
I am satisfied with the support that I receive from the local government I was assigned.	+50.0
I receive words of encouragement from DOH or local government personnel.	+50.0
I have access to equipment that I need to perform my job safely and efficiently.	+37.5
I have access to medical supplies that I need to perform my job safely and efficiently.	+33.7
My health facility has ready access to essential drugs and medications.	+32.7
The DOH appreciates my work.	+28.4
I am satisfied with the support that I receive from the DOH.	+26.0

Note: Authors' calculations based on online survey with DOH-HRH deployment program alumni. Net agreement is calculated as the difference between the proportion of respondents indicating either "Strongly agree" or "agree", and those indicating either "Strongly disagree" or "disagree" on the statement. The statements were adopted from Leonardia, et. al. (2012)

Table 12. Program benefits receipt frequency and satisfaction by profession

	Frequency of receipt (%)			Satisfaction (%)		
	At least once a month	Less frequent than once a month	Never	Dis-satisfied	Neither dissatisfied nor satisfied	Satisfied
A. Midwives (n = 3)						
Monthly compensation	0.0	33.3	66.7	0.0	33.3	66.7
Funds, logistics and materials for programs/project	0.0	33.3	66.7	0.0	33.3	66.7
Monthly allowance/honorarium	33.3	33.3	33.3	33.3	33.3	33.3
Meals or meal allowance during duty	100.0	0.0	0.0	100.0	0.0	0.0
Transportation or transportation allowance	100.0	0.0	0.0	100.0	0.0	0.0
Communication allowance	66.7	33.3	0.0	66.7	33.3	0.0
Board and lodging, or commensurate allowance	66.7	33.3	0.0	66.7	33.3	0.0
Learning and development opportunities/activities	33.3	0.0	66.7	33.3	0.0	66.7
B. Nurses (n = 35)						
Monthly compensation	80.0	11.4	8.6	14.3	8.6	77.1
Funds, logistics and materials for programs/project	48.6	31.4	20.0	31.4	11.4	57.1
Monthly allowance/honorarium	42.9	8.6	48.6	48.6	20.0	31.4
Meals or meal allowance during duty	5.7	2.9	91.4	60.0	31.4	8.6
Transportation or transportation allowance	8.6	0.0	91.4	62.9	28.6	8.6
Communication allowance	2.9	5.7	91.4	62.9	31.4	5.7
Board and lodging, or commensurate allowance	2.9	8.6	88.6	57.1	31.4	11.4
Learning and development opportunities/activities	20.0	45.7	34.3	14.3	37.1	48.6

Table 12. Program benefits receipt frequency and satisfaction by profession (Continued)

	Frequency of receipt (%)			Satisfaction (%)		
	At least once a month	Less frequent than once a month	Never	Dis-satisfied	Neither dissatisfied nor satisfied	Satisfied
C. Physicians (n = 66)						
Monthly compensation	90.9	6.1	3.0	10.6	4.6	84.9
Funds, logistics and materials for programs/project	27.3	65.2	7.6	45.5	19.7	34.9
Monthly allowance/honorarium	90.9	0.0	9.1	19.7	15.2	65.2
Meals or meal allowance during duty	28.8	7.6	63.6	42.4	30.3	27.3
Transportation or transportation allowance	63.6	4.6	31.8	34.9	22.7	42.4
Communication allowance	40.9	6.1	53.0	48.5	22.7	28.8
Board and lodging, or commensurate allowance	62.1	0.0	37.9	28.8	19.7	51.5
Learning and development opportunities/activities	36.4	50.0	13.6	22.7	19.7	57.6
D. All respondents (n = 104)						
Monthly compensation	87.5	7.7	4.8	11.5	6.7	81.7
Funds, logistics and materials for programs/project	35.6	52.9	11.5	39.4	17.3	43.3
Monthly allowance/honorarium	74.0	2.9	23.1	29.8	17.3	52.9
Meals or meal allowance during duty	20.2	5.8	74.0	50.0	29.8	20.2
Transportation or transportation allowance	43.3	2.9	53.9	46.2	24.0	29.8
Communication allowance	26.9	5.8	67.3	53.9	26.0	20.2
Board and lodging, or commensurate allowance	40.4	2.9	56.7	39.4	24.0	36.5
Learning and development opportunities/activities	31.7	48.1	20.2	20.2	25.0	54.8

Note: Authors' calculations based on online survey with DOH-HRH deployment program alumni. Caution must be exercised when interpreting results from subpopulations with small sample sizes. Values for "All respondents" exclude 4 responses with no profession stated.

In terms of training benefits, the DTTB respondents are unanimous in their position that there is sufficient training provided to them as part of the program package. However, it is a common observation among other health worker participants that there is no training available for them. When asked about the specific trainings they are expecting to be provided, several mentioned basic life support and other trends in health care as suggestions. Moreover, trainings related to administrative functions also surfaced. In general, the trainings mentioned are basically capacity-building in nature.

As far as the program managers are concerned, trainings are part of what should be offered to the HRH. When trainings are DOH-sanctioned or externally conducted, the DOH shoulders the expenses incurred by the HRH. The program managers however did not mention a regular training conducted for the HRH particularly for the nurses and midwives.

Some health care worker participants in the FGD also raised not receiving sufficient learning and development interventions which may hinder their capacities to competently carry out the tasks assigned to them. Based on discussions with health care workers, these training interventions are seen as important in enhancing their professional skills and expanding their knowledge about their disciplines. However, among respondents in the online survey, about a third of nurses, and about a fifth of physicians never received any learning and development opportunity during their deployment.

When asked about additional incentives that local governments provide to deployed health care workers that they host, FGD participants from local governments mentioned providing transportation or transportation allowance, and other funding for special activities. Some program managers concede that additional incentives are not being provided by low-income local governments due to budgetary concerns. In some cases, the travel expenses are provided on a refund basis. Further, some local governments provide non-monetary incentives, including rice, meals and vaccines.

Overall, majority of deployed workers who responded in the survey (81.7%) stated that they are satisfied with the monthly compensation that they received (Table 12). However, satisfaction is much lower for other program benefits: learning and development opportunities (54.8%); monthly allowance/honorarium (52.9%); funds, logistics and materials for programs/projects (43.3%); board and lodging allowance (36.5%); transportation allowance (29.8%); meal allowance (20.2%); and communication allowance (20.2%). There appears to be differences in satisfaction on the program benefits by profession, with deployed physicians being generally more satisfied than deployed nurses.

The benefits from the DOH-HRH deployment program may also be in terms of perceived professional standing. In the online survey with program alumni, we asked respondents to rate themselves relative to other professionals in their field at three time points: before deployment, right after deployment, and currently. Table 13 shows the average percentile rank that respondents perceived themselves to be in each of these time points. The results suggest that nurses who were accepted into the DOH-HRH deployment program perceived themselves to be in the upper 30 percent of nurses before they were deployed, after which they rank themselves higher at the upper 10 percent of nurses. Deployed physicians, on the other hand, ranked themselves lower before deployment, with self-ranking averaging at 41.6-th percentile of all physicians. Their self-ranking increases significantly right after deployment, averaging 65-th percentile, and years after, with their current self-ranking averaging at 68.8-th percentile.

Table 13. Percentile self-rating by selected characteristics

	Before deployment	Right after deployment	Currently
All respondents (n=104)	52.0	72.3	76.3
By Profession			
Midwives (n=3)	56.7	68.3	78.3
Nurses (n=35)	70.7	86.7	90.3
Physicians (n=66)	41.6	65.0	68.8
By Sex			
Female (n=57)	50.3	70.9	76.6
Male (n=51)	53.8	73.7	75.9
By Marital Status			
Ever married (n=15)	58.6	74.3	82.0
Single, dating (n=40)	49.5	71.5	73.8
Single, not dating (n=52)	51.8	72.2	76.4

Note: Authors' calculations based on online survey with DOH-HRH deployment program alumni. Caution must be exercised when interpreting results from subpopulations with small sample sizes. Values for "All respondents" exclude 4 responses with no profession stated.

5.2.6. Retention and absorption

Program managers perceive the retention and absorption of deployed health care workers to be an important concern that the DOH-HRH deployment program needs to work on. During FGDs with program managers, some expressed their concern that local governments appear to lack initiative to hire deployed HRH to eventually become part of the local government's personnel, or to open positions to be able to hire needed health care workers. A common observation expressed by the program managers is the seeming complacency of the local governments due to the availability of assistance provided through the DOH-HRH deployment program.

Many local government representatives, on other hand, expressed that their governments have endeavored to hire more health care workers alongside the deployment from DOH. However, based on discussions with these representatives, the growing mandates on local governments, including those coming from DOH, have increased their workloads, which the deployed health care workers are able to ease. Further, many local government representatives cited hiring caps based on local government income, which effectively limits their capacity to hire more workers whether for health services or in others.

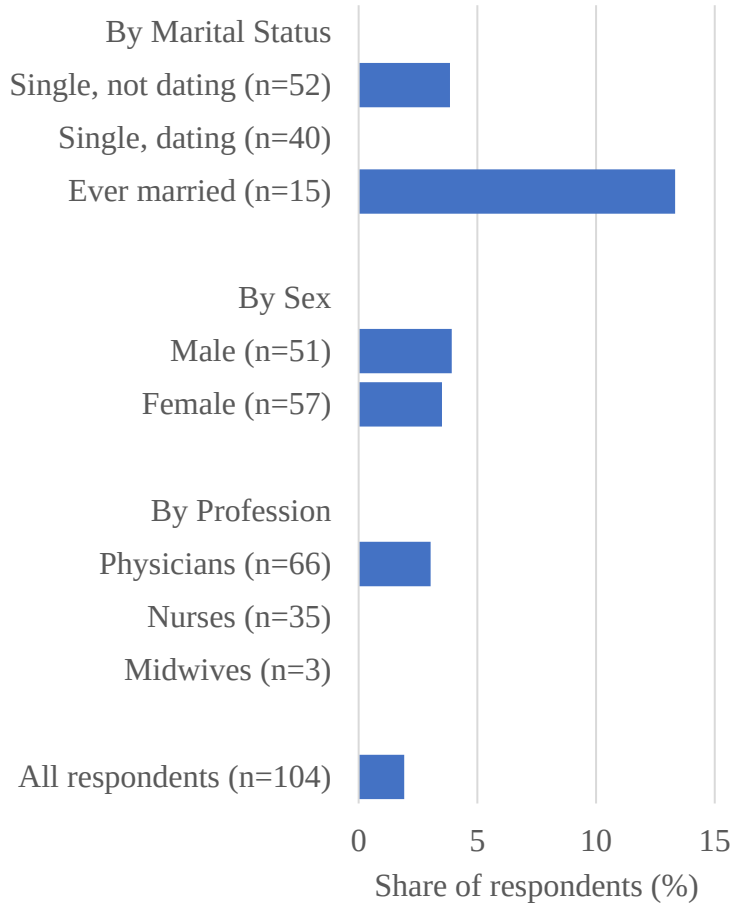
Among deployed health care workers, some cited being discouraged by resistance from the community, which contributed to their decision to discontinue pursuing certain services or renewing deployment contracts. For example, some HRH participants mentioned having encountered resistance from barangay officials and residents who are uncooperative or unsupportive of the health care programs and services that deployed HRH offer. Few respondents also mentioned the lack of legislative support from the barangay council, cultural beliefs of some indigenous communities, and having to deal with other functions beyond one's

job description to be factors which affect their decision to discontinue with the deployment program. More respondents, nevertheless, are willing to continue and be renewed for another contract for varying reasons.

Based on our online survey with DOH-HRH deployment program alumni, program attrition is relatively low at about 2% (see Figure 5). Among survey respondents, attrition is observed only among physicians with a rate of about 3%. Among those who reported not having finished their deployment contract, the cited reasons include (1) being hired by the DOH-RO as a permanent employee, (2) being homesick, and (3) not being able to submit required documents (for contract renewal) on time.

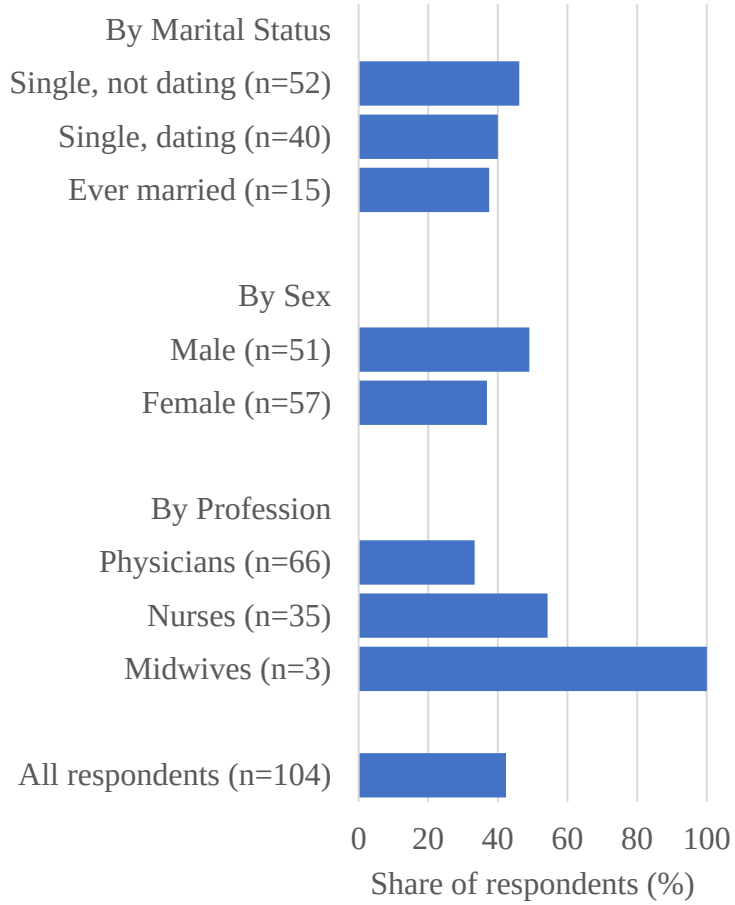
The absorption rate of DOH-deployed health care workers is at 42% among respondents in our online survey (see Figure 6). When disaggregated by profession, more than half of nurses (54%) reported currently working in the place of their deployment. The absorption rate is lower among physicians at only 33%. Interestingly, males are statistically more likely to report that they are currently working in their area of deployment compared with females.

Figure 5. Attrition rate by selected characteristics



Note: Authors' calculations based on online survey with DOH-HRH deployment program alumni. Caution must be exercised when interpreting results from subpopulations with small sample sizes. Values for "All respondents" exclude 4 responses with no profession stated.

Figure 6. Absorption rate by selected characteristics



Note: Authors' calculations based on online survey with DOH-HRH deployment program alumni. Caution must be exercised when interpreting results from subpopulations with small sample sizes. Values for "All respondents" exclude 4 responses with no profession stated.

6. Summary and Recommendations

6.*1.* *Summary*

The DOH-HRH deployment program is an important mechanism that allows the continuous delivery of health care services in underserved areas. This process evaluation aims to assess the program design and logic, as well as document the insights and experiences of key stakeholders, including program managers, health care workers, and local government representatives, on its implementation.

Various design aspects of the program are laudable. In terms of organization, having the program managed by national and regional institutions theoretically allows the program to reallocate human resources for health from areas with relatively ample supply of health care workers to areas where health care workers are of more limited supply. The benefits provided by the program are above median wages for the professions being deployed, and matches optimal wage premia calculated from a willingness to accept experiment.

However, there are some design aspects that may need to be rethought. For example, while the program was originally designed to deploy in underserved areas, it has since expanded to include practically any area in the country. As documented in this report, the DOH-HRH deployment program has been deploying even in areas with high income, with high HRH-to-population ratio, and with relatively low poverty incidence. While this may be beneficial to receiving local governments and may promote political support to expand the national HRH deployment program, this nonetheless may be fiscally and operationally suboptimal. Further, while eventual absorption of deployed HRH by local governments has been one of the longer-term goals of the program, policies to support this has not been built into the program.

The experiences of local governments appear to be generally positive, with all interviewed being appreciative of hosting deployed health care workers. Many were proposing to have the program be permanent. The experience of deployed health care workers, however, are more varied. As we documented in this report, the receipt of program benefits and satisfaction over it vary among survey respondents. Delay in receiving monthly compensation among deployed health care workers is common, while transportation allowance is not provided in a relatively large number of cases, which may negatively impact the experience of deployed HRH.

Overall, deployed health care workers appear to derive non-pecuniary benefits from being part of the DOH-HRH deployment program. We have documented that survey respondents have relatively high personal satisfaction in their work despite issues on access to necessary medical equipment, supplies, and medications that they need to perform their job safely and efficiently, as well as their perceived low support that they receive from the DOH. In addition, we also document increase in self-assessed professional ranking among health care workers after their participation in the national HRH deployment program.

Although attrition among health care workers appear to be rather small over the duration of their deployment contracts, the propensity for retention and absorption in host communities is also small. This is an important concern for many program managers. However, as we documented in this report, this may be expected since even with the same benefits offered to deployed health care workers, a substantial portion of them are likely to not accept continuing working in their area of deployment. When combined with the fact that the offered compensation by local governments is likely to be below those offered by the DOH-HRH deployment program, more deployed health care workers are likely to not accept being absorbed by the local government if offered a position. This highlights the need to better understand the motivations of health care workers, as well as the resources available to local governments to attract them.

6.2. Recommendations

Based on the results of this process evaluation, we propose several actions that may be taken to further improve the DOH-HRH deployment program.

- **The program may need to return its original focus of augmenting health care workers in underserved areas.** This will allow the program to focus its resources on areas where its interventions are most needed. As we have noted in this report, the inclusion criteria for deployment sites have become relatively more general in recent years, which has allowed sending health care workers to practically any local government in the country. This may be contrary to the original design of the program.

- **Selection of deployment sites must be designed in a way to discourage dependence among local governments.** This may include designing a scoring system that puts higher weights on local governments that have (a) long term plans to develop their own cadre of health care workers, or have actually (b) initiated activities to attract and hire health care workers. This may be balanced with counterweights for perceived needs of local governments that the national government have stakes on. In this way, the program may be able to ensure the continuous delivery of health care services across the country without distorting the incentives for local governments to build its own local HRH capacity.

- **The delivery of program benefits needs to be strengthened.** As we have noted in this report, except for the receipt of monthly compensation paid by the national government, the receipt of other benefits due from local governments vary. Program benefits that are necessary to provide health care services, such as meals and transportation allowance during community visits, need to be provided, otherwise this negatively impacts the experience of deployed health care workers, which reflect negatively on the program. In addition, delays in providing these benefits need to be resolved.

- **The program benefits may need to be increased in areas where recruitment success rates are relatively low.** This will allow greater incentivizes for health care workers to consider being deployed in underserved areas. However, it must be designed in such a way to not crowd-out the private sector in underserved areas. Rather, the program should leverage on its design that allows it to reallocate human resources for health across space.

- **The program needs to leverage on identified factors that contribute to HRH retention.** In this study, we have identified that health care workers respond to monetary incentives to accept to continue working in their place of deployment after their DOH-HRH deployment program contract. There is a need to identify other levers, including characteristics related to the program, the host communities and governments, and the health care workers themselves, that may be used to increase the chances of deployed HRH to continue working in underserved areas even in cases where benefits need to be cut down.

- **The pre-deployment orientation program may need to be expanded.** The pre-deployment orientation program is an important avenue for program managers to set and manage expectations of health care workers to be deployed in host local governments. Expanding the orientation program to areas critical to delivery of service by health care workers, but also their personal welfare may be beneficial.

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Appendix

Appendix A. Interview Guide for Program Managers

Objectives
The key-informant interviews with program managers, including those from the DOH central and regional offices, is designed to generate information on program logic, design, implementation, and challenges as perceived by the key informants. It also aims to generate recommendations to improve similar programs in the future.

Guide questions
Discuss the background of the study, and the objectives of the interview. Ask the respondents to sign the prepared consent if they agree to be part of the discussion. Ask the participants to introduce themselves starting with their names, their work and education history, and their current role as program manager. Remind them to wait for them to be recognized before speaking during the discussion to allow the documenter/transcriptionist to properly record the proceedings.
*** Get sample or related statistics

A. Program design and logic

1. In your opinion, what is the objective of DOH's Health Human Resource Deployment Program? Based on your experience working with DOH, has that objective been always the same? Do you feel that the objectives have been met so far?
2. What is your agency's roles and responsibilities in the implementation of the HRH DEPLOYMENT PROGRAM? Do you feel that your agency is able to effectively perform its roles and responsibilities?

B. Deployment process
Can you walk us through the whole deployment process? What is your and your agency's role in each of these processes? How do you coordinate with other offices who you work with in these activities? Please note recent changes in the processes and roles.

1. Identification of HRH DEPLOYMENT PROGRAM slots: How many slots are available? How is this number arrived at? What information is used? Who decides on these targets? ***
2. Selection of sites for deployment: How are the sites selected? How is the criteria decided? What information is used? Is there a standard scoring mechanism? Who decides on the sites? ***
3. Acceptance of requests for personnel augmentation from local government units (LGU): How many requests do you get in a year? How do you rank these requests? Who gets the final say? Are there instances where some requests are not met? ***
4. Recruitment and selection of HHR: What are the requirements for HRH to be part of the program? How many HRH apply? How do you choose which HRH to hire? What information do you use? Is there a scoring mechanism? Are there instances where you do not hire HHR? If so, why? ***
5. Pre-deployment orientation (HHR) and social preparation (LGU): How do you prepare the HHR/LGU before deployment? What are your clients' feedback? Do you think this activity is effective? ***
6. Deployment of HHR, including matching of HRH and LGU: How do you match HRH to their deployment site? What information or ranking system do you use? Is there a scoring mechanism? Can HRH say no? ***

7. Monitoring and evaluation of HHR: How do you ensure that deployed HRH are doing their work? How do you guard against HRH doing other work during deployment? How do you ensure their safety? Are there instances when HHRs are not able to finish their contract? What do you do in such instances? ***
8. Reentry of HHR: Are there instances where HRH gets deployed in multiple cycles? Why do they choose to get re-deployed, in your opinion? Do you think this is good for them? Is this good for the program? In your experience, what do HHRs do after their contract under the HRH DEPLOYMENT PROGRAM? ***
9. Other activities to capacitate LGUs to hire HHR: Do you have programs to capacitate LGUs to hire HRH on their own? If so, do you think these are effective? If not, do you think the program should have one?

C. Program benefits

1. What benefits do HRH get from the HRH DEPLOYMENT PROGRAM? How are these benefits identified? Do you feel that these benefits are insufficient, sufficient or more than sufficient?
   a. Basic pay
   b. Allowances
   c. Education and training opportunity
2. Do you feel that the benefits package may be improved? How?

D. Administration and financing

1. How is the HRH DEPLOYMENT PROGRAM funded? How is the budget arrived at? Can you walk us through the steps and processes of your annual budget and expenditure cycle? In your opinion, are the financial resources available for HRH DEPLOYMENT PROGRAM sufficient? ***
2. Do you have data detailing the major expenditure items, e.g. planning, administration, honoraria/basic pay, training, etc.? How does your unit determine how much should be allocated to each expenditure item? ***
3. Are local governments expected to provide counterpart funding? What is the counterpart funding for? How is your experience with LGUs on this regard so far? What does the program do if LGUs are not able to provide counterpart funding? ***
4. How many people are in-charge of running the program in your agency? Can you describe their roles? Are they working on HRH DEPLOYMENT PROGRAM full time? Do you think this is enough to run the program most effectively? ***
5. Besides your designation as program manager for HRH DEPLOYMENT PROGRAM, do you have other roles and responsibilities in your agency? Do these additional roles and responsibilities improve or hinder your capacity to manage the HRH DEPLOYMENT PROGRAM?

E. Sustainability

1. In your opinion, is HRH DEPLOYMENT PROGRAM a permanent program or a transitory augmentation program? Should it be otherwise? Why do you think so?
2. What is the current political and administrative support for HRH DEPLOYMENT PROGRAM? Is the current administration for its continuance? How has this changed through the years?
3. With the current set up of the HRH DEPLOYMENT PROGRAM, in your opinion, do you think its operations are sustainable? Do you see the program HRH DEPLOYMENT PROGRAM continuing into the not so near future? How do you think HRH DEPLOYMENT PROGRAM should change?

4. Recommendations

1. Besides those that were already mentioned, are there other issues or problems that you have experienced with the implementation of the HRH DEPLOYMENT PROGRAM? What do you think caused these problems?
2. In your opinion, what are the main areas of HRH DEPLOYMENT PROGRAM that need improvement?
3. Are there lessons that you would like to share to future HRH DEPLOYMENT PROGRAM managers?
4. Do you have other concerns about HRH DEPLOYMENT PROGRAM that you want to talk about?

Appendix B. Interview Guide for Deployed Health Care Worker

Objectives
The key-informant interviews/focus group discussion with past and presently deployed HHRs is designed to generate information on the HHRs experiences during the whole deployment cycle, as well as their motivations for pursuing employment under the HRH DEPLOYMENT PROGRAM and future employment trajectory. It also aims to generate recommendations to improve similar programs in the future.

Guide questions
Discuss the background of the study, and the objectives of the interview. Ask the respondents to sign the prepared consent if they agree to be part of the discussion. Ask the participants to introduce themselves starting with their names, their work and education history, and their current role engagement with the HRH DEPLOYMENT PROGRAM. If the interview is with a group, remind them to wait for them to be recognized before speaking during the discussion to allow the documenter/ transcriptionist to properly record the proceedings.

A. Program design and logic

1. In your opinion, what is the objective of DOH's Health Human Resource Deployment Program? Do you feel that the objectives have been met based on your experience?

B. Deployment process

Can you walk us through your experience with the whole deployment process?

1. Motivation: How did you learn of the HRH DEPLOYMENT PROGRAM? Why did you apply? Is this your first choice for employment? Has your motivation changed now relative to when you applied to HRH DEPLOYMENT PROGRAM?
2. Recruitment and selection of HHR: Can you tell me how you were recruited? What are the requirements that you need to submit? Do you feel that these requirements are sufficient?
3. Pre-deployment orientation: How did you prepare for the deployment? Was there an orientation given? What was covered during the orientation? Do you feel that the orientation prepared you enough? What areas need to be improved?
4. Deployment of HHR: What were your expectations about your deployment sites? Is reality far from your expectations?
    a. Please describe the characteristics of the resources (e.g. facilities, equipment, supplies, living conditions, security, organizational support, etc.) available to you during deployment? Do you feel that the support given to you is sufficient?
    b. Please describe your roles and responsibilities during deployment.
    c. Please describe a usual day during your deployment. How many patients do you see? Did you do any administrative work? What do you do during weekends?
    d. During the course of your deployment, where there instances where you do not want to continue or be deployed in another site?
    e. What did you enjoy most during your deployment?
    f. What challenges did you face during deployment?
    g. How was your relationship with the community (e.g., mayor, other personnel and organic staff, patients)? How was your relationship with the program managers?
    h. How would you rate the service you provided to the community? Do you feel that you were appreciated by the community? With your experience and knowledge of

the HRH DEPLOYMENT PROGRAM, will you still apply for HRH DEPLOYMENT PROGRAM?

5. Monitoring and evaluation of HHR: How are you monitored by DOH? In your opinion, is the monitoring and evaluation mechanism implemented by DOH fair and appropriate?
6. Retention and absorption: Were you ever encouraged by the LGU or the DOH to continue working in your deployment site? What strategies did they use? Why did you decide to or not to continue working in the community where you were deployed? What circumstances will make you continue working there?

C. Program benefits

1. What benefits did you get from the HRH DEPLOYMENT PROGRAM? How did you receive these benefits? Were they provided on time?
   d. Basic pay
   e. Allowances
   f. Education and training opportunity
2. In your opinion, do you think the benefits you provided were sufficient? Do you feel that the benefits package may be improved? How?

D. Recommendations

1. Besides those that were already mentioned, are there other issues or problems that you have experienced with the implementation of the HRH DEPLOYMENT PROGRAM? What do you think caused these problems?
2. In your opinion, what are the main areas of HRH DEPLOYMENT PROGRAM that need improvement?
3. Are there lessons that you would like to share to future HHRs in HRH DEPLOYMENT PROGRAM?
4. Do you have other concerns about HRH DEPLOYMENT PROGRAM that you want to talk about?

Appendix C. Interview Guide for Local Chief Executives

Objectives
The key-informant interviews/focus group discussion with local chief executives is designed to generate information on the motivation and experiences of local government units in requesting HRH augmentation from DOH and the benefits from having HRH in the community. It also aims to generate recommendations to improve similar programs in the future.

Guide questions
Discuss the background of the study, and the objectives of the interview. Ask the respondents to sign the prepared consent if they agree to be part of the interview. Ask the participants to introduce themselves starting with their names, their work and education history, and their current role in the local government unit. If the interview is with a group, remind them to wait for them to be recognized before speaking during the discussion to allow the documenter/ transcriptionist to properly record the proceedings.

A. Program design and logic

1. In your opinion, what is the objective of DOH's Health Human Resource Deployment Program? Do you feel that the objectives have been met based on your experience?

B. Deployment process

Can you walk us through your or your team's experience with the whole process of requesting for HRH augmentation?

1. Motivation: How did you learn about the DOH's Health Human Resource Deployment Program? Why did you apply for HRH augmentation? Were all your requests been accepted positively? How does your request tie with your overall agenda for the local government unit? How many times have you applied for HRH augmentation? What do you think make it more likely for you to get HRH augmentation from DOH?
2. Request for HRH augmentation: Can you explain the process that you did to request for HRH augmentation? What information did you provide? Did you have to show proof that you have exerted all efforts to hire, but were not able to do?
3. Social preparation: How did you prepare for the deployment? Did you have a media campaign to introduce the new HHR? What was the general sentiment of the community about the possibility of having HRH augmentation in your municipality?
4. Deployment of HHR: What were your expectations about the HHR? Was the deployed HRH able to satisfy your expectation? What resources did you provide to the HHR?
    i. Please describe the characteristics of the resources (e.g. facilities, equipment, supplies, living conditions, security, organizational support, etc.) that your LGU provided to the deployed HHR? Do you feel that the support that you gave was sufficient for the HRH to do their tasks?
    j. Were you able to interact with deployed HHR? How was your relationship with the deployed HHR? Do you find him/her generally agreeable? Helpful? Can you describe the HHR's positive qualities? How about qualities that needs improvement?
    k. How would you rate the service that the deployed HRH provided to the community? Do you feel that the HRH was appreciated by the community? With your experience and knowledge of the HRH DEPLOYMENT PROGRAM, will you still request augmentation from HRH DEPLOYMENT PROGRAM?

5. Monitoring and evaluation of HHR: Do you monitor the activities of the deployed HHR? What information do you use? In your opinion, is the monitoring and evaluation mechanism that your LGU implements fair and appropriate?
6. Retention and absorption: Have you encouraged the deployed HRH to continue working in your community? What strategies did you use? Why did you decide to or not to encourage the deployed HRH to continue working in your community? What circumstances will make you hire the HHR?

C. Program benefits

1. What benefits did you provide to the deployed HHR? How did you fund these benefits? Were the benefits provided on time?
   g. Basic pay
   h. Allowances
   i. Education and training opportunity
2. In your opinion, do you think the benefits provided were sufficient? Do you feel that the benefits package may be improved? How?

D. Recommendations

1. Besides those that were already mentioned, are there other issues or problems that you have experienced with the implementation of the HRH DEPLOYMENT PROGRAM? What do you think caused these problems?
2. In your opinion, what are the main areas of HRH DEPLOYMENT PROGRAM that need improvement?
3. Are there lessons that you would like to share to future HHRs in HRH DEPLOYMENT PROGRAM?

Appendix D. HRH Deployment Program Alumni Survey

PAGE 1: ABOUT THE SURVEY

The Philippine Institute for Development Studies (www.pids.gov.ph), a government think-tank administratively attached to the National Economic Development Authority (www.neda.gov.ph), in partnership with the Department of Health (www.doh.gov.ph), is currently conducting a process evaluation of the government's health human resource (HRH) deployment program. This survey aims to document the experiences of program alumni to further improve the government's HRH deployment program. The target respondents of this survey are DOH-HRH Deployment Program alumni who were deployed between 2014 and 2018.

This survey has about 60 questions and should take approximately 30 minutes to complete. You may edit your response from the same device until you submit the completed survey form.

PAGE 2: RESPONDENT ELIGIBILITY: HHRDP COHORT

1. Are you a DOH-HRH Deployment Program alumna/alumnus who participated in the program between 2014 and 2018?
    1 – Yes (Go to page 3)
    2 – No (Go to page 4)

PAGE 3: RESPONDENT ELIGIBILITY: PROFESSION

2. What is your profession?
    1 – Physician (Go to page 5)
    2 – Nurse (Go to page 5)
    3 – Midwife (Go to page 5)
    4 – Others (Go to page 4)

PAGE 4: THANK YOU!

Thank you so much for participating in this survey! Your answer(s) have been recorded. Unfortunately, your qualifications do not match this survey's eligibility requirements. We are looking forward to have you in our next surveys.

If you have questions about the study or the survey, you may directly contact the Project Director, Dr. Michael R.M. Abrigo (mabrigo@mail.pids.gov.ph).

PAGE 5: INFORMED CONSENT

Before we begin with the survey, please go through the following information to know more about your rights as survey participant, the potential benefits and risks of the survey, and details of whom to contact in case you have questions about this study.

Voluntary Participation

Your participation in this survey is voluntary. You may refuse to take part in the research or exit the survey at any time without penalty. You are free to decline to answer or skip any questions you find sensitive or are not comfortable answering.

Benefits and Risks

You will receive no direct benefits from participating in this study. However, your responses may help us and the DOH understand what motivates health professional to seek deployment to rural or remote areas. This information will be very useful to DOH in strategies for

advocacy, recruitment, and incentives.

There are no foreseeable risks involved in participating other than those encountered in day-to-day life.

Confidentiality
Your answers will be stored initially with Google forms where data will be stored in a password protected electronic format. Your name and email address will not be shared to the DOH and will only be used by the PIDS research team for monitoring and follow-up purposes. After the data has been downloaded, your name, email address, and telephone number will be removed from this data set. Data will be stored in password protected computers only the PIDS research team can access.

Your responses will remain anonymous and strictly confidential. Outside of the PIDS research team, no one will be able to identify you or your answers, and no one will know whether or not you participated in the study. You will also not be personally identified in any publication or presentation about this study.

Contact
If you have questions about the study or the survey, you may contact directly contact the Project Director, Dr. Michael R.M. Abrigo (mabrigo@mail.pids.gov.ph).

For questions about your rights as a study participant or grievances, you may contact the St. Cabrini Medical Center - Asian Eye Institute (SCMC - AEI) Ethics Review Committee at (632) 8-898-2020 loc. 815 or email scmcaeierc@gmail.com.

3. Do you with to continue with the survey?
    1 – Yes (Go to page 6)
    2 – No (Go to page 4)

PAGE 6: CONSENT FORM

4. By affixing your complete name and email address in below fields, you are voluntarily accepting to take part in the study. Your responses in this survey are strictly confidential. Only consolidated responses will be presented in the study's final report.
    1 – First Name
    2 – Middle Name
    3 – Last Name
    4 – Email address
    5 – Telephone
    6 – Province
    7 – City/Municipality

PAGE 7: DEMOGRAPHIC CHARACTERISTICS

5. What is your sex at birth?
    1 – Male
    2 – Female
    1 – Choose not to answer
6. When were you born? (Please specify birthday)
7. What is your civil status *at the time of your deployment*?
    1 – Single and not exclusively dating

2 – Single and exclusively dating
3 – Married/Living in
4 – Separated/Annulled/Divorced
5 – Widowed
6 – Others (specify)

8. *At the time of your deployment*, did you have at least one child or were expecting to have a child?
   1 – Yes, had child(ren)
   2 – Yes, expecting a child
   3 – No
9. What is your *current* civil status?
   1 – Single and not exclusively dating
   2 – Single and exclusively dating
   3 – Married/Living in
   4 – Separated/Annulled/Divorced
   5 – Widowed
   6 – Others (specify)
10. What is your father's highest educational attainment?
   1 – No grade completed
   2 – Some elementary
   3 – Elementary graduate
   4 – Some high school
   5 – High school graduate
   6 – Technical/Vocational certificate
   7 – Some college
   8 – College graduate or higher
11. Where did your father spend most of his childhood?
   1 – Province
   2 – City/Municipality
12. What is your mother's highest educational attainment?
   1 – No grade completed
   2 – Some elementary
   3 – Elementary graduate
   4 – Some high school
   5 – High school graduate
   6 – Technical/Vocational certificate
   7 – Some college
   8 – College graduate or higher
13. Where did your mother spend most of her childhood?
   1 – Province
   2 – City/Municipality
14. Which of the following amenities does your household have? Please tick all that apply.
   1 – Radio
   2 – Television
   3 – CD/VCD/DVD player
   4 – Component/Stereo set
   5 – Refrigerator/Freezer
   6 – Stove with oven/Gas range
   7 – Washing machine

8 – Air conditioner
9 – Personal computer (e.g. desktop, laptop, notebook, netbook, tablet, etc.)
10 – Landline/Wireless telephone
11 – Cellular phone
12 – Car, jeep, or van
13 – Motorcycle/Tricycle
14 – Motorized boat/banca

PAGE 8: EDUCATION AND BOARD EXAMINATION

15. In what year did you earn your degree? Please use YYYY format.
16. Where did you earn your degree? (Please provide complete name)
    1 – Name of school
    2 – Province
    3 – City/Municipality
17. What was your *primary source* of financing for school while you were studying? Please choose one.
    1 – Self (own income, savings)
    2 – Family, immediate (parents, siblings, spouse)
    3 – Family, extended (grandparents, uncles, aunts)
    4 – Scholarship grant, private
    5 – Scholarship grant, government
    6 – Loans taken by self
    7 – Loans taken by family
    8 – Others (Please specify)
18. What were your *other* sources of financing for school while you were studying? Please tick all that apply.
    1 – Self (own income, savings)
    2 – Family, immediate (parents, siblings, spouse)
    3 – Family, extended (grandparents, uncles, aunts)
    4 – Scholarship grant, private
    5 – Scholarship grant, government
    6 – Loans taken by self
    7 – Loans taken by family
    8 – Others (Please specify)
19. In what year did you first take your board examination? Please use YYYY format.
20. How many tries did it take you to pass your board examination?
    1 – One
    2 – Two
    3 – Three
    4 – Four
    5 – Five or more

PAGE 9: CURRENT EMPLOYMENT (SECTION 1)

21. In the past week, did you work for at least one hour?
    1 – Yes (Go to page 11)
    2 – No (Go to page 10)

PAGE 10: CURRENT EMPLOYMENT (SECTION 2)

22. Although you did not work, did you have a job or business during the past week?
    1 – Yes (Go to page 11)
    2 – No (Go to page 13)

PAGE 11: CURRENT EMPLOYMENT (SECTION 3)

23. What was your primary occupation during the past week? (Please specify.)
    - 1 – Physician (Go to page 5)
    - 2 – Nurse (Go to page 5)
    - 3 – Midwife (Go to page 5)
    - 4 – Others (Go to page 4)
24. Where is your primary occupation primarily located?
    - 1 – Province
    - 2 – Municipality/City
25. What is the nature of your employment?
    - 1 – Province Permanent job/ business/paid family work
    - 2 – Short-term or seasonal or casual job/business/unpaid family work
26. For whom did you work for in the past week?
    - 0 – Worked for private households
    - 1 – Worked for private establishment
    - 2 – Worked for government/government corporation
    - 3 – Self-employed without any paid employee
    - 4 – Employer in own family-operated farm or business
    - 5 – Worked with pay in own family-operated farm or business
    - 6 – Worked without pay in own family-operated farm or business
27. What is the total number of hours you worked for your primary occupation during the past week? Please round your answer to nearest number of hours.
28. Did you want more hours of work during the past week?
    - 1 – Yes
    - 2 – No
29. Did you have another job or business during the past week?
    - 1 – Yes
    - 2 – No
30. What is the total number of hours you worked for *all* your jobs during the past week?
    - 1 – Less than 40 hours (Go to page 15)
    - 2 – 40 hours to less than 48 hours (Go to page 15)
    - 3 – More than 48 hours (Go to page 12)

PAGE 12: CURRENT EMPLOYMENT (SECTION 4)

31. Why did you work for more than 48 hours during the past week?
    - 1 – Wanted more earnings (Go to page 15)
    - 2 – Requirements of the job (Go to page 15)
    - 3 – Exceptional week (Go to page 15)
    - 4 – Ambition, passion for the job (Go to page 15)
    - 5 – Others (Please specify) (Go to page 15)

PAGE 13: CURRENTLY NOT EMPLOYED (SECTION 1)

32. Had opportunity for work existed last week or within two weeks, would have you been available?
    - 1 – Yes
    - 2 – No
33. Did you look for work or try to establish a business during the past week?
    - 1 – Yes (Go to page 15)
    - 2 – No (Go to page 14)

PAGE 14: CURRENTLY NOT EMPLOYED (SECTION 2)

34. Why did you not look for work?
    1 – Tired/Believe no work available
    2 – Awaiting results of previous job applications
    3 – Temporary illness/Disability
    4 – Bad weather
    5 – Waiting for rehire/Job recall
    6 – Too young/Old or retired/Permanent disability
    7 – Household, family duties
    8 – Schooling/Training
    9 – Others (Please specify)

PAGE 15: DOH-HRH DEPLOYMENT EXPERIENCE

35. How did you learn about the DOH-HRH Deployment Program? Please tick all that apply.
    1 – Radio
    2 – TV
    3 – Print media (newspaper, magazine, etc.)
    4 – Social media (Facebook, Twitter, etc.)
    5 – DOH website/office
    6 – School
    7 – Family
    8 – Friends
    9 – Others (Please specify)
36. In what year did your original appointment under the DOH Deployment Program *start*?
    1 – 2014
    2 – 2015
    3 – 2016
    4 – 2017
    5 – 2018
37. In what year did your appointment under the DOH Deployment Program *end*?
    1 – 2014
    2 – 2015
    3 – 2016
    4 – 2017
    5 – 2018
    6 – 2019
    7 – Currently deployed
38. Where were you deployed? In case of multiple deployment sites, please provide the location of last or most recent deployment.
    1 – Province (Specify)
    2 – Municipality (Specify)
39. Where did you submit your application to get admitted to the DOH-HHR Deployment Program?
    1 – DOH Central Office
    2 – DOH Regional Office (or DOH ARMM if in ARMM) or extension offices
    3 – Others (Please specify)

40. Prior to your deployment, did you attend a Pre-Deployment Orientation Seminar conducted by the DOH Regional Office (or DOH ARMM if deployed in ARMM)?
    1 – Yes
    2 – No
41. During your deployment, how many hours in an *average week* did you spend on the following activities?
    1 – Clinical work (Specify)
    2 – Community health visits (Specify)
    3 – Administrative work (Specify)
42. During your deployment, how many patients do you see for health consultation on an *average day*?
43. During your deployment, did you ever work in a night duty?
    1 – Yes
    2 – No
44. If yes, were you accompanied by a LGU-hired health personnel?
    1 – Yes
    2 – No
    3 – Not applicable; Did not work in night duty
45. Have you received the following incentives or support from the Department of Health or the host Local Government Unit?

	Never	Once every week	Once every two weeks	Once every month	Once every three months	Once every six months	Once a year
Monthly compensation							
Funds, logistics and materials for health-related programs/project							
Monthly allowance or honorarium							
Meals or meal allowance during tour of duty							
Transportation or transportation allowance							
Communication allowance							
Board and lodging, or commensurate allowance							
Learning and development opportunities/activities							

46. To what extent can you say that you were satisfied or dissatisfied with following incentives or support from the Department of Health or the host Local Government Unit?

	Very satisfied	Somewhat satisfied	Neither satisfied nor dissatisfied	Somewhat dissatisfied	Very dissatisfied
Monthly compensation					
Funds, logistics and materials for health-related programs/project					
Monthly allowance or honorarium					
Meals or meal allowance during tour of duty					
Transportation or transportation allowance					
Communication allowance					
Board and lodging, or commensurate allowance					
Learning and development opportunities/activities					

47. On an average month, how much did you receive for the following during your deployment? Please put "0" if not provided by DOH or the host local government unit.
    1 – Monthly compensation
    2 – Meal allowance (or value of provided meals)
    3 – Transportation allowance (or value of provided transportation)
    4 – Communication allowance
    5 – Board and lodging (or value if provided in-kind)
48. During your deployment, to what extent would you have agreed or disagreed with the following statements?

	Strongly agree	Agree	Neither disagree or agree	Disagree	Strongly disagree
The community where I am assigned generally appreciates my work.					

My family supports my decision to be part of the DOH deployment program.					
I find fulfillment in serving my community.					
Considering everything, I am satisfied with my job.					
I have good friends at work.					
I feel that my views are respected at work.					
The government officials in the community where I am assigned appreciates my work.					
The DOH appreciates my work.					
The work I am doing is meaningful and stimulating.					
I know what is expected of me when I come to work.					
I feel that there is sufficient opportunities to develop my career.					
The job matches my skill and expertise.					
I receive recognition for doing good work.					
I am satisfied with the support that I receive from the DOH.					
I am satisfied with the support that I receive from the local government I was assigned.					
I receive words of encouragement from DOH or local government personnel.					
I have sufficient training to perform the task expected of me.					

I am fairly evaluated on my work.					
I am satisfied with the quality of care that my health facility can provide.					
I can take time to eat lunch and snacks every day.					
The workload is manageable.					
I have the flexibility to balance workplace demands and my personal life.					
I have regular electricity at my workplace.					
I have clean running water at my workplace.					
My health facility has ready access to essential drugs and medications.					
I work with a competent local government.					
I have access to medical supplies that I need to perform my job safely and efficiently.					
I have access to equipment that I need to perform my job safely and efficiently.					
I feel safe working in the community where I am deployed.					
I feel safe living in the community where I am deployed.					

49. Were you able to finish your tour of duty under the DOH-HHR deployment program contract?
    1 – Yes
    2 – No, please specify reason
50. After your DOH-HHR deployment program contract has ended, did you continue to work in your place of assignment?
    1 – Yes
    2 – No, please specify reason

51. If you were offered a position with the same benefits (compensation, allowance, etc.) in your place of assignment, would you stay and continue working at your place of deployment?
    1 – Yes (Go to page 16)
    2 – No (Go to page 17)

PAGE 16: WILLINGNESS TO ACCEPT LOCAL ASSIGNMENT (SECTION 1)

52. Suppose you are only to receive regular monthly compensation at 90% of the original rate provided to you, would you have continued working?
    1 – Yes
    2 – No
53. Suppose you are only to receive regular monthly compensation at 80% of the original rate provided to you, would you have continued working?
    1 – Yes
    2 – No
54. Suppose you are only to receive regular monthly compensation at 70% of the original rate provided to you, would you have continued working?
    1 – Yes (Go to page 18)
    2 – No (Go to page 18)

PAGE 17: WILLINGNESS TO ACCEPT LOCAL ASSIGNMENT (SECTION 2)

55. How much total compensation per month would have you been willing to accept to stay and continue working at your place of deployment?
    1 – No amount will be enough
    2 – Refuse to answer
    2 – Specific amount (PhP)

PAGE 18: PROFESSIONAL STANDING

Please read the following described scenario carefully.

Think of a ladder as representing all professionals in your chosen field in the Philippines. Imagine everyone in this group is standing somewhere on this ladder.

At the TOP of the ladder are professionals who are the best in your profession -- those who are most skilled, the most liked, and the most valuable in your profession.

At the BOTTOM are professionals in your field who are the worst off -- those who are the least skilled, the least liked, and the least valuable in your profession.

The higher up you are on the ladder, the closer you are to the people at the very top. The lower you are on this ladder, the closer you are to the people at the very bottom.

Suppose the ladder has 100 steps, with 100 being the TOP (best) and 0 being the BOTTOM (worst).

56. Where would you place your self on this ladder compared to other professionals in your field BEFORE you were accepted into the DOH-HHR deployment program?
57. Where would you place your self on this ladder compared to other professionals in your field IMMEDIATELY AFTER your tour of duty under the DOH-HHR deployment program?

58. Where would you place your self CURRENTLY on this ladder compared to other professionals in your field?

PAGE 19: PERSONAL ATTITUDE AND BEHAVIOR

The following section asks questions about you that will help us understand more about your personal attitudes and behaviors. Please answer the following questions as honestly as possible. There are no right or wrong answers, and all your answers will remain strictly confidential.

59. Please read the following descriptions below and rate to what degree they describe you.

	Very much like me	Mostly like me	Somewhat like me	Not much like me	Not like me at all
New ideas and projects sometimes distract me from previous ones.					
Setbacks don't discourage me.					
I have been obsessed with a certain idea or project for a short time but later lost interest.					
I am a hard worker.					
I often set a goal but later choose to pursue a different one.					
I have difficulty maintaining my focus on projects that take more than a few months to complete.					
I finish whatever I begin.					
I am diligent.					

60. Suppose there is a rich philanthropist who presents to you the following options. The philanthropist offers you either a <u>sure</u>:

    (a) PhP100,000 that you will *receive one year from today*, OR
    (b) Some amount less than PhP100,000 that you will *receive today*. You may think of the difference as processing fee necessary to facilitate the release of the cash offer.

    There are no conditions to the offer. You may spend the amount for whatever reason you see fit.

    How much money would you be willing to receive today to not wait for one whole year to receive the full PhP100,000?

61. Please read the following descriptions below and indicate how frequently you experience them.

	All of the time	Most of the time	A good bit of the time	Some of the time	A little of the time	None of the time
How much of the time, during the past month, have you felt so down in the dumps that nothing could cheer you up?						
During the past month, how much of the time were you a happy person?						
How much of the time, during the past month, have you been a very nervous person?						
How much of the time, during the past month, have you felt calm and peaceful?						
How much of the time, during the past month, have you felt downhearted and blue?						

62. Please read the following descriptions below and indicate how frequently you experience them.

Suppose you entered a raffle contest wherein the winner will win a pot money of PhP10,000. There is no cost to joining the raffle. There are no conditions to the winnings. Joining the raffle is entirely anonymous among entrants – only the organizer will know who are in the raffle.

Suppose out of only TWO entrants in the raffle, you won. You received PHP 10,000. Will you be willing to part some of your winning to the other entrant? If so, how much will you be willing to give to the other player? Each other's information will remain anonymous among the two of you regardless of your decision.

You may give an amount between 0 (nothing) to 10,000 (all).

-END of SURVEY-

Appendix E. HRH Deployment Program Student Survey

PAGE 1: ABOUT THE SURVEY

The Philippine Institute for Development Studies (www.pids.gov.ph), a government think-tank administratively attached to the National Economic Development Authority (www.neda.gov.ph), in partnership with the Department of Health (www.doh.gov.ph), is conducting a process evaluation of the government's health human resource (HHR) deployment program.

This survey aims to assess the potential future supply of health personnel who are willing to be deployed in under-served areas in the Philippines under the government's deployment program. The target respondents of this survey are Filipino students currently matriculating in the Philippines under the following degree programs: (a) Medicine, (b) Nursing, or (c) Midwifery.

This survey has about 30 questions and should take approximately 30 minutes to complete. You may edit your response from the same device until you submit the completed survey form.

PAGE 2: RESPONDENT ELIGIBILITY: HHRDP COHORT

4. Are you a Filipino student currently attending any of the following degree program in the Philippines: (a) Medicine, (b) Nursing, or (c) Midwifery?
    1 – Yes (Go to page 4)
    2 – No (Go to page 3)

PAGE 3: THANK YOU!

Thank you so much for participating in this survey! Your answer(s) have been recorded. Unfortunately, your qualifications do not match this survey's eligibility requirements. We are looking forward to have you in our next surveys.

If you have questions about the study or the survey, you may directly contact the Project Director, Dr. Michael R.M. Abrigo (mabrigo@mail.pids.gov.ph).

PAGE 4: INFORMED CONSENT

Before we begin with the survey, please go through the following information to know more about your rights as survey participant, the potential benefits and risks of the survey, and details of whom to contact in case you have questions about this study.

Voluntary Participation

Your participation in this survey is voluntary. You may refuse to take part in the research or exit the survey at any time without penalty. You are free to decline to answer or skip any questions you find sensitive or are not comfortable answering.

Benefits and Risks

You will receive no direct benefits from participating in this study. However, your responses may help us and the DOH understand what motivates health professional to seek deployment to rural or remote areas. This information will be very useful to DOH in strategies for advocacy, recruitment, and incentives.

There are no foreseeable risks involved in participating other than those encountered in day-to-day life.

Confidentiality
Your answers will be stored initially with Google forms where data will be stored in a password protected electronic format. Your name and email address will not be shared to the DOH and will only be used by the PIDS research team for monitoring and follow-up purposes. After the data has been downloaded, your name, email address, and telephone number will be removed from this data set. Data will be stored in password protected computers only the PIDS research team can access.

Your responses will remain anonymous and strictly confidential. Outside of the PIDS research team, no one will be able to identify you or your answers, and no one will know whether or not you participated in the study. You will also not be personally identified in any publication or presentation about this study.

Contact
If you have questions about the study or the survey, you may contact directly contact the Project Director, Dr. Michael R.M. Abrigo (mabrigo@mail.pids.gov.ph).

For questions about your rights as a study participant or grievances, you may contact the St. Cabrini Medical Center - Asian Eye Institute (SCMC - AEI) Ethics Review Committee at (632) 8-898-2020 loc. 815 or email scmcaeierc@gmail.com.

5. Do you with to continue with the survey?
    1 – Yes (Go to page 5)
    2 – No (Go to page 3)

PAGE 5: CONSENT FORM

3. By affixing your complete name and email address in below fields, you are voluntarily accepting to take part in the study. Your responses in this survey are strictly confidential. Only consolidated responses will be presented in the study's final report.
    1 – First Name
    2 – Middle Name
    3 – Last Name
    4 – Email address
    5 – Telephone
    6 – Province
    7 – City/Municipality

PAGE 6: DEMOGRAPHIC CHARACTERISTICS

63. What is your sex at birth?
    1 – Male
    2 – Female
    1 – Choose not to answer
64. When were you born? (Please specify birthday)
65. What is your civil status *at the time of your deployment*?
    1 – Single and not exclusively dating
    2 – Single and exclusively dating

3 – Married/Living in
4 – Separated/Annulled/Divorced
5 – Widowed
6 – Others (specify)

66. What is your father's highest educational attainment?
    1 – No grade completed
    2 – Some elementary
    3 – Elementary graduate
    4 – Some high school
    5 – High school graduate
    6 – Technical/Vocational certificate
    7 – Some college
    8 – College graduate or higher
67. Where did your father spend most of his childhood?
    1 – Province (specify)
    2 – City/Municipality (specify)
68. What is your mother's highest educational attainment?
    1 – No grade completed
    2 – Some elementary
    3 – Elementary graduate
    4 – Some high school
    5 – High school graduate
    6 – Technical/Vocational certificate
    7 – Some college
    8 – College graduate or higher
69. Where did your mother spend most of her childhood?
    1 – Province (specify)
    2 – City/Municipality (specify)
70. Which of the following amenities does your household have? Please tick all that apply.
    1 – Radio
    2 – Television
    3 – CD/VCD/DVD player
    4 – Component/Stereo set
    5 – Refrigerator/Freezer
    6 – Stove with oven/Gas range
    7 – Washing machine
    8 – Air conditioner
    9 – Personal computer (e.g. desktop, laptop, notebook, netbook, tablet, etc.)
    10 – Landline/Wireless telephone
    11 – Cellular phone
    12 – Car, jeep, or van
    13 – Motorcycle/Tricycle
    14 – Motorized boat/banca

PAGE 7: EDUCATION

71. What is the name and address of the school you currently attending? Please provide complete name.
    1 – Name of school (specify)
    2 – Province (specify)

3 – City/Municipality (specify)

72. What degree program are you currently attending?
    1 – Medicine
    2 – Nursing
    3 – Midwifery
73. What year level are you currently in? Specify year level standing, and not actual years of studying.
    1 – First Year
    2 – Second Year
    3 – Third Year
    4 – Fourth Year
    5 – Fifth Year or Higher
74. What is your *primary source* of financing for schooling? Please choose one.
    1 – Self (own income, savings)
    2 – Family, immediate (parents, siblings, spouse)
    3 – Family, extended (grandparents, uncles, aunts)
    4 – Scholarship grant, private
    5 – Scholarship grant, government
    6 – Loans taken by self
    7 – Loans taken by family
    8 – Others (Please specify)
75. What are your *other* sources of financing for schooling? Please tick all that apply.
    1 – Self (own income, savings)
    2 – Family, immediate (parents, siblings, spouse)
    3 – Family, extended (grandparents, uncles, aunts)
    4 – Scholarship grant, private
    5 – Scholarship grant, government
    6 – Loans taken by self
    7 – Loans taken by family
    8 – Others (Please specify)

PAGE 8: STUDENT STANDING

Please read the following described scenario carefully.

Think of a ladder as representing all students in your batch currently enrolled in your program. Imagine everyone in this group is standing somewhere on this ladder.

At the TOP of the ladder are students who are the best in your batch – those who are most skilled, the most liked, and the most valuable in your program.

At the BOTTOM are students in your batch who are the worst off – those who are the least skilled, the least liked, and the least valuable in your program.

The higher up you are on the ladder, the closer you are to the people at the very top. The lower you are on this ladder, the closer you are to the people at the very bottom.

Suppose the ladder has 100 steps, with 100 being the TOP (best) and 0 being the BOTTOM (worst).

76. Where would you place your self on this ladder compared to other students in your batch currently enrolled in your program? (Range of 0-100)

PAGE 9: PERSONAL ATTITUDE AND BEHAVIOR

The following section asks questions about you that will help us understand more about your personal attitudes and behaviors. Please answer the following questions as honestly as possible. There are no right or wrong answers, and all your answers will remain strictly confidential.

77. Please read the following descriptions below and rate to what degree they describe you.

	Very much like me	Mostly like me	Somewhat like me	Not much like me	Not like me at all
New ideas and projects sometimes distract me from previous ones.					
Setbacks don't discourage me.					
I have been obsessed with a certain idea or project for a short time but later lost interest.					
I am a hard worker.					
I often set a goal but later choose to pursue a different one.					
I have difficulty maintaining my focus on projects that take more than a few months to complete.					
I finish whatever I begin.					
I am diligent.					

78. Suppose there is a rich philanthropist who presents to you the following options. The philanthropist offers you either a sure:

    (a) PhP100,000 that you will *receive one year from today*, OR
    (b) Some amount less than PhP100,000 that you will *receive today*. You may think of the difference as processing fee necessary to facilitate the release of the cash offer.

    There are no conditions to the offer. You may spend the amount for whatever reason you see fit.

    How much money would you be willing to receive today to not wait for one whole year to receive the full PhP100,000? (Range of 1Php-100,000Php)

79. Please read the following descriptions below and indicate how frequently you experience them.

	All of the time	Most of the time	A good bit of the time	Some of the time	A little of the time	None of the time
How much of the time, during the past month, have you felt so down in the dumps that nothing could cheer you up?						
During the past month, how much of the time were you a happy person?						
How much of the time, during the past month, have you been a very nervous person?						
How much of the time, during the past month, have you felt calm and peaceful?						
How much of the time, during the past month, have you felt downhearted and blue?						

80. Please read the following descriptions below and indicate how frequently you experience them.

Suppose you entered a raffle contest wherein the winner will win a pot money of PhP10,000. There is no cost to joining the raffle. There are no conditions to the winnings. Joining the raffle is entirely anonymous among entrants -- only the organizer will know who are in the raffle.

Suppose out of only TWO entrants in the raffle, you won. You received PHP 10,000. Will you be willing to part some of your winning to the other entrant? If so, how much will you be willing to give to the other player? Each other's information will remain anonymous among the two of you regardless of your decision.

You may give an amount between 0 (nothing) to 10,000 (all). (Range of 0-10,000)

PAGE 10: DOH-HHR DEPLOYMENT PROGRAM (SECTION 1)

81. Have you ever heard of any DOH health human resource deployment program?
    1 – Yes (Go to page 11)
    2 – No (Go to page 12)

PAGE 11: DOH-HHR DEPLOYMENT PROGRAM (SECTION 2)

82. Which deployment programs have you ever heard of? Please tick all that apply.
    1 – Doctors to the Barrios Program
    2 – Medical Pool Placement and Utilization Program
    3 – Post-residency Deployment Program
    4 – Dentists Deployment Program
    5 – Nurses Deployment Program
    6 – Pharmacists Deployment Program
    7 – Medical Technologists Deployment Program
    8 – Universal Health Care Implementer Deployment Program/Project
    9 – Public Health Associate Deployment Program
    10 – Rural Health Midwives Placement Program
    11 – Physical Therapists Deployment Program
    12 – Others (specify)
83. How did you hear about the DOH Deployment Program? Please tick all that apply.
    1 – Radio
    2 – TV
    3 – Print media (newspaper, magazine, etc.)
    4 – Social media (Facebook, Twitter, etc.)
    5 – DOH website/office
    6 – School
    7 – Family
    8 – Friends
    9 – Others (Please specify)
84. Please describe, in your own words, why you think the DOH instituted a health human resource deployment program.
85. Please describe, in your own words, the benefits that you remember are provided for deployed health care workers under the DOH deployment programs.

PAGE 12: DOH-HHR DEPLOYMENT PROGRAM (SECTION 3)

The DOH implements a Health Human Resources Deployment Program (HHRDP) that covers the deployment of different health professionals, including physicians, nurses, midwives, dentists, nutritionists/dieticians, medical technologists, pharmacists, physical therapists, occupational therapists, and public health managers to rural and remote areas. It's overarching purpose is to improve health care access and health service delivery in under-served areas.

Under the program, interested HRH follow a prescribed application process, and, if selected, are deployed to pre-identified under-served areas, including: (a) geographically isolated and disadvantaged areas, (b) municipalities with indigenous people, and (c) fourth to sixth class municipalities, among others.

Now, suppose you have already graduated from school, and obtained the necessary board certifications from the Philippine Regulatory Commission. You are available and ready to practice your chosen profession. You have a number of options. Two of your options may be:

Option A – To work in a health facility in any of the Philippines' major cities
OR
Option B – To be deployed to a rural or under-served area through the DOH-HRH Deployment Program

If you choose **Option A...**

...and you are a Physician: The average basic compensation for an entry level position in your profession is PHP28,000 (Range: PHP11,000 to PHP40,000). The position offered is residency training in your chosen field of specialization, with the option for continuing sub-specialization training once diplomate board examination is passed. Standard working hours is 40 hours per week, but you will be on-call. Magna carta benefits are available if working in a government health facility. Being in a city, you have access to common urban amenities, including cellular phone signal, commercial centers, etc.

...and a Nurse: The average basic compensation for an entry level position in your profession is PhP14,500 (Range: PHP10,000 to PHP18,000). The position offered is in a tertiary hospital, and only involves clinical practice. Standard working hours is 40 hours per week. Magna carta benefits are available if working in a government health facility. Being in a city, you have access to common urban amenities, including cellular phone signal, cable internet, commercial centers, etc.

...and a Midwife: average basic compensation for an entry level position in your profession is PHP13,000 (Range: PHP9,000 to PHP17,000). The position offered is in a tertiary hospital, and only involves clinical practice. Standard working hours is 40 hours per week. Magna carta benefits are available if working in a government health facility. Being in a city, you have access to common urban amenities, including cellular phone signal, cable internet, commercial centers, etc.

If you are to choose **Option B:**

The position offered has guaranteed one year of funding. The position is available in one of the country's 4th to 6th class municipalities. Modest allowance for board, lodging and food, as well as magna carta benefits and representation and travel allowance are provided. The nearest urban area from the duty station is about three hours (2 hours by boat/motorcycle/foot + 1 hour by bus). Cellular phone signal is patchy and only available in the town proper. The rural health unit has basic amenities and supplies. Standard working hours are 8:00am to 5:00pm from Monday to Friday. The job usually involves three days of community practice in barangay communities, and two days of clinical practice in the rural health unit in the town proper.

86. Please choose one of the following [sets] to be directed to the next set of questions.
    1 – Set A (Go to page 13)
    2 – Set B (Go to page 14)
    3 – Set C (Go to page 15)
    4 – Set D (Go to page 16)
    5 – Set E (Go to page 17)
    6 – Set F (Go to page 18)
    7 – Set G (Go to page 19)
    8 – Set H (Go to page 20)

9 – Set I (Go to page 21)
10 – Set J (Go to page 22)

PAGE 13: SET A

For each of the following number, please read the following options provided to you. Please rank them from your least preferred scenario (Value = 1) to your most preferred scenario (Value = 5).

For reference, these are the monthly basic pay (and inter-quartile range) among professionals aged 35 years or below based on the latest available data:

Physicians: PhP28,000 (Range: PhP11,000 to PhP44,000)
Nurses: PhP14,500 (Range: PhP10,000 to PhP18,000)
Midwives: PhP13,000 (Range: PhP9,000 to PhP17,000)

87. Please read the following options and rank them from your least preferred (Value = 1) to your most preferred (Value = 5) scenario.
    1 – I will participate in the government's HHR deployment program. Monthly compensation is same as national average for my profession. There will be no additional regular allowance provided. I may elect where I will be deployed, depending on slot availability. Scheduled training sessions, which may count towards my Continuing Professional Development requirements, will be provided.
    2 – I will participate in the government's HHR deployment program. Monthly compensation is 200% higher relative to national average for my profession. Regular housing and travel allowance will be provided. I have no choice on where I will be deployed. Scheduled training sessions, which may count towards my Continuing Professional Development requirements, will be provided.
    3 – I will participate in the government's HHR deployment program. Monthly compensation is 200% higher relative to national average for my profession. Regular housing and travel allowance will be provided. My area of deployment will be limited to the province where I or may parents' were raised. Training opportunities are not guaranteed.
    4 – I will participate in the government's HHR deployment program. Monthly compensation is 200% higher relative to national average for my profession. There will be no additional regular allowance provided. I have no choice on where I will be deployed. Scheduled training sessions, which may count towards my Continuing Professional Development requirements, will be provided.
    5 – I choose not participate in the government's HHR deployment program given the available options.

88. Please read the following options and rank them from your least preferred (Value = 1) to your most preferred (Value = 5) scenario.
    1 – I will participate in the government's HHR deployment program. Monthly compensation is 100% higher relative to national average for my profession. Regular housing and travel allowance will be provided. I may elect where I will be deployed, depending on slot availability. Training opportunities are not guaranteed.

2 – I will participate in the government's HHR deployment program. Monthly compensation is same as national average for my profession. There will be no additional regular allowance provided. My area of deployment will be limited to the province where I or may parents' were raised. Scheduled training sessions, which may count towards my Continuing Professional Development requirements, will be provided.
3 – I will participate in the government's HHR deployment program. Monthly compensation is 50% higher relative to national average for my profession. There will be no additional regular allowance provided. I may elect where I will be deployed, depending on slot availability. Training opportunities are not guaranteed.
4 – I will participate in the government's HHR deployment program. Monthly compensation is same as national average for my profession. There will be no additional regular allowance provided. I have no choice on where I will be deployed. Training opportunities are not guaranteed.
5 – I choose not participate in the government's HHR deployment program given the available options.

89. Please read the following options and rank them from your least preferred (Value = 1) to your most preferred (Value = 5) scenario.
    1 – I will participate in the government's HHR deployment program. Monthly compensation is 50% higher relative to national average for my profession. There will be no additional regular allowance provided. My area of deployment will be limited to the province where I or may parents' were raised. Training opportunities are not guaranteed.
    2 – I will participate in the government's HHR deployment program. Monthly compensation is 200% higher relative to national average for my profession. Regular housing and travel allowance will be provided. I have no choice on where I will be deployed. Training opportunities are not guaranteed.
    3 – I will participate in the government's HHR deployment program. Monthly compensation is same as national average for my profession. Regular housing and travel allowance will be provided. My area of deployment will be limited to the province where I or may parents' were raised. Scheduled training sessions, which may count towards my Continuing Professional Development requirements, will be provided.
    4 – I will participate in the government's HHR deployment program. Monthly compensation is 150% higher relative to national average for my profession. There will be no additional regular allowance provided. My area of deployment will be limited to the province where I or may parents' were raised. Scheduled training sessions, which may count towards my Continuing Professional Development requirements, will be provided.
    5 – I choose not participate in the government's HHR deployment program given the available options.

PAGE 14: SET B

For each of the following number, please read the following options provided to you. Please rank them from your least preferred scenario (Value = 1) to your most preferred scenario (Value = 5).

For reference, these are the monthly basic pay (and inter-quartile range) among professionals aged 35 years or below based on the latest available data:

Physicians: PhP28,000 (Range: PhP11,000 to PhP44,000)
Nurses: PhP14,500 (Range: PhP10,000 to PhP18,000)
Midwives: PhP13,000 (Range: PhP9,000 to PhP17,000)

90. Please read the following options and rank them from your least preferred (Value = 1) to your most preferred (Value = 5) scenario.
    1 – I will participate in the government's HHR deployment program. Monthly compensation is 100% higher relative to national average for my profession. Regular housing and travel allowance will be provided. My area of deployment will be limited to the province where I or may parents' were raised. Scheduled training sessions, which may count towards my Continuing Professional Development requirements, will be provided.
    2 – I will participate in the government's HHR deployment program. Monthly compensation is 200% higher relative to national average for my profession. Regular housing and travel allowance will be provided. I may elect where I will be deployed, depending on slot availability. Scheduled training sessions, which may count towards my Continuing Professional Development requirements, will be provided.
    3 – I will participate in the government's HHR deployment program. Monthly compensation is 150% higher relative to national average for my profession. There will be no additional regular allowance provided. My area of deployment will be limited to the province where I or may parents' were raised. Training opportunities are not guaranteed.
    4 – I will participate in the government's HHR deployment program. Monthly compensation is 150% higher relative to national average for my profession. There will be no additional regular allowance provided. My area of deployment will be limited to the province where I or may parents' were raised. Scheduled training sessions, which may count towards my Continuing Professional Development requirements, will be provided.
    5 – I choose not participate in the government's HHR deployment program given the available options.

91. Please read the following options and rank them from your least preferred (Value = 1) to your most preferred (Value = 5) scenario.
    1 – I will participate in the government's HHR deployment program. Monthly compensation is 100% higher relative to national average for my profession. Regular housing and travel allowance will be provided. I have no choice on where I will be deployed. Training opportunities are not guaranteed.
    2 – I will participate in the government's HHR deployment program. Monthly compensation is 50% higher relative to national average for my profession. Regular housing and travel allowance will be provided. I may elect where I will be deployed, depending on slot availability. Scheduled training sessions, which may count towards my Continuing Professional Development requirements, will be provided.
    3 – I will participate in the government's HHR deployment program. Monthly compensation is 150% higher relative to national average for my profession. There will be no additional regular allowance provided. I have no choice on

where I will be deployed. Scheduled training sessions, which may count towards my Continuing Professional Development requirements, will be provided.
4 – I will participate in the government's HHR deployment program. Monthly compensation is 200% higher relative to national average for my profession. There will be no additional regular allowance provided. I may elect where I will be deployed, depending on slot availability. Scheduled training sessions, which may count towards my Continuing Professional Development requirements, will be provided.
5 – I choose not participate in the government's HHR deployment program given the available options.

92. Please read the following options and rank them from your least preferred (Value = 1) to your most preferred (Value = 5) scenario.
    1 – I will participate in the government's HHR deployment program. Monthly compensation is 50% higher relative to national average for my profession. There will be no additional regular allowance provided. My area of deployment will be limited to the province where I or may parents' were raised. Training opportunities are not guaranteed.
    2 – I will participate in the government's HHR deployment program. Monthly compensation is 200% higher relative to national average for my profession. Regular housing and travel allowance will be provided. I have no choice on where I will be deployed. Training opportunities are not guaranteed.
    3 – I will participate in the government's HHR deployment program. Monthly compensation is same as national average for my profession. Regular housing and travel allowance will be provided. My area of deployment will be limited to the province where I or may parents' were raised. Scheduled training sessions, which may count towards my Continuing Professional Development requirements, will be provided.
    4 – I will participate in the government's HHR deployment program. Monthly compensation is 150% higher relative to national average for my profession. There will be no additional regular allowance provided. My area of deployment will be limited to the province where I or may parents' were raised. Scheduled training sessions, which may count towards my Continuing Professional Development requirements, will be provided.
    5 – I choose not participate in the government's HHR deployment program given the available options.

PAGE 15: SET C

For each of the following number, please read the following options provided to you. Please rank them from your least preferred scenario (Value = 1) to your most preferred scenario (Value = 5).

For reference, these are the monthly basic pay (and inter-quartile range) among professionals aged 35 years or below based on the latest available data:

Physicians: PhP28,000 (Range: PhP11,000 to PhP44,000)
Nurses: PhP14,500 (Range: PhP10,000 to PhP18,000)
Midwives: PhP13,000 (Range: PhP9,000 to PhP17,000)

93. Please read the following options and rank them from your least preferred (Value = 1) to your most preferred (Value = 5) scenario.

    1 – I will participate in the government's HHR deployment program. Monthly compensation is same as national average for my profession. There will be no additional regular allowance provided. My area of deployment will be limited to the province where I or may parents' were raised. Training opportunities are not guaranteed.

    2 – I will participate in the government's HHR deployment program. Monthly compensation is 50% higher relative to national average for my profession. Regular housing and travel allowance will be provided. I have no choice on where I will be deployed. Training opportunities are not guaranteed.

    3 – I will participate in the government's HHR deployment program. Monthly compensation is 50% higher relative to national average for my profession. Regular housing and travel allowance will be provided. My area of deployment will be limited to the province where I or may parents' were raised. Training opportunities are not guaranteed.

    4 – I will participate in the government's HHR deployment program. Monthly compensation is 200% higher relative to national average for my profession. Regular housing and travel allowance will be provided. I may elect where I will be deployed, depending on slot availability. Training opportunities are not guaranteed.

    5 – I choose not participate in the government's HHR deployment program given the available options.

94. Please read the following options and rank them from your least preferred (Value = 1) to your most preferred (Value = 5) scenario.

    1 – I will participate in the government's HHR deployment program. Monthly compensation is 100% higher relative to national average for my profession. Regular housing and travel allowance will be provided. My area of deployment will be limited to the province where I or may parents' were raised. Training opportunities are not guaranteed.

    2 – I will participate in the government's HHR deployment program. Monthly compensation is same as national average for my profession. Regular housing and travel allowance will be provided. I have no choice on where I will be deployed. Scheduled training sessions, which may count towards my Continuing Professional Development requirements, will be provided.

    3 – I will participate in the government's HHR deployment program. Monthly compensation is 150% higher relative to national average for my profession. There will be no additional regular allowance provided. My area of deployment will be limited to the province where I or may parents' were raised. Training opportunities are not guaranteed.

    4 – I will participate in the government's HHR deployment program. Monthly compensation is 150% higher relative to national average for my profession. There will be no additional regular allowance provided. I may elect where I will be deployed, depending on slot availability. Training opportunities are not guaranteed.

    5 – I choose not participate in the government's HHR deployment program given the available options.

95. Please read the following options and rank them from your least preferred (Value = 1) to your most preferred (Value = 5) scenario.
    1 – I will participate in the government's HHR deployment program. Monthly compensation is 50% higher relative to national average for my profession. Regular housing and travel allowance will be provided. My area of deployment will be limited to the province where I or may parents' were raised. Scheduled training sessions, which may count towards my Continuing Professional Development requirements, will be provided.
    2 – I will participate in the government's HHR deployment program. Monthly compensation is 50% higher relative to national average for my profession. There will be no additional regular allowance provided. I have no choice on where I will be deployed. Scheduled training sessions, which may count towards my Continuing Professional Development requirements, will be provided.
    3 – I will participate in the government's HHR deployment program. Monthly compensation is 200% higher relative to national average for my profession. Regular housing and travel allowance will be provided. My area of deployment will be limited to the province where I or may parents' were raised. Training opportunities are not guaranteed.
    4 – I will participate in the government's HHR deployment program. Monthly compensation is 50% higher relative to national average for my profession. Regular housing and travel allowance will be provided. I may elect where I will be deployed, depending on slot availability. Training opportunities are not guaranteed.
    5 – I choose not participate in the government's HHR deployment program given the available options.

PAGE 16: SET D

For each of the following number, please read the following options provided to you. Please rank them from your least preferred scenario (Value = 1) to your most preferred scenario (Value = 5).

For reference, these are the monthly basic pay (and inter-quartile range) among professionals aged 35 years or below based on the latest available data:

Physicians: PhP28,000 (Range: PhP11,000 to PhP44,000)
Nurses: PhP14,500 (Range: PhP10,000 to PhP18,000)
Midwives: PhP13,000 (Range: PhP9,000 to PhP17,000)

96. Please read the following options and rank them from your least preferred (Value = 1) to your most preferred (Value = 5) scenario.
    1 – I will participate in the government's HHR deployment program. Monthly compensation is 200% higher relative to national average for my profession. Regular housing and travel allowance will be provided. I have no choice on where I will be deployed. Training opportunities are not guaranteed.
    2 – I will participate in the government's HHR deployment program. Monthly compensation is 200% higher relative to national average for my profession. There will be no additional regular allowance provided. I have no choice on where I will be deployed. Training opportunities are not guaranteed.

3 – I will participate in the government's HHR deployment program. Monthly compensation is same as national average for my profession. There will be no additional regular allowance provided. I may elect where I will be deployed, depending on slot availability. Scheduled training sessions, which may count towards my Continuing Professional Development requirements, will be provided.
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5 – I choose not participate in the government's HHR deployment program given the available options.

97. Please read the following options and rank them from your least preferred (Value = 1) to your most preferred (Value = 5) scenario.
    1 – I will participate in the government's HHR deployment program. Monthly compensation is 50% higher relative to national average for my profession. Regular housing and travel allowance will be provided. My area of deployment will be limited to the province where I or may parents' were raised. Scheduled training sessions, which may count towards my Continuing Professional Development requirements, will be provided.
    2 – I will participate in the government's HHR deployment program. Monthly compensation is 200% higher relative to national average for my profession. There will be no additional regular allowance provided. I may elect where I will be deployed, depending on slot availability. Scheduled training sessions, which may count towards my Continuing Professional Development requirements, will be provided.
    3 – I will participate in the government's HHR deployment program. Monthly compensation is 50% higher relative to national average for my profession. Regular housing and travel allowance will be provided. I may elect where I will be deployed, depending on slot availability. Training opportunities are not guaranteed.
    4 – I will participate in the government's HHR deployment program. Monthly compensation is 200% higher relative to national average for my profession. There will be no additional regular allowance provided. I have no choice on where I will be deployed. Scheduled training sessions, which may count towards my Continuing Professional Development requirements, will be provided.
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98. Please read the following options and rank them from your least preferred (Value = 1) to your most preferred (Value = 5) scenario.
    1 – I will participate in the government's HHR deployment program. Monthly compensation is 100% higher relative to national average for my profession. Regular housing and travel allowance will be provided. I may elect where I will be deployed, depending on slot availability. Training opportunities are not guaranteed.

2 – I will participate in the government's HHR deployment program. Monthly compensation is same as national average for my profession. There will be no additional regular allowance provided. I have no choice on where I will be deployed. Scheduled training sessions, which may count towards my Continuing Professional Development requirements, will be provided.
3 – I will participate in the government's HHR deployment program. Monthly compensation is 100% higher relative to national average for my profession. Regular housing and travel allowance will be provided. I have no choice on where I will be deployed. Training opportunities are not guaranteed.
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5 – I choose not participate in the government's HHR deployment program given the available options.

PAGE 17: SET E
For each of the following number, please read the following options provided to you. Please rank them from your least preferred scenario (Value = 1) to your most preferred scenario (Value = 5).

For reference, these are the monthly basic pay (and inter-quartile range) among professionals aged 35 years or below based on the latest available data:

Physicians: PhP28,000 (Range: PhP11,000 to PhP44,000)
Nurses: PhP14,500 (Range: PhP10,000 to PhP18,000)
Midwives: PhP13,000 (Range: PhP9,000 to PhP17,000)

99. Please read the following options and rank them from your least preferred (Value = 1) to your most preferred (Value = 5) scenario.
    1 – I will participate in the government's HHR deployment program. Monthly compensation is 150% higher relative to national average for my profession. Regular housing and travel allowance will be provided. I have no choice on where I will be deployed. Training opportunities are not guaranteed.
    2 – I will participate in the government's HHR deployment program. Monthly compensation is 100% higher relative to national average for my profession. Regular housing and travel allowance will be provided. I may elect where I will be deployed, depending on slot availability. Training opportunities are not guaranteed.
    3 – I will participate in the government's HHR deployment program. Monthly compensation is 100% higher relative to national average for my profession. There will be no additional regular allowance provided. I may elect where I will be deployed, depending on slot availability. Scheduled training sessions, which may count towards my Continuing Professional Development requirements, will be provided.
    4 – I will participate in the government's HHR deployment program. Monthly compensation is same as national average for my profession. There will be no additional regular allowance provided. I may elect where I will be deployed,

depending on slot availability. Scheduled training sessions, which may count towards my Continuing Professional Development requirements, will be provided.
5 – I choose not participate in the government's HHR deployment program given the available options.

100. Please read the following options and rank them from your least preferred (Value = 1) to your most preferred (Value = 5) scenario.
1 – I will participate in the government's HHR deployment program. Monthly compensation is 200% higher relative to national average for my profession. Regular housing and travel allowance will be provided. My area of deployment will be limited to the province where I or my parents' were raised. Training opportunities are not guaranteed.
2 – I will participate in the government's HHR deployment program. Monthly compensation is 200% higher relative to national average for my profession. Regular housing and travel allowance will be provided. My area of deployment will be limited to the province where I or my parents' were raised. Training opportunities are not guaranteed.
3 – I will participate in the government's HHR deployment program. Monthly compensation is 150% higher relative to national average for my profession. Regular housing and travel allowance will be provided. I have no choice on where I will be deployed. Scheduled training sessions, which may count towards my Continuing Professional Development requirements, will be provided.
4 – I will participate in the government's HHR deployment program. Monthly compensation is 150% higher relative to national average for my profession. There will be no additional regular allowance provided. I may elect where I will be deployed, depending on slot availability. Training opportunities are not guaranteed.
5 – I choose not participate in the government's HHR deployment program given the available options.

101. Please read the following options and rank them from your least preferred (Value = 1) to your most preferred (Value = 5) scenario.
1 – I will participate in the government's HHR deployment program. Monthly compensation is 200% higher relative to national average for my profession. There will be no additional regular allowance provided. I may elect where I will be deployed, depending on slot availability. Training opportunities are not guaranteed.
2 – I will participate in the government's HHR deployment program. Monthly compensation is same as national average for my profession. There will be no additional regular allowance provided. My area of deployment will be limited to the province where I or my parents' were raised. Scheduled training sessions, which may count towards my Continuing Professional Development requirements, will be provided.
3 – I will participate in the government's HHR deployment program. Monthly compensation is 100% higher relative to national average for my profession. Regular housing and travel allowance will be provided. I have no choice on where I will be deployed. Scheduled training sessions, which may count

towards my Continuing Professional Development requirements, will be provided.
4 – I will participate in the government's HHR deployment program. Monthly compensation is 50% higher relative to national average for my profession. There will be no additional regular allowance provided. I may elect where I will be deployed, depending on slot availability. Training opportunities are not guaranteed.
5 – I choose not participate in the government's HHR deployment program given the available options.

PAGE 18: SET F
For each of the following number, please read the following options provided to you. Please rank them from your least preferred scenario (Value = 1) to your most preferred scenario (Value = 5).

For reference, these are the monthly basic pay (and inter-quartile range) among professionals aged 35 years or below based on the latest available data:

Physicians: PhP28,000 (Range: PhP11,000 to PhP44,000)
Nurses: PhP14,500 (Range: PhP10,000 to PhP18,000)
Midwives: PhP13,000 (Range: PhP9,000 to PhP17,000)

102. Please read the following options and rank them from your least preferred (Value = 1) to your most preferred (Value = 5) scenario.
1 – I will participate in the government's HHR deployment program. Monthly compensation is 150% higher relative to national average for my profession. Regular housing and travel allowance will be provided. My area of deployment will be limited to the province where I or my parents' were raised. Scheduled training sessions, which may count towards my Continuing Professional Development requirements, will be provided.
2 – I will participate in the government's HHR deployment program. Monthly compensation is 100% higher relative to national average for my profession. Regular housing and travel allowance will be provided. I may elect where I will be deployed, depending on slot availability. Scheduled training sessions, which may count towards my Continuing Professional Development requirements, will be provided.
3 – I will participate in the government's HHR deployment program. Monthly compensation is 50% higher relative to national average for my profession. There will be no additional regular allowance provided. I have no choice on where I will be deployed. Training opportunities are not guaranteed.
4 – I will participate in the government's HHR deployment program. Monthly compensation is 200% higher relative to national average for my profession. There will be no additional regular allowance provided. My area of deployment will be limited to the province where I or my parents' were raised. Scheduled training sessions, which may count towards my Continuing Professional Development requirements, will be provided.
5 – I choose not participate in the government's HHR deployment program given the available options.

103. Please read the following options and rank them from your least preferred (Value = 1) to your most preferred (Value = 5) scenario.

1 – I will participate in the government's HHR deployment program. Monthly compensation is same as national average for my profession. There will be no additional regular allowance provided. I may elect where I will be deployed, depending on slot availability. Scheduled training sessions, which may count towards my Continuing Professional Development requirements, will be provided.

2 – I will participate in the government's HHR deployment program. Monthly compensation is 150% higher relative to national average for my profession. There will be no additional regular allowance provided. I may elect where I will be deployed, depending on slot availability. Scheduled training sessions, which may count towards my Continuing Professional Development requirements, will be provided.

3 – I will participate in the government's HHR deployment program. Monthly compensation is 200% higher relative to national average for my profession. There will be no additional regular allowance provided. I have no choice on where I will be deployed. Scheduled training sessions, which may count towards my Continuing Professional Development requirements, will be provided.

4 – I will participate in the government's HHR deployment program. Monthly compensation is 50% higher relative to national average for my profession. Regular housing and travel allowance will be provided. I have no choice on where I will be deployed. Training opportunities are not guaranteed.

5 – I choose not participate in the government's HHR deployment program given the available options.

104. Please read the following options and rank them from your least preferred (Value = 1) to your most preferred (Value = 5) scenario.

1 – I will participate in the government's HHR deployment program. Monthly compensation is 200% higher relative to national average for my profession. Regular housing and travel allowance will be provided. I have no choice on where I will be deployed. Scheduled training sessions, which may count towards my Continuing Professional Development requirements, will be provided.

2 – I will participate in the government's HHR deployment program. Monthly compensation is 150% higher relative to national average for my profession. Regular housing and travel allowance will be provided. I have no choice on where I will be deployed. Training opportunities are not guaranteed.

3 – I will participate in the government's HHR deployment program. Monthly compensation is 200% higher relative to national average for my profession. Regular housing and travel allowance will be provided. I have no choice on where I will be deployed. Scheduled training sessions, which may count towards my Continuing Professional Development requirements, will be provided.

4 – I will participate in the government's HHR deployment program. Monthly compensation is 100% higher relative to national average for my profession. There will be no additional regular allowance provided. I have no choice on where I will be deployed. Training opportunities are not guaranteed.

5 – I choose not participate in the government's HHR deployment program given the available options.

PAGE 19: SET G

For each of the following number, please read the following options provided to you. Please rank them from your least preferred scenario (Value = 1) to your most preferred scenario (Value = 5).

For reference, these are the monthly basic pay (and inter-quartile range) among professionals aged 35 years or below based on the latest available data:

Physicians: PhP28,000 (Range: PhP11,000 to PhP44,000)
Nurses: PhP14,500 (Range: PhP10,000 to PhP18,000)
Midwives: PhP13,000 (Range: PhP9,000 to PhP17,000)

105. Please read the following options and rank them from your least preferred (Value = 1) to your most preferred (Value = 5) scenario.

1 – I will participate in the government's HHR deployment program. Monthly compensation is same as national average for my profession. Regular housing and travel allowance will be provided. My area of deployment will be limited to the province where I or my parents' were raised. Scheduled training sessions, which may count towards my Continuing Professional Development requirements, will be provided.

2 – I will participate in the government's HHR deployment program. Monthly compensation is 200% higher relative to national average for my profession. There will be no additional regular allowance provided. I may elect where I will be deployed, depending on slot availability. Training opportunities are not guaranteed.

3 – I will participate in the government's HHR deployment program. Monthly compensation is same as national average for my profession. Regular housing and travel allowance will be provided. My area of deployment will be limited to the province where I or my parents' were raised. Training opportunities are not guaranteed.

4 – I will participate in the government's HHR deployment program. Monthly compensation is 200% higher relative to national average for my profession. There will be no additional regular allowance provided. My area of deployment will be limited to the province where I or my parents' were raised. Training opportunities are not guaranteed.

5 – I choose not participate in the government's HHR deployment program given the available options.

106. Please read the following options and rank them from your least preferred (Value = 1) to your most preferred (Value = 5) scenario.

1 – I will participate in the government's HHR deployment program. Monthly compensation is 150% higher relative to national average for my profession. There will be no additional regular allowance provided. My area of deployment will be limited to the province where I or my parents' were raised. Training opportunities are not guaranteed.

2 – I will participate in the government's HHR deployment program. Monthly compensation is 150% higher relative to national average for my profession.

Regular housing and travel allowance will be provided. I may elect where I will be deployed, depending on slot availability. Scheduled training sessions, which may count towards my Continuing Professional Development requirements, will be provided.
3 – I will participate in the government's HHR deployment program. Monthly compensation is same as national average for my profession. There will be no additional regular allowance provided. My area of deployment will be limited to the province where I or my parents' were raised. Training opportunities are not guaranteed.
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107. Please read the following options and rank them from your least preferred (Value = 1) to your most preferred (Value = 5) scenario.
1 – I will participate in the government's HHR deployment program. Monthly compensation is 150% higher relative to national average for my profession. There will be no additional regular allowance provided. My area of deployment will be limited to the province where I or my parents' were raised. Training opportunities are not guaranteed.
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5 – I choose not participate in the government's HHR deployment program given the available options.

PAGE 20: SET H

For each of the following number, please read the following options provided to you. Please rank them from your least preferred scenario (Value = 1) to your most preferred scenario (Value = 5).

For reference, these are the monthly basic pay (and inter-quartile range) among professionals aged 35 years or below based on the latest available data:

Physicians: PhP28,000 (Range: PhP11,000 to PhP44,000)
Nurses: PhP14,500 (Range: PhP10,000 to PhP18,000)
Midwives: PhP13,000 (Range: PhP9,000 to PhP17,000)

108. Please read the following options and rank them from your least preferred (Value = 1) to your most preferred (Value = 5) scenario.

1 – I will participate in the government's HHR deployment program. Monthly compensation is 150% higher relative to national average for my profession. Regular housing and travel allowance will be provided. My area of deployment will be limited to the province where I or my parents' were raised. Scheduled training sessions, which may count towards my Continuing Professional Development requirements, will be provided.

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3 – I will participate in the government's HHR deployment program. Monthly compensation is 100% higher relative to national average for my profession. There will be no additional regular allowance provided. I may elect where I will be deployed, depending on slot availability. Training opportunities are not guaranteed.

4 – I will participate in the government's HHR deployment program. Monthly compensation is 50% higher relative to national average for my profession. Regular housing and travel allowance will be provided. I may elect where I will be deployed, depending on slot availability. Scheduled training sessions, which may count towards my Continuing Professional Development requirements, will be provided.

5 – I choose not participate in the government's HHR deployment program given the available options.

109. Please read the following options and rank them from your least preferred (Value = 1) to your most preferred (Value = 5) scenario.

1 – I will participate in the government's HHR deployment program. Monthly compensation is 100% higher relative to national average for my profession. Regular housing and travel allowance will be provided. My area of deployment will be limited to the province where I or my parents' were raised. Scheduled training sessions, which may count towards my Continuing Professional Development requirements, will be provided.

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3 – I will participate in the government's HHR deployment program. Monthly compensation is 150% higher relative to national average for my profession.

There will be no additional regular allowance provided. My area of deployment will be limited to the province where I or my parents' were raised. Scheduled training sessions, which may count towards my Continuing Professional Development requirements, will be provided.
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PAGE 21: SET I
For each of the following number, please read the following options provided to you. Please rank them from your least preferred scenario (Value = 1) to your most preferred scenario (Value = 5).

For reference, these are the monthly basic pay (and inter-quartile range) among professionals aged 35 years or below based on the latest available data:

Physicians: PhP28,000 (Range: PhP11,000 to PhP44,000)
Nurses: PhP14,500 (Range: PhP10,000 to PhP18,000)
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111. Please read the following options and rank them from your least preferred (Value = 1) to your most preferred (Value = 5) scenario.

1 – I will participate in the government's HHR deployment program. Monthly compensation is 150% higher relative to national average for my profession. There will be no additional regular allowance provided. I may elect where I will be deployed, depending on slot availability. Training opportunities are not guaranteed.
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5 – I choose not participate in the government's HHR deployment program given the available options.

112. Please read the following options and rank them from your least preferred (Value = 1) to your most preferred (Value = 5) scenario.

1 – I will participate in the government's HHR deployment program. Monthly compensation is same as national average for my profession. Regular housing and travel allowance will be provided. I have no choice on where I will be deployed. Training opportunities are not guaranteed.
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4 – I will participate in the government's HHR deployment program. Monthly compensation is 50% higher relative to national average for my profession. There will be no additional regular allowance provided. My area of deployment will be limited to the province where I or my parents' were raised. Training opportunities are not guaranteed.
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5 – I choose not participate in the government's HHR deployment program given the available options.

PAGE 22: SET J
For each of the following number, please read the following options provided to you. Please rank them from your least preferred scenario (Value = 1) to your most preferred scenario (Value = 5).

For reference, these are the monthly basic pay (and inter-quartile range) among professionals aged 35 years or below based on the latest available data:

Physicians: PhP28,000 (Range: PhP11,000 to PhP44,000)
Nurses: PhP14,500 (Range: PhP10,000 to PhP18,000)
Midwives: PhP13,000 (Range: PhP9,000 to PhP17,000)

114. Please read the following options and rank them from your least preferred (Value = 1) to your most preferred (Value = 5) scenario.
1 – I will participate in the government's HHR deployment program. Monthly compensation is 150% higher relative to national average for my profession. Regular housing and travel allowance will be provided. I have no choice on where I will be deployed. Training opportunities are not guaranteed.
2 – I will participate in the government's HHR deployment program. Monthly compensation is 200% higher relative to national average for my profession. Regular housing and travel allowance will be provided. I may elect where I will be deployed, depending on slot availability. Training opportunities are not guaranteed.
3 – I will participate in the government's HHR deployment program. Monthly compensation is 200% higher relative to national average for my profession. Regular housing and travel allowance will be provided. I may elect where I

will be deployed, depending on slot availability. Training opportunities are not guaranteed.
4 – I will participate in the government's HHR deployment program. Monthly compensation is 100% higher relative to national average for my profession. There will be no additional regular allowance provided. I have no choice on where I will be deployed. Scheduled training sessions, which may count towards my Continuing Professional Development requirements, will be provided.
5 – I choose not participate in the government's HHR deployment program given the available options.

115. Please read the following options and rank them from your least preferred (Value = 1) to your most preferred (Value = 5) scenario.
1 – I will participate in the government's HHR deployment program. Monthly compensation is 100% higher relative to national average for my profession. Regular housing and travel allowance will be provided. I have no choice on where I will be deployed. Scheduled training sessions, which may count towards my Continuing Professional Development requirements, will be provided.
2 – I will participate in the government's HHR deployment program. Monthly compensation is 100% higher relative to national average for my profession. There will be no additional regular allowance provided. My area of deployment will be limited to the province where I or my parents' were raised. Scheduled training sessions, which may count towards my Continuing Professional Development requirements, will be provided.
3 – I will participate in the government's HHR deployment program. Monthly compensation is 200% higher relative to national average for my profession. Regular housing and travel allowance will be provided. I may elect where I will be deployed, depending on slot availability. Training opportunities are not guaranteed.
4 – I will participate in the government's HHR deployment program. Monthly compensation is 150% higher relative to national average for my profession. Regular housing and travel allowance will be provided. I have no choice on where I will be deployed. Scheduled training sessions, which may count towards my Continuing Professional Development requirements, will be provided.
5 – I choose not participate in the government's HHR deployment program given the available options.

116. Please read the following options and rank them from your least preferred (Value = 1) to your most preferred (Value = 5) scenario.
1 – I will participate in the government's HHR deployment program. Monthly compensation is 100% higher relative to national average for my profession. There will be no additional regular allowance provided. I may elect where I will be deployed, depending on slot availability. Training opportunities are not guaranteed.
2 – I will participate in the government's HHR deployment program. Monthly compensation is 50% higher relative to national average for my profession. There will be no additional regular allowance provided. My area of deployment will be limited to the province where I or my parents' were raised.

Scheduled training sessions, which may count towards my Continuing Professional Development requirements, will be provided.
3 – I will participate in the government's HHR deployment program. Monthly compensation is same as national average for my profession. There will be no additional regular allowance provided. I have no choice on where I will be deployed. Scheduled training sessions, which may count towards my Continuing Professional Development requirements, will be provided.
4 – I will participate in the government's HHR deployment program. Monthly compensation is 200% higher relative to national average for my profession. There will be no additional regular allowance provided. I have no choice on where I will be deployed. Training opportunities are not guaranteed.
5 – I choose not participate in the government's HHR deployment program given the available options.

-END of SURVEY-