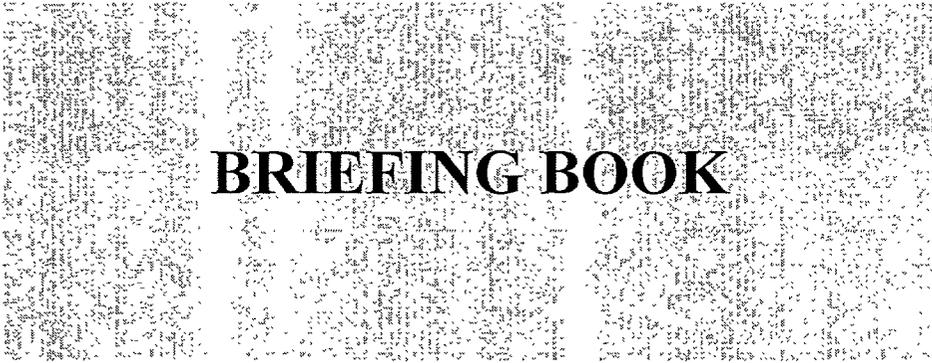


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USAID/PHILLIPPINES

OFFICE OF POPULATION, HEALTH AND NUTRITION



BRIEFING BOOK

**Second Edition
December, 1997**

Introduction

This second edition of the Office of Population, Health and Nutrition (OPHN) briefing book is designed to provide a brief overview of the population, health and nutrition sectors in the Philippines for professionals in these fields who are not yet familiar with the Philippine programs and the contribution of the U.S. Agency for International Development (USAID) in the Philippines. It provides key data on the population and health situation in the Philippines as of 1997; it goes on to describe the major programs that exist to address critical needs in these sectors; and then outlines USAID's program of assistance. A variety of other information that may be useful for those new to these issues in the Philippines is also included, e.g., organizational charts and contact information for key people and organizations and a list of the major sources used in the preparation of the briefing book that can guide readers to further information.

In compiling the briefing book, USAID's OPHN has drawn on numerous documents, both published and unpublished. Many experts in population, health and nutrition also provided important information for the book and OPHN is most appreciative of these individuals' contributions. OPHN believes that the information and data presented here are the best and most reliable available but recognizes that this document has its limitations and that should be considered a "work in progress." As new and better information and data become available, this book will be periodically updated.

The briefing book does *not* set out to be an exhaustive review of the population, health and nutrition sectors. The information included is no more than an introduction. Moreover, a host of crucial problems in these sectors are not addressed in this book. It is not our intention to imply in any way that issues that are not covered here are not important. Rather, the focus of this book is on the concerns that USAID has chosen to address through its programs. We leave it to others who know more of other concerns to describe those.

Despite its many limitations, it is hoped that the briefing book will help donors, consultants and others interested in these sectors and USAID's contribution to become oriented.



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December 1997

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ACRONYMS AND ABBREVIATIONS

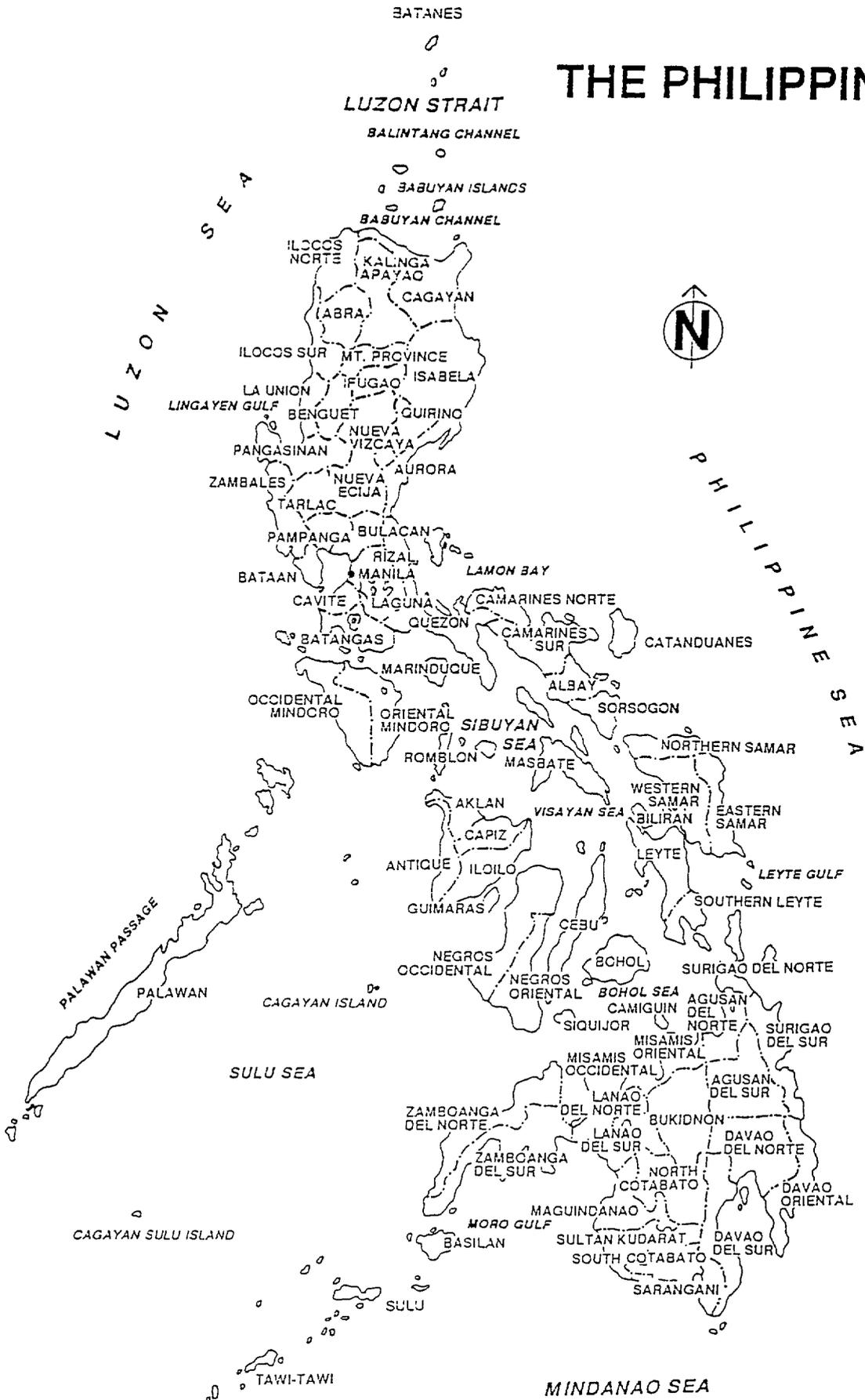
ADB	Asian Development Bank
AIDS	Acquired Immune Deficiency Syndrome
AIDSCAP	AIDS Control and Prevention project/Family Health International (USAID)
ARI	Acute respiratory infections
ASEP	AIDS Surveillance and Education Project (USAID)
AusAID	Australian Agency for International Development
ARMM	Autonomous Region of Muslim Mindanao
ASAP	Araw ng Sangkap Pinoy
ASIN	Act on Salt Iodization Nationwide
BCG	Bacillus Calmet Guerin
BF	Breastfeeding
BFAD	Bureau of Food and Drugs (DOH)
BF/W	Breastfeeding/weaning
BHS	Barangay health station
BHW	Barangay health worker
BOT	Build-operate-transfer
BRL	Bureau of Research and Laboratories (DOH)
BSPO	Barangay Service Point Officer
C.	Central
CAR	Cordillera Administrative Region
CARE	Cooperation for American Relief Everywhere (NGO)
CARI	Control of Acute Respiratory Infection
CDD	Control of Diarrheal Diseases
CDLMIS	Contraceptive Distribution Logistics and Management Information System
CHCA	Comprehensive Health Care Agreement
CIDA	Canadian International Development Agency
CPC	Country Programme for Children (UNICEF)
CPR	Contraceptive prevalence rate
CSW	Commercial Sex Workers
CYP	Couple-year of protection
DECS	Department of Education, Culture and Sports
DK	Don't know
DKT	DKT International
DMPA	Depo Medroxy Progesterone Acetate
DOH	Department of Health
DOLE	Department of Labor and Employment
DPT	Diphtheria Pertussis Tetanus
DOST	Department of Science and Technology
E.	East/eastern
ENV	Office of Environment (USAID)
EPI	Expanded Program for Immunization

FETP	Field Epidemiology Training Program (DOH)
FHSIS	Field Health Services Information System
FNRC	Food and Nutrition Research Center
FNRI	Food and Nutrition Research Institute
FPAP	Family Planning Assistance Project (USAID)
FPOP	Family Planning Organization of the Philippines
FPS	Family Planning Service (DOH)
GDP	Gross domestic product
GMP	Growth Monitoring Promotion
GNP	Gross national product
GOP	Government of the Philippines
GTZ	Gesellschaft fuer Technische Zusammenarbeit (German technical cooperation)
HIS	Health Intelligence Service (DOH)
HIV	Human Immunodeficiency Virus
HMO	Health maintenance organization
HOMS	Hospital Operations and Management Service (DOH)
HRG	High Risk Groups
HSS	HIV Sentinel Surveillance System
IDA	Iron deficiency anemia
IDD	Iodine deficiency disorders
IEC	Information, education and communication
IFPMHP	Integrated Family Planning and Maternal Health Program (USAID)
IMCCSDI	Integrated Maternal and Child Care Services Development, Inc.
IMCH	Institute of Maternal and Child Health
IMR	Infant mortality rate
IOC	Iodized oil capsule
IPPF	International Planned Parenthood Federation
IUD	Intrauterine device
JHU	Johns Hopkins University
JICA	Japan International Cooperation Agency
JOICFP	Japanese Organization for International Cooperation in Family Planning
JSI/RTI	John Snow, Inc./Research and Training Institute
KfW	Kreditanstalt fuer Wiederaufbau (German assistance)
LAM	Lactational amenorrhea method
LGU	Local government unit
LPP	LGU Performance Program (component of IFPMHP)
MAI	Multilateral Assistance Initiative
MCH	Maternal and child health
MCHS	Maternal and Child Health Service (DOH)
MCP	Maternal Care Program
MIS	Management information system
MMR	Maternal mortality ratio
MSH	Management Sciences for Health

MWRA	Married women of reproductive age
N.	North/northern
NAMRU	U.S. Naval Medical Research Unit - 2
NAPOCOR	National Power Corporation
NASPCP	National AIDS/STD Prevention and Control Program
NCR	National Capitol Region
NDS	National Demographic Survey (NSO)
NFP	Natural family planning
NGO	Non-governmental organization
NIC	Newly-industrialized country
NID	National Immunization Day
NNS	National Nutrition Survey
NS	Nutrition Service (DOH)
NSCB	National Statistical Coordination Board
NSO	National Statistics Office
OED	Office of Economic Development (USAID)
OGP	Office of Governance and Participation (OGP)
OPHN	Office of Population, Health and Nutrition (USAID)
OPHS	Office for Public Health Services (DOH)
OPT	Operation Timbang
OPV	Oral polio vaccine
ORS	Oral rehydration solution
ORT	Oral rehydration therapy
P.	Philippine Peso
PATH	Program for Appropriate Technology in Health (NGO)
PCPD	Philippine Center for Population and Development
PEM	Protein energy malnutrition
PFPP	Philippine Family Planning Program
PFNFP	Philippine Federation for Natural Family Planning
P.L. 480	Food for Peace (US donated commodities)
PNAC	Philippine National AIDS Council
PNGOC	Philippine Non-Government Organizations Council on Population, Health and Welfare
POPDEV	Population and development
POPCOM	Commission on Population
POPED	Population Education
PPMP	Philippine Population Management Program
PRE	Population, resources and environment
PVO	Private voluntary organization
RA	Republic Act
RH	Reproductive Health
RHU	Rural health unit
RITM	Research Institute for Tropical Medicine
RP	Results package (USAID)
RTI	Reproductive tract infection

S.	South/southern
SMS	Safe Motherhood Survey
SO	Strategic objective (USAID)
SO 3	Strategic objective 3, i.e. population and health (USAID)
SOMARC	Social Marketing for Change (Futures Group)
STD	Sexually transmitted disease
TA	Technical Assistance
TBA	Traditional birth attendant
TuC	Copper T (IUD)
TFAP	Targeted Food Assistance Program
TFR	Total fertility rate
TT	Tetanus toxoid
UFC	Under-five care
UFMR	Under-five mortality rate
UHNP	Urban Health and Nutrition Project
UN	United Nations
UNAIDS	UN Programme on HIV/AIDS
UNDP	United Nations Development Programme
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
US	United States
USAID	United States Agency for International Development
VAD	Vitamin A deficiency
VSS	Voluntary surgical sterilization
W.	West/western
WHO	World Health Organization
WHSM	Women's Health and Safe Motherhood Project

THE PHILIPPINES



I. BACKGROUND ON POPULATION, HEALTH AND NUTRITION IN THE PHILIPPINES

A. Population

Population Size and Growth Rate

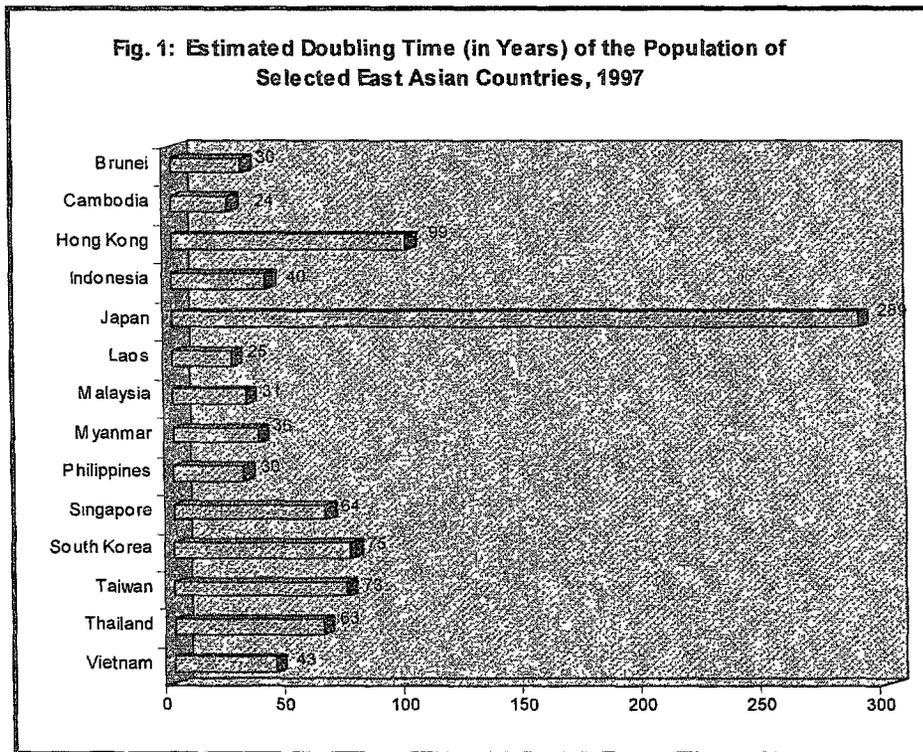
The 1995 Philippine population census found a population size of 68.6 million and a population growth rate of 2.32 percent a year for the period 1990 - 1995. The population grew by 7.9 million people, or 13.0 percent, as compared to 1990 and has grown nine times since the first census was undertaken in 1903 and two-and-a-half times since 1960. (See Table 1.) The population growth rate remained virtually the same as that for the 1980s, indicating that the slow but steady decline in the population growth rate that occurred since the first half of the 1970s may have stalled.

Table 1: Population Size and Annual Rate of Increase, Census Years since 1960

	Population (000s)	Average Annual Rate of Increase
1960	27,088	2.89
1970	36,684	3.08
1975	42,071	2.78
1980	48,098	2.71
1990	60,703	2.35
1995	68,616	2.32

Source: 1997 Philippine Statistical Yearbook, NSO 1995 Census of Population Highlights.

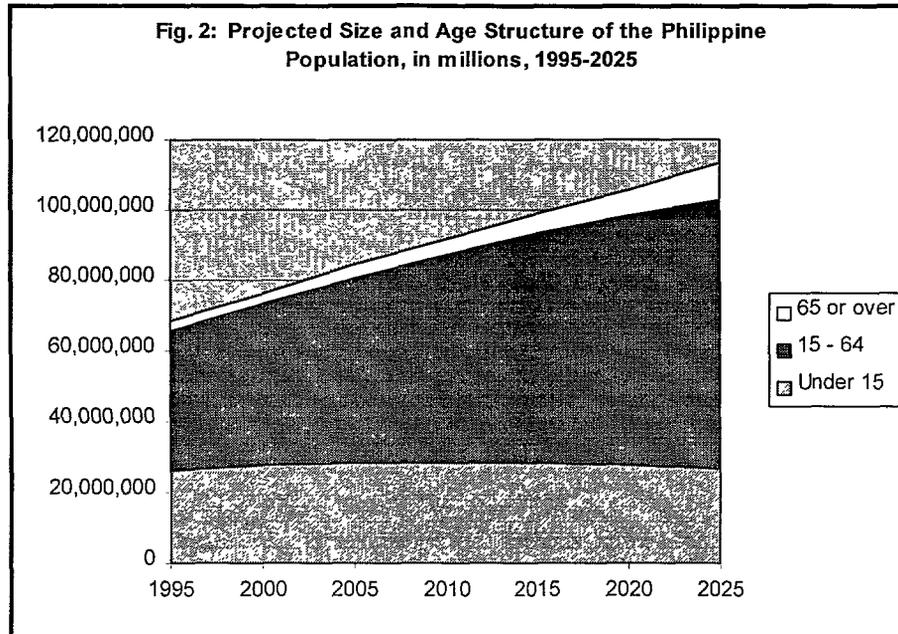
According to the 1995 census results, 9.5 million people live in the National Capital Region (NCR) and almost two out of five people (38 percent) live either there, in Central Luzon or Southern Tagalog. Southern Tagalog is the fastest-growing region in the country, with a growth rate of 3.5 percent a year. Cebu, the fastest growing center of industry and trade outside NCR, had the largest population of all the provinces, with 2.9 million persons. Negros Occidental and Pangasinan also had populations in excess of two million. (See Annex 1 for population by region and province.)



Source: Population Reference Bureau, 1997 World Population Data Sheet

If the 1990-1995 growth rate continues, the population is expected to double in less than 30 years, based on the new census data. Compared with other countries in East Asia, only Cambodia and Laos are growing faster than the Philippines, while Brunei is growing at about the same rate as the Philippines (see Fig. 1).

The medium-assumption population projections of the National Statistics Office (NSO), however—which use the 1995 census count, show only about 63 percent growth over the next 30 years (Fig. 2). Even so, that projection shows the population reaching about 100 million before 2015. Either way, the population is growing rapidly, placing enormous demands on the government to keep up with the need for infrastructure and basic services and straining the natural resource base, the labor market and other development efforts.



Source: 1995 Census-Based National and Regional Population Projections

Births and Deaths

The large number of births is the major factor in population growth. The 1993 birth rate was 25.1 per 1,000 population, based on 1.7 million reported births. These figures are known to be low, however, because births are significantly under-reported. The actual number, based on NSO estimates for 1995, is thought to be two million a year. Even though the birth rate has been declining since 1979, the number of births is increasing each year, because of the ever-growing cohort of women of childbearing age.

Death rates have been declining relatively slowly and are a small factor in population growth. The NSO reports about 319,000 deaths in 1993, for a death rate of 5.0 per 1,000 population, but this figure--like the number of births and the birth rate--is also thought to be low. The rate of natural increase was 20.3 per thousand population in 1993, according to NSO.

Population Structure

The Philippine population is predominantly young, with 38.2 percent under age 15 (48.7 percent are under age 20), 58.1 percent of working age (15 - 64) and 3.5 percent aged 65 or over in 1995, according to NSO's population projections (medium assumption, using the 1995 census count as the base). The median age, however, increased from 17.1 in 1960 to 20.4 in 1995.

Looking to the future, the current population of young people (aged 0 - 14) is expected to grow by over 11 percent to 28.5 million before it peaks around the year 2010 (Fig. 2).

Even though that age group is expected to decline in size after that, it is still projected that there will be about three percent more young people in 2025 than today. The number of young children (under age five) is expected to peak a little sooner, around the year 2000, so that their number would have actually dropped to about 90 percent of the current figure by 2025. These numbers, of course, have important implications for investments in education, health and other human services.

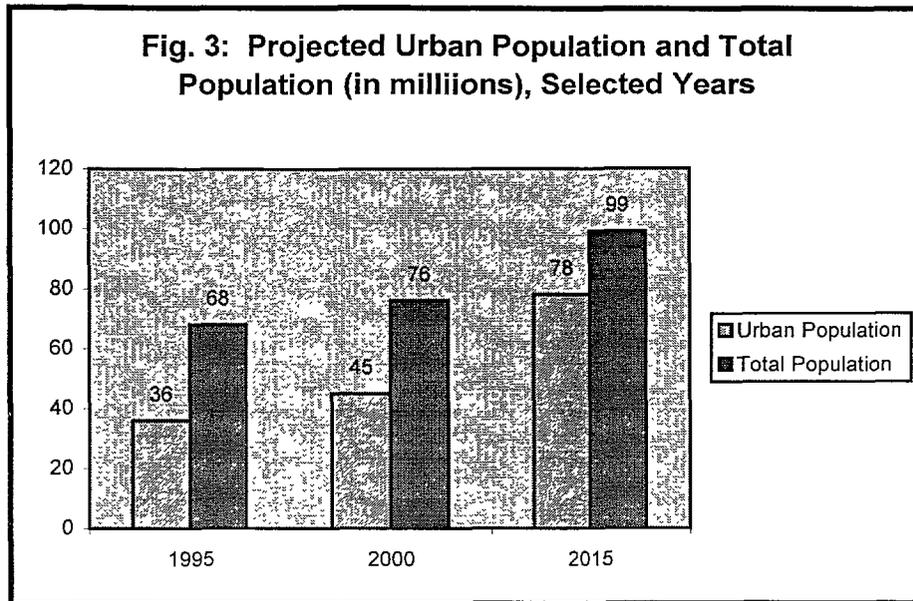
The working-age population, by contrast, is projected to grow dramatically, from 39.7 million in 1995 to 75.7 million in 2025, creating a growing demand for employment. The marriage and childbearing patterns of the women in this age group will have far-reaching implications for population growth far into the future. There are an estimated 11.0 million married women of reproductive age (MWRA) in 1995 and that number is expected to grow to 12.6 million by 2000 and 18.8 million in 2020--more than two-thirds as many again as now.

While the number of elderly is expected to remain small compared to other segments of the population, it will be the fastest-growing segment of the population, more than four times in size between 1995 and 2025.

For every 100 Filipinos in the productive age groups, there are 70 dependents: young people under age 15 and the elderly. The dependency ratio has been declining in recent years, implying a reduction in the burden borne by the working age group. Nevertheless, the current dependency ratio implies a serious strain on households, that must pour substantial resources into food and basic needs, and on public resources that must be pumped into social services rather than profit-making economic investments for the country.

Urbanization and Migration

Population pressures in the countryside are driving people to the cities in search of jobs and a better life. The proportion of the population living in urban areas has grown from 37.4 percent in 1980 to 52.8 percent now and it has been estimated that, by 2015, 77.9 million people--or more than the entire current population--will be living in urban areas (Fig. 3). Such rapid urbanization requires major investments in infrastructure and social services--investments that are already sadly lacking.



Source: NSO, Philippine Population Projections (medium assumption), June 1995, and U.S. Bureau of the Census, "Population Trends: Philippines," February 1996

N.B. The 1990 census count was the base population for the NSO projections, they do not take into account the results of the 1995 census.

While many move to the cities in search of work, large numbers go overseas. The number of overseas contract workers is estimated at six million by the Commission on Filipinos Overseas, with 2.4 million being documented and the rest undocumented. The press release on the 1996 Overseas Filipino Workers (OFWs) reports that, in 1996 alone, about 900,000 overseas contract workers were deployed overseas--mostly to the Middle East or Asia. The number of international migrants has been increasing in recent years, contributing significantly to the economy through their remittances, but with sometimes devastating consequences for families that cannot withstand extended separation.

Thus, rapid population growth presents major challenges to the economy and society not only to increase living standards for a stable population, but to do so for a growing one.

B. Health

Life Expectancy and Causes of Death

People born in 1995 could expect to live three years longer than those born a decade earlier and 12 years longer than those born in 1970. Life expectancy at birth was estimated at 68.2 years in 1995, according to NSO, with women's life expectancy being 5.3 years longer than men's (70.8 versus 65.5 years).

Disease patterns show increasing incidence of chronic diseases in recent years, while certain infectious diseases persist as major health problems. As can be seen in Table 2, the three leading causes of death in recent years have been diseases of the heart, pneumonias, and diseases of the vascular system, according to the Department of Health's (DOH) Health Intelligence Service (HIS). It should be kept in mind, however, that these are the causes of *reported* deaths, so that they may not fully reflect the causes of death in areas where reporting of deaths is not as efficient as expected.

Table 2: Five Leading Causes of Death, Selected Years

	Percent of all Deaths	
	1988 – 1992	1993
Diseases of the heart	14.4	15.3
Pneumonias	11.2	11.7
Diseases of the vascular system	13.3	11.2
Malignant neoplasms	7.6	8.0
Tuberculosis, all forms	7.4	7.7

Source: DOH, HIS, 93 Philippine Health Statistics, Table 20

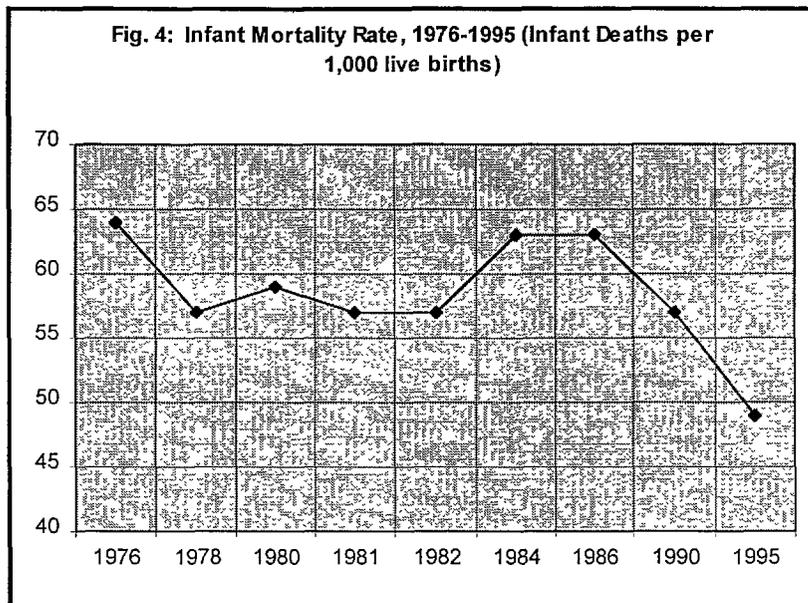
Death rates are still high in infancy and childhood, based on DOH's mortality statistics-- which, however, probably significantly understate actual mortality. Infants accounted for 14.6 percent of all deaths in 1993. Young children aged 1 - 4 had a death rate three times as high or higher than older children and accounted for 5.3 percent of all deaths. Moreover, of deaths to children under age five, almost two thirds occurred in the first year of life, pointing to the need to focus programs on the youngest age group .

It is also noteworthy that about 30 percent of reported deaths occur without any medical attention during the illness prior to death, based on the 1991 DOH-PIDS Household Survey, suggesting that many people have inadequate access to the health care system.

Infant Mortality

Estimates of infant mortality in the Philippines vary widely. The official Government of the Philippines (GOP) figures recommended by the National Statistics Coordination Board (NSCB), early in 1996 place the 1995 infant mortality rate at 48.9 per 1,000 live

births, 13.7 percent below the 1990 level. The infant mortality rate fluctuated between 1976 and 1986 but, since then, it appears to have embarked on a path of steady decline as can be seen in the graph below.



Source: NSCB, *Final Report of the Task Force on Infant Mortality Rate*, NSCB Technical Report Series, No. 03-93, December 1993 and Technical Working Group on Maternal and Child Mortality, *Recommended Infant Mortality Rates, Child Mortality Rates, Under-Five Mortality Rates and Maternal Mortality Ratios, National, Regional, Provincial and City Levels, 1990 - 1995*, November 1995

The lowest rate of infant mortality is in NCR, where it stands at 32.2/1,000 live births, followed by Central Luzon. The highest rate is in the Eastern Visayas--where it is more than 30 percent above the national figure--and in the Autonomous Region of Muslim Mindanao (ARMM) (See Annex 2 for regional data).

The NSCB estimates of infant mortality are substantially higher than those in the 1993 National Demographic Survey (NDS) which estimated the 1990 rate at 33.6 and the 1980 rate at 51.3. For the 10-year period prior to the survey, the NDS found dramatic regional differences in infant mortality and a rate almost 40 percent higher in rural than in urban areas. Infant mortality was lower for women with a high school education or higher than for those with less education; as well as lower for those with prenatal and delivery care than no care.

The leading causes of infant mortality in recent years, according to DOH's HIS, were pneumonias, respiratory conditions, congenital anomalies and diarrheal diseases (Table 3). It should be kept in mind, however, that these are the causes of *reported* infant deaths which are thought to be well below the actual number and may not accurately reflect the causes of *all* infant deaths. Almost half of infant mortality (48.6 percent) in 1993 occurred in the first month after birth and over a third (38.3 percent)

occurred in the first week.

Table 3: The Ten Leading Causes of Infant Death, Selected Years

	Percent of Infant Deaths	
	1988 - 1992	1993
Pneumonias	25.1	22.0
Respiratory conditions of fetus and newborn	14.5	16.3
Congenital anomalies	5.2	6.8
Diarrheal diseases	4.5	4.8
Septicemia	3.4	3.6
Birth injury and difficult labor	2.9	3.4
Avitaminoses and other nutritional deficiency	3.0	2.7
Goiter Thytoxicosis Hyperthyroidism and other Endocrine and Metabolic Diseases	2.4	2.4
Measles	2.0	1.9
Diseases of Pulmonary Circulation	1.4	1.7

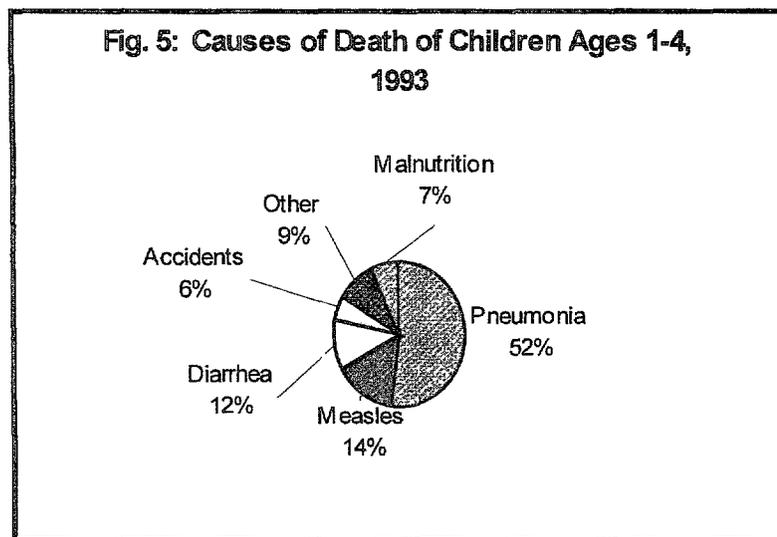
Source: DOH, HIS, 93 Philippine Health Statistics, Table 28

Under-Five Mortality

The Philippines has just adopted the under-five mortality rate as a health indicator. This rate measures the probability of a newborn baby dying before reaching age five and stood at 66.8 per 1,000 live births in 1995, according to estimates from the NSCB. This is a 16.1 percent decline since 1990. The lowest under-five mortality rate is found in NCR, where the figure is more than 40 percent lower than the national figure, and significantly below the next-lowest region, Central Luzon. At the other end of the spectrum, the Eastern Visayas and ARMM have rates more than a third higher than the national rate. (See Annex 2 for regional data.)

The 1993 NDS made a lower estimate of the under-five mortality rate: 54.2 in 1990. For the ten-year period prior to the survey, it found the rate almost 40 percent higher in

rural areas than in urban ones and there were significant regional differences, ranging from 35.5 in Central Luzon to 97.5 in the Eastern Visayas. The rate was also dramatically higher among women with no education (151.8) than among those with a high school education (46.0), college education or higher (35.7). The following were the major causes of mortality identified for children in this age group:



Note: Other – includes meningitis (4%), congenital anomalies (3%), nephritis, nephrotic syndrome, nephrosis (1%), and leukemia (1%)

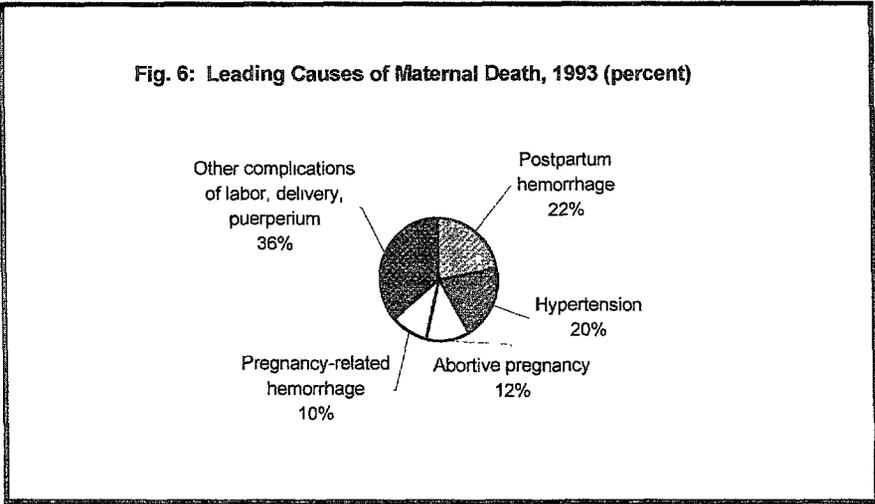
Source: DOH, 1993 HIS

Maternal Mortality

The 1993 NDS estimated the maternal mortality ratio to be 209 maternal deaths for every 100,000 live births in 1990. The NSCB, using that figure as a base, estimated the 1995 maternal mortality ratio at 179.7 -- a figure 14.0 percent below 1990. By far the highest maternal mortality ratio is found in the ARMM region, according to the NSCB estimates, where it was more than 50 percent higher than the national figure, at 320.3 maternal deaths/100,000 births in 1995, but Northern and Western Mindanao also had high ratios. At the other end of the spectrum, NCR and Southern Tagalog had the lowest ratios. (See Annex 2 for regional data.)

The leading causes of maternal mortality in 1993, according to DOH, complications occurring in the course of labor, delivery and the puerperium (36 percent of maternal deaths), post-partum hemorrhage (22 percent), hypertension complicating pregnancy, childbirth and puerperium (20 percent), pregnancy with abortive outcome (12 percent), and hemorrhage related to pregnancy (10 percent).

Fig. 6: Leading Causes of Maternal Death, 1993 (percent)

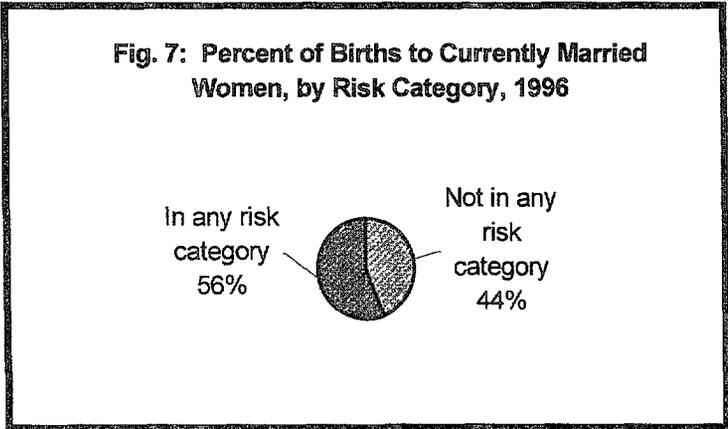


Source: DOH, HIS '93 Philippine Health Statistics, Table 30.

High Risk Births

One of the important factors contributing to maternal and infant mortality in the Philippines is a high incidence of births to women who, by virtue of their demographic characteristics, are disproportionately likely to experience an adverse pregnancy outcome. Data from the 1997 NSO Family Planning Survey show that 56.2 percent of births in the past year were to women in high risk groups, i.e. those under age 18, aged 35 or older, with an interval of less than 24 months since the last birth and/or with three or more prior births (Fig. 7). This is an improvement over 1993, when the figure was 62.4 percent, but the prevalence remains high. Three groups of women contribute a large number of high risk births: women who have already had three or more births, women with birth intervals of less than 24 months, and those aged 35 or older who have also had at least three prior births.

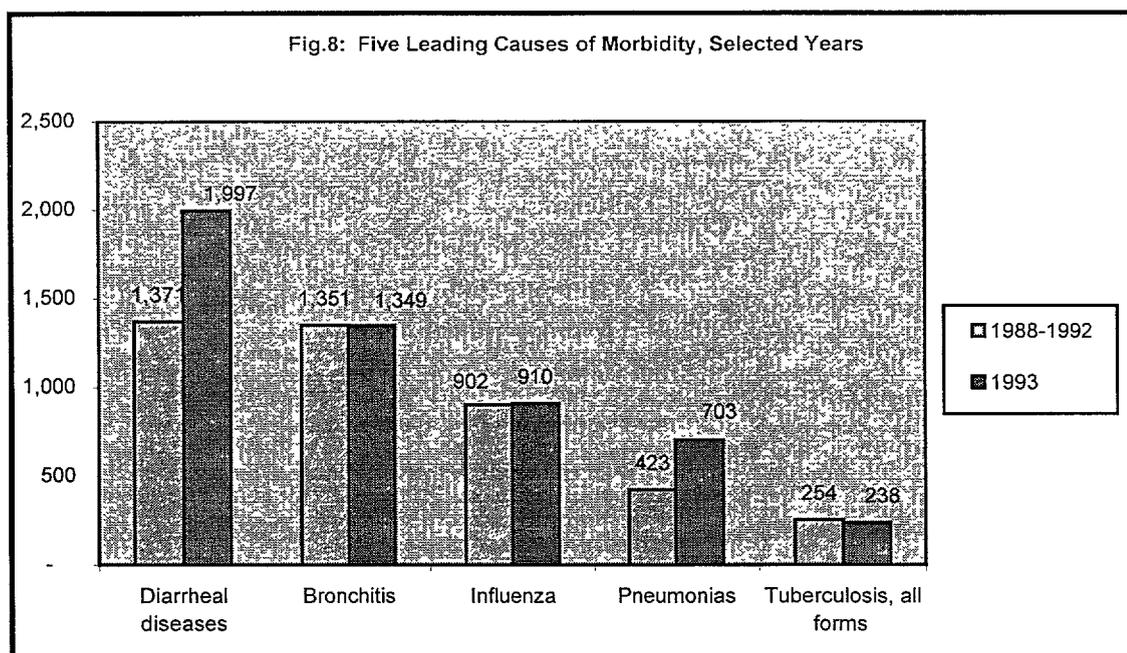
Fig. 7: Percent of Births to Currently Married Women, by Risk Category, 1996



Source: NSO, 1997 Family Planning Survey

Morbidity

Infectious and communicable diseases figure prominently as major causes of morbidity, with the top five causes in recent years being diarrhea, bronchitis, influenza, pneumonia and tuberculosis. Of the top ten causes of morbidity reported to DOH, diarrhea accounted for 33.8 percent of cases in 1993, followed by bronchitis (22.9 percent) and influenza (15.4 percent). Respiratory diseases, namely bronchitis, pneumonias and tuberculosis, together accounted for 39 percent of the top 10 causes, while almost 20 percent more were due to viral infections, namely influenza, varicella and measles.



Source: DOH, HIS, '93 Philippine Health Statistics, Table 13.

Data on the leading causes of morbidity among women are not readily available. For infants and children, they have been analyzed by World Bank researchers, based on data from DOH's HIS. They show that both infants and young children suffer from virtually the same causes, namely bronchitis, diarrhea, influenza and pneumonia--with respiratory conditions accounting for almost half of morbidity, as can be seen in Table 4.

Table 4: Causes of Infant and Child (Age 1 - 4) Morbidity, 1990 (Percent)

	<u>Infant Morbidity</u>	<u>Child Morbidity</u>
Bronchitis	38	39
Diarrhea	31	30
Influenza	14	14
Pneumonia	13	10
Measles	2	4
Other	2	3

Source: R.A.Heaver, J.M. Hunt, Improving Early Childhood Development, an Integrated Program for the Philippines, The World Bank, Washington, D.C., Figure 2.5 and 2.7

STD/AIDS Situation in the Philippines

The Philippines remains a low HIV prevalence country. The first case of Acquired Immune Deficiency Syndrome (AIDS) was reported in the Philippines in 1984. Since then, a cumulative total of 968 people have tested positive for the Human Immunodeficiency Virus (HIV) of which 295 have developed AIDS as reported in the DOH's National AIDS Registry, as of December 1997. The total number of persons living with HIV was 17,500 (a prevalence rate of 0.04% in adult population, 15 years of age and above).

HIV Sentinel Surveillance

Since 1993, HIV serological surveys among groups namely: registered female CSWs, free lance CSWs, male CSW, male STD patients, men who have sex with me and injecting drug users), have been performed every six months in ten sentinel sites throughout the country (Quezon, Cebu, Angeles, Pasay, Davao, Iloilo, General Santos, and Zamboanga). The National HIV sentinel surveillance system (HSS) has shown very low HIV prevalence (<0.3%) rates among sentinel groups. No significant increase of cases may be expected in the next few years. The HIV infection could continue to expand progressively at a slow rate, as supported by serological survey conducted among sentinel groups of population.

The major mode of transmission is sexual, both heterosexual and homosexual, while injected drug use and perinatal transmission also account for some cases.

In 1994, the national HSS system added seroprevalence for syphilis to its routine six months surveys. High syphilis seropositivity prevalence was found among groups known to be at increased risk of STDs in the sentinel cities where surveillance is being conducted.

Registered female commercial sex workers	-	up to 9 percent
Freelance commercial sex workers	-	up to 15 percent
Male sex workers	-	up to 22 percent
Male STD patients	-	up to 10 percent
Men who have sex with men	-	up to 20 percent
Injecting drug users	-	up to 33 percent

In the National Capital Region, in 1990, 1.4 percent of blood donors tested positive for syphilis but, among donors who made a business of selling their blood, 19 percent tested positive, showing that "professional" blood donors were much more likely to have tainted blood.

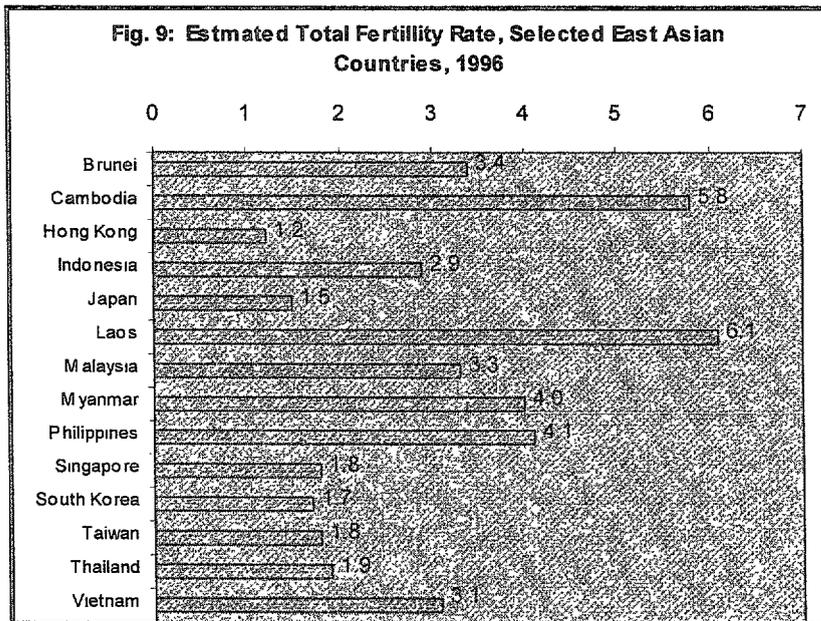
In 1994, the HSS added seroprevalence for syphilis to its routine six month surveys. High syphilis seropositivity prevalence was found among all groups in all sites. Relatively higher rates were observed in free lance female sex workers (1%-12%) and male sex workers (1-9%), than in male STD patients (1%-9%) and registered female sex workers (1%-4%).

Another survey was conducted in Cebu and Metro Manila in 1994. High prevalence were observed not only for syphilis but also for three other STDs under study. Highest rates were found among female sex workers in Cebu (22.2% for gonorrhoea; 22.7% for chlamydia; 6.7% for syphilis; 30.9% for trichomoniasis). In female sex workers in Metro Manila, rates were found at 10.6% for gonorrhoea; 17.3% for chlamydia; 2.8% for syphilis and 6.7% for trichomoniasis. Prevalence rates among women attending antenatal clinics were 1% for gonorrhoea; 5.6% for chlamydia; 0.5% for syphilis and 1% for trichomoniasis.

C. Fertility and Contraceptive Use

Fertility

Fertility in the Philippines remains high. Laos and Cambodia are the only countries in East Asia with higher fertility rates, as can be seen in Figure 9 below.



Population Reference Bureau, 1997 World Population Data Sheet

Yet, fertility has been falling steadily since 1970 and stood at 4.1 children per woman in 1991, according to the 1993 NDS (Table 5). Fertility rates vary by socio-economic characteristics, with urban women having, on average, 1.3 children less than rural women (3.5 versus 4.8) and women with no education having one child more than women with a college education (4.9 versus 2.8). There are also significant regional variations, with the lowest fertility rates found in Metro Manila (2.8), Central Luzon and Southern Tagalog and the highest in Bicol (5.9) and the Cordillera Administrative Region (CAR). (See Annex 3 for regional fertility rates).

Table 5: Total Fertility Rate, Selected Years, 1970 – 1991

1970	5.97
1975	5.24
1980	5.08
1984	4.42
1991	4.09

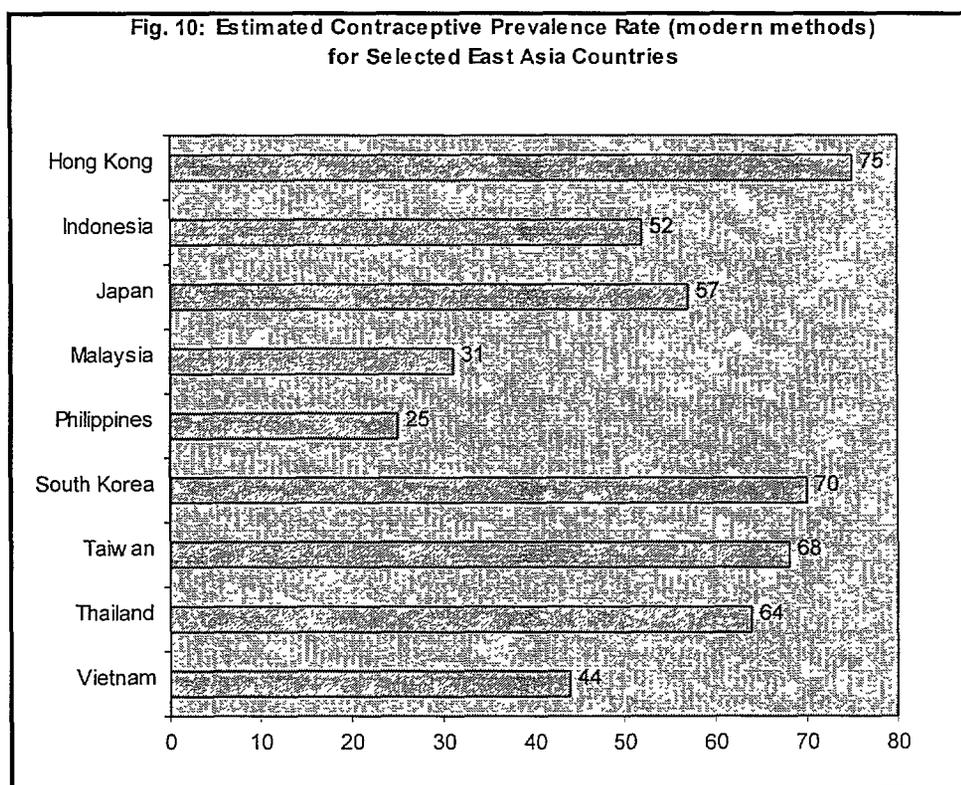
Source: NSO and Macro International, NDS 1993," Table 3.3

There is a significant gap between women's ideal number of children and the actual fertility rate of 4.1, however, with women expressing a preference for 3.2 children, and younger women desiring even fewer.

Knowledge and Use of Contraception

Knowledge of contraception is virtually universal in the Philippines: 97.2 percent of married women and 95.9 percent of all women in the reproductive age, according to the 1993 NDS. The most widely known methods are the pill, condom, voluntary surgical sterilization (VSS) and the intrauterine device (IUD) and knowledge of traditional methods is somewhat lower than of modern methods. However, knowledge of a modern family planning method does not always translate into knowledge of where to obtain it. Just 88.8 percent of all women and 93.3 percent of married women know where to obtain a method.

For a country with a highly educated population, where women enjoy relatively high status and where economic growth is taking off, prevalence of modern contraceptive methods is very low. Compared to other East Asian countries for which data are available, the contraceptive prevalence rate (CPR) for modern methods in the Philippines is by far the lowest, as can be seen in Figure 10.



Source: Population Reference Bureau, "1997 World Population Data Sheet"

Prevalence of modern methods has increased at a sluggish pace over the years that national demographic surveys have been conducted, as can be seen in Table 6. Use of traditional methods has been high but prevalence has fluctuated over the years.

Table 6: Percent of Currently Married Women Using Contraception, 1968 – 1997

	<u>Modern Methods</u>	<u>Traditional Methods</u>	<u>Total</u>
1968 National Demographic Survey	2.9	12.5	15.4
1973 National Demographic Survey	10.7	6.7	17.4
1978 Republic of the Philippines Fertility Survey	17.2	21.3	38.5
1983 National Demographic Survey	18.9	13.1	32.0
1988 National Demographic Survey	21.6	14.5	36.1
1993 National Demographic Survey	25.2	14.8	40.0
1995 Family Planning Survey	25.7*	25.0	50.7
1996 Family Planning Survey, preliminary data	30.2	17.9	48.1
1997 Family Planning Survey	30.9	16.1	47.0

Note: Data from 1968 to 1988 are for currently married women 15-44 and modern methods do not include modern NFP; from 1993 onward, data are for currently married women 15-49 and modern methods include modern NFP.

* After adjusting for a methodological flaw in ascertaining use of VSS in the 1995 survey, the modern method rate was 28.5 percent.

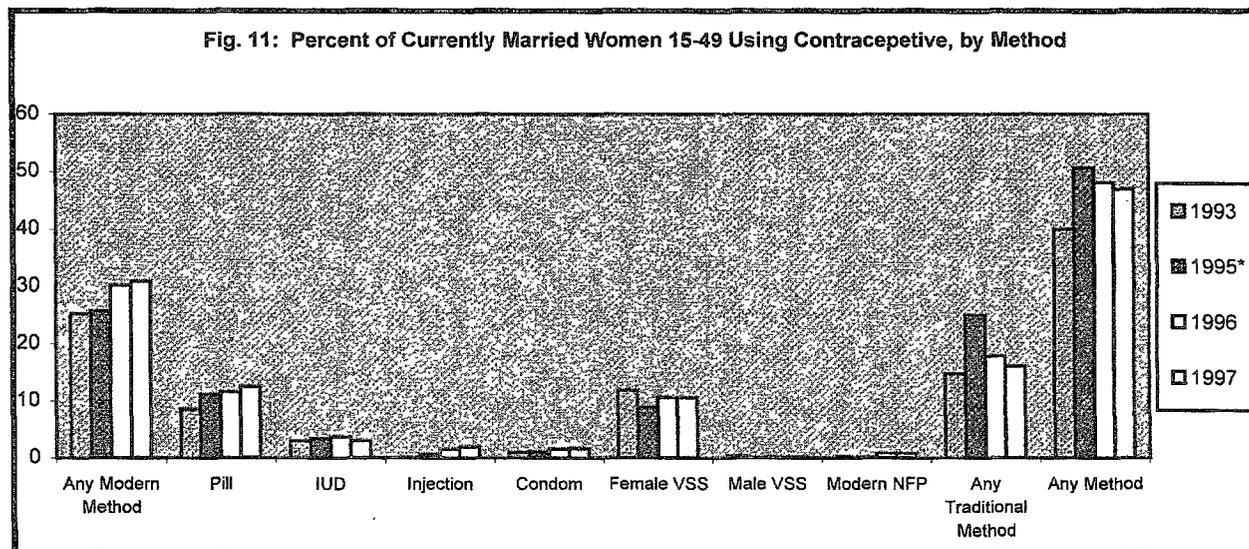
Source: NSO and Macro International, NDS 1993, Table 4.5; unpublished tabulations from NDS 1993, NSO Family Planning Survey 1995; 1996 Family Planning Survey, 1997 Family Planning Survey.

Data from the 1997 Family Planning Survey conducted by NSO show prevalence of modern methods increasing by about 1.4 percentage points a year since 1993, with 30.9 percent of MWRA using a modern method, including modern natural family planning (NFP), in 1997. The most widely-used method is the pill, followed by VSS and the IUD (12.5, 10.8 and 3.0 percent of MWRA respectively). Modern methods of NFP are very rare: used by less than one percent of married women. Traditional methods (which are not officially part of the Philippine Family Planning Program (PFPP)) remained high, with 16.1 percent of MWRA relying on them. When both modern and traditional methods are taken together, overall contraceptive prevalence stood at 47.0 percent in 1997.

It should be noted that the data in Table 6 from recent years cannot be directly compared with the earlier data. The surveys prior to 1993 measured contraceptive prevalence among married women age 15 - 44 and did not include modern NFP as a modern method of family planning. From 1993 onwards, women aged 15 - 49 were included in the survey and modern NFP is classified as a modern contraceptive method.

As compared to 1993, there was a 5.7 percentage point increase in use of modern methods in 1997, with a significant shift in the pattern of method-use. VSS declined 1.5 percentage points, while reversible methods increased 6.7 percentage points. The pill increased 4.0 percentage points in prevalence, displacing VSS as the most widely used modern method. Methods new to the program since 1993, notably the injectable and modern NFP, also contributed significantly to the increase, growing 2.9 percentage points between them. Use of traditional methods was also more widespread, going from 14.8 to 16.1 percent of MWRA, giving an overall increase in contraceptive

prevalence from 40.0 to 47.0 percent. (See Figure 11.)



* Adjustments by a U.S. Bureau of the Census Advisor to account for possible underestimation of VSS yielded the following figures, which, in light of the results of the 1996 NSO survey, may be a more accurate reflection of the situation in 1995. Any modern method – 28.5%, Pill – 11.4%; IUD – 13.7%, Injection – 10.7%, Condom – 1.1%, Female VSS – 11.3%, Male VSS – 0.1%, Modern NFP – 0.3%, Any traditional method – 24.9%, Any method – 53.4% and not using a method – 46.6

Source: NSO and Macro International, NDS 1993; NSO Family Planning Survey 1995; 1996 Family Planning Survey, 1977 Family Planning Survey

Data for 1997 show that there are significant differences in contraceptive use by region (see Annex 4). The highest prevalence of modern methods is found in the Cagayan Valley (40.8 percent), Northern Mindanao (40.7 percent), Central Luzon (36.4 percent), and Southern Mindanao (37.2 percent), while the lowest by far is in ARMM (6.4 percent), followed by Bicol (19.6 percent) and the Eastern Visayas (20.2 percent). Metro Manila, which might have been expected to have high use, ranks only sixth among the regions. Use of traditional methods also varies, although less dramatically, with Southern Mindanao and Central Visayas having the highest rates (22.7 and 19.8 percent respectively) and ARMM having the lowest by far (6.6 percent), followed by the Cagayan Valley (9.5 percent). Interestingly, high use of modern methods is not necessarily reflected in low use of traditional methods, or vice versa.

Method-use also differs by region. Female VSS is widely used in Central Luzon, Metro Manila, CAR, Ilocos and Southern Tagalog (18.4, 13.4, 12.1 and 11.8 percent respectively), while the IUD is popular in Mindanao, except for ARMM (ranging from 6.0 to 11.0 percent). Use of other methods also varies significantly, although patterns cutting across neighboring regions are not so apparent.

Despite the efforts of the PFPP to encourage a larger private sector role, the great majority of users of modern methods (72.9 percent) obtain the method from a public sector provider, according to the 1997 NSO survey (Table 7). In fact, the private sector role actually shrank from 27.0 to 24.4 percent between 1993 and 1997. It is not

clear why this occurred, but it may be that the private sector is not keeping pace with the expansion of services in the public sector, so that it accounts for a declining share of a larger pie.

Table 7: Source of Supply for Modern Contraceptive Methods, 1993 - 1996

	1993	1995	1996	1997
Public Sector	71.4	78.3	73.1	72.9
Government Hospital	32.6	26.5	24.2	24.5
RHU/Urban Health Center ⁽¹⁾	12.4	16.1	27.7	27.2
BHS	25.0	33.8	18.5	18.3
BSPO/Health Worker	1.5	2.0	2.7	3.0
Private Sector	27.0	18.3	23.9	24.4
Private hospital/clinic ⁽²⁾	16.4	9.8	11.8	11.1
Private doctor	2.6	1.5	2.4	2.9
Private midwife	NA	NA	0.4	0.3
Pharmacy	7.3	6.0	7.1	8.1
Store	0.2	0.7	0.6	0.4
NGO ⁽²⁾	NA	NA	0.9	1.2
Industry-based clinic ⁽²⁾	NA	NA	0.4	0.2
Church	0.5	0.3	0.2	0.2
Others	1.2	1.6	1.4	1.5
Puericulture Center ⁽¹⁾	NA	NA	0.8	0.9
Friend/relative	0.8	0.7	0.3	0.2
Other	0.4	0.9	0.3	0.3
Don't Know	0.1	1.8	0.0	1.0
Missing	0.4	0.0	1.6	0.1
TOTAL	100	100	100	100

(1) In 1993 and 1995, puericulture center was included with RHU, and urban health center was not explicitly mentioned.

(2) In 1993 and 1995, neither industry-based nor NGO clinics were explicitly identified and their responses were subsumed under private hospital/clinic.

Note: Totals and subtotals may not add due to rounding.

Source: NSO and Macro International, NDS 1993; NSO Family Planning Survey 1995; NSO Family Planning Survey 1996; NSO Family Planning Survey 1997

Unmet Need for Family Planning

More than a quarter (26.2 percent) of married women had an unmet need for family planning, according to the 1993 NDS (Table 8). This figure should have declined since 1993, given the increase in overall contraceptive prevalence, but many users of family planning may fail to achieve their family planning objectives, given the high use of traditional methods. The regions that have been most successful in meeting the need for family planning services--and accordingly have the lowest unmet need--are the Central Visayas, Central Luzon and Northern Mindanao. At the other end of the

spectrum, with a high unmet need, are the Eastern Visayas, Bicol and Western Mindanao. (See Annex 5 for regional data.) The unmet need was generally higher in rural than in urban areas, and among women with lower levels of education than those with more education.

Table 8: Percent of Currently Married Women with an Unmet Need for Family Planning Services, by Residence, 1993

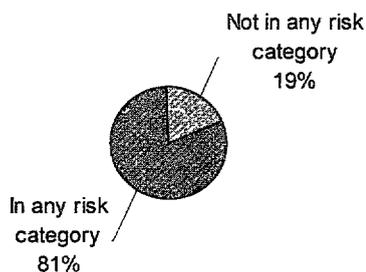
<u>Residence</u>	<u>For Spacing</u>	<u>For Limiting</u>	<u>Total</u>
Urban	11.4	12.1	23.5
Rural	13.6	15.6	29.1
Total	12.4	13.8	26.2

Source: NSO and Macro International, NDS 1993, Table 6.4

The demand for *limiting* family size was somewhat greater than that for *spacing* births, as can be seen in the table above. There was a particularly large unmet need for limiting births in the Eastern Visayas, Bicol and Southern Tagalog. The unmet need for spacing births was highest in CAR and Western Mindanao.

There is also a large unmet need for family planning among women for whom pregnancy presents health risks. Data from the 1997 Family Planning Survey show that, among all married women—whether or not they have given birth recently—80.6 percent would fall into a high risk group if they were to become pregnant (Fig. 12). By far the largest group of these women are those aged 35 or older with three or more prior births (37.3 percent). Other large groups are women who have already had at least three births, regardless of age (13.4 percent) and those aged 35 or above, regardless of the number of prior births (10.9 percent). These groups should be priority populations to be reached with family planning information and services.

Fig. 12: Percent of Currently Married Women in a Risk Category, 1996



Source: NSO, 1997 Family Planning Survey

Sexual Activity and Marriage

Under the New Family Code of the Philippines which went into effect in 1988, 18 is the minimum age of marriage for both men and women. Filipino women marry relatively late and the age of marriage is increasing, according to the 1993 NDS. Among younger women, those aged 25 - 29 in 1993, half were married by age 21.8, while among women 25 - 49, the median age at marriage was 21.4 (see Table 9). Women in rural areas married a year and a half later than those in urban areas.

Most women have their first sexual intercourse after marriage, with the median age at first intercourse being 21.5. That age is increasing, though very slowly, with half of women aged 25 - 29 having experienced intercourse by age 21.9. The median age at first birth for all women was 22.8 in 1993, with urban women waiting almost two years later than their rural counterparts before their first birth. The age at first birth has been increasing steadily, with the median age among young women (25 - 29) being 23.1.

Table 9: Median Age at First Marriage, First Intercourse and First Birth, All Women and Young Women, 1993

Age Group	Median Age		
	First Marriage	First Intercourse	First Birth
25 - 49	21.4	21.5	22.8
25 - 29	21.8	21.9	23.1

Source. NSO and Macro International, NDS 1993, Tables 3.9, 5.4 and 5.5

D. Nutrition

The main source of data on nutrition is the National Nutrition Survey (NNS) undertaken every five years by the Food and Nutrition Research Institute (FNRI) of the Department of Science and Technology (DOST). The NNS actually consists of several different surveys covering anthropometric, clinical nutrition, biochemical and food consumption data. The latest survey, in 1993, involved over 4,000 households and more than 22,000 household members.

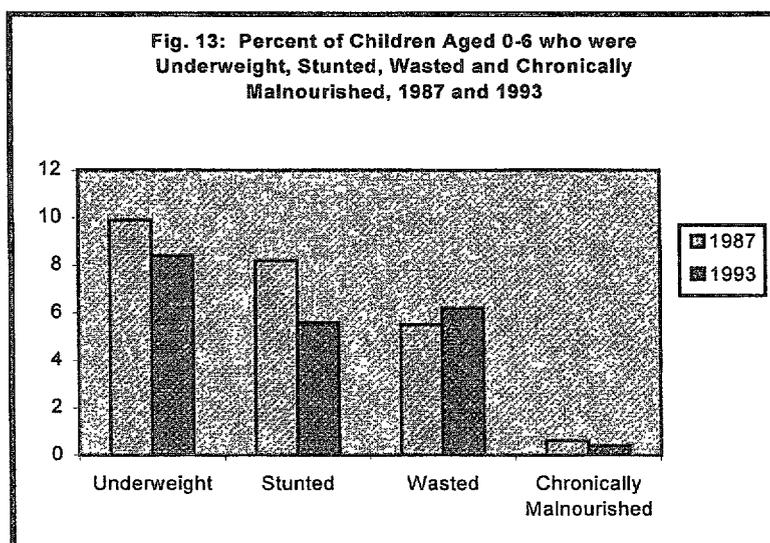
Protein-Energy Malnutrition (PEM)

The proportion of children under age seven who were moderately or severely underweight stood at 8.4 percent, according to the 1993 NNS (Fig. 13). Very young infants were the least affected, with 4.9 percent prevalence among 0 - 5 month-olds, but underweight worsened to 7.2 percent at weaning age (6 - 11 months), and then almost doubled to 13.9 percent for one-year-olds. Poor weaning and child feeding practices could have contributed to this high prevalence of underweight. Underweight appears to be declining, however, it was 1.5 percentage points lower among children under age seven in 1993 than in 1987.

It should be noted that the prevalence rates for underweight, stunting and wasting are based on a Philippine reference standard and would be considerably higher if international reference standards were used. Thus, the rates cited here cannot be compared with other countries.

Stunting--low height for age--indicates chronic or long-standing PEM. This afflicted 5.6 percent of preschoolers, with severe stunting occurring among 0.4 percent of the stunted children. As was the case with underweight, the 0 - 5 month-old infants were the least affected, with 2.4 percent prevalence, which increased to 5.4 percent among 6 - 11 month-olds. Two- and three-year-old children showed the highest prevalence, however, with 8.4 and 6.7 percent respectively. Five years earlier, in 1987, stunting had been significantly more prevalent, affecting 8.2 percent of preschool-age children.

Wasting (thinness) or current malnutrition, which is indicative of acute PEM was manifested in 6.2 percent of preschoolers, with 0.7 percent severely affected by this form of malnutrition. The youngest children recorded the highest incidence, with 11.6 percent of 0 - 5 month-old infants, followed by six year-olds at 8.3 percent. Wasting appeared to have increased from the 1987 level of 5.5 percent, but the increase was not statistically significant.



Note: The prevalence rates for underweight, stunted and wasted are based on Philippine standard and would be considerable higher if international reference standards were used.
 Source: FNRI, DOST, Fourth National Nutrition Survey, Philippines 1993, Part B Anthropometric Survey, Tables 5 and 6

The worst form of malnutrition which is severe chronic malnutrition (both wasted and stunted) was suffered by 0.4 percent of the children aged 0 - 6.

Rural areas were more nutritionally vulnerable than urban areas, manifesting higher prevalence for the various forms of malnutrition. Among the regions, ARMM, the Eastern and Western Visayas had the highest prevalence of all forms of malnutrition. The regions with better nutritional situations were the Cagayan Valley and CAR.

Among pregnant women, about one out of every five (21.2 percent) had weight-for-height below 90 percent of the reference standard. Interestingly, pregnant women in rural areas fared somewhat better than their urban counterparts, with just 19.6 percent being underweight-for-height, as compared to 22.8 percent of urban women. The risk of being underweight-for-height was significantly greater among pregnant teenagers (age 15 - 19) than for other pregnant women, with 34.1 percent of this group falling below the reference standard. Indeed, among pregnant teenagers in urban areas, almost half (47.7 percent) were underweight for height.

Among non-pregnant women, 17.1 percent were found underweight-for-height in the NNS and, among lactating women, 12.8 percent.

Data from the 1993 Safe Motherhood Survey (SMS) provided the first national-level assessment of the PEM status of women of reproductive age in general. They showed that 12.7 percent of women had a body mass index (a combined measure of weight and height) less than 18.5, the level indicating chronic undernutrition and likely adverse effects on fetal growth for those who are pregnant. When faced with the additional biological demands of pregnancy, these women are more likely to have babies with low birthweight.

Vitamin A Deficiency (VAD)

VAD is a significant public health problem, with 10.4 percent of children aged six months to six years found to have deficient serum Vitamin A levels in 1993--twice the WHO cut-off level of five percent--and 35.3 percent having either deficient or low levels. Pregnant and lactating women were substantially less likely to have low or deficient levels, at 3.0 and 5.2 percent respectively. There were no major differences between rural and urban areas in VAD. However, all regions of the country except the Cagayan Valley, Western Visayas, Central Visayas and Central Mindanao had a significant VAD problem.

VAD as manifested by nightblindness stood at 1.1 percent against the WHO cut-off point of one percent; and, as manifested by Bitot's spots, it stood at 0.1 percent--below WHO's 0.5 percent cut-off point. At the regional level, however, nightblindness was still found at levels above the WHO cut-off point in Central Luzon, Eastern Visayas, Southern Tagalog, Ilocos and Southern Mindanao and VAD may well exist in some highly depressed areas within regions. With respect to Bitot's spots, only the Eastern Visayas and Southern Tagalog exhibited prevalence above the WHO level of 0.5 percent. There was no major change from 1987, when nightblindness stood at 0.8 percent and Bitot's spots at 0.3 percent.

VAD in the Philippines is mostly at subclinical levels but it remains a problem because of the link with mortality.

Iron Deficiency Anemia (IDA)

IDA is the most common form of micronutrient malnutrition in the country, affecting 28.9 percent of the population in 1993, as measured by hemoglobin levels. Infants aged six months to one year had the highest prevalence rate (49.2 percent), probably because complementary feeding did not provide sufficient absorbable iron and because infants have disproportionately high iron requirements. The prevalence among pregnant and lactating women was only slightly lower than among infants, at 43.6 and 43.0 percent respectively. Among children aged one to six, the rate was lower, at 26.7 percent.

While anemia is still widespread, there were major improvements between 1987 and 1993, with the prevalence overall dropping from 37.2 to 28.9 percent, even though no major nutritional interventions against IDA were undertaken during the period. There were dramatic declines among infants and preschoolers aged 1 - 6 and prevalence also declined, though less dramatically, among pregnant and lactating women. The prevalence of anemia in urban areas was lower than in rural areas (27.1 versus 29.3 percent). Among the regions, Central Mindanao, Bicol and ARMM had the highest prevalence of anemia (37.0, 34.5 and 34.3 percent), while the Eastern Visayas, CAR and the Central Visayas had the lowest prevalence, at 21.5, 22.1 and 22.5 percent respectively.

The clinical nutrition survey of the NNS found that the signs and symptoms of anemia, as manifested by pale conjunctiva, had increased from 12.5 percent in 1987 to 19.2 in 1993 among the general population. Anemia was particularly widespread among pregnant and lactating women (34.3 and 32.8 percent respectively) and was higher in rural than in urban areas. There were also substantial regional differences.

Iodine Deficiency

The 1993 NNS showed that the prevalence of goiter almost doubled between 1987 and 1993, from 3.5 percent to 6.7 percent of the population aged seven or older, indicating a significant iodine deficiency problem^a. Females, particularly pregnant and lactating women, were more likely than males to be afflicted. This was particularly the case for pregnant women: 27.4 percent of pregnant women aged 13 - 20 had goiter and 22.8 percent of those aged 21 - 49 had it. Among lactating women, 22.3 percent of 13 - 20 year-olds had goiter, as did 17.2 percent of 21 - 49 year-olds. There were no big differences between rural and urban areas in the prevalence of goiter, but the NNS, being national in scope, would not have identified endemic areas.

^a A total goiter prevalence rate of more than five percent is evidence of a significant iodine deficiency problem.

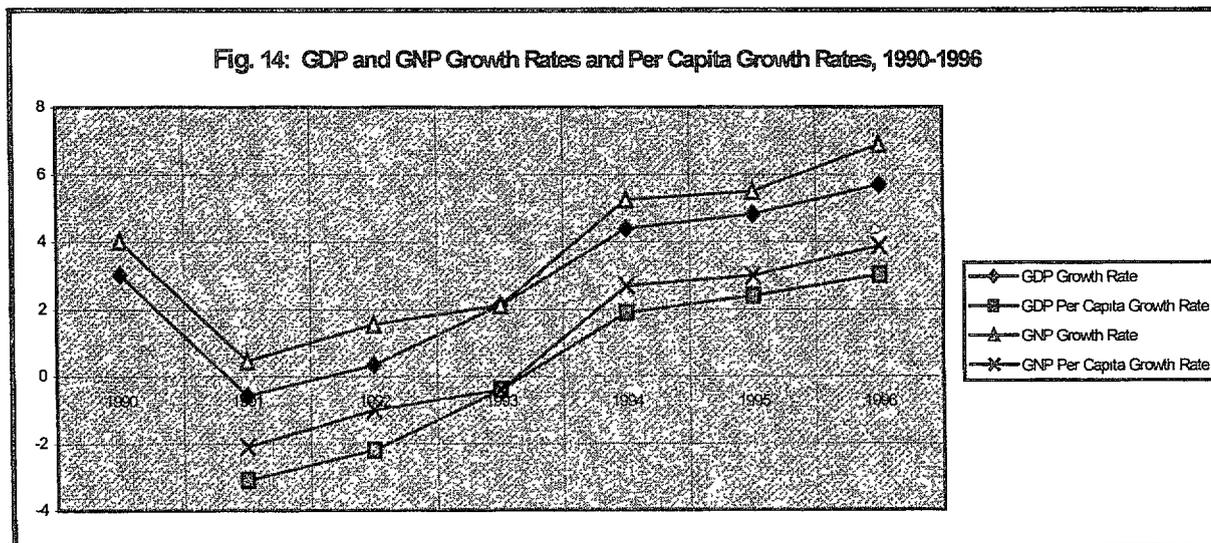
E. The Broader Context for Population and Health Programs

The Economy

In 1986, the Philippine economy entered a period of robust economic growth after years of 1983-1984. The annual growth rate of the country's Gross Domestic Product (GDP) accelerated from 3.4% to 6.8% from 1986 to 1989. During the period from 1990 to 1991, the economy decelerated as investments and exports dropped precipitously, partly due to the negative effects of the 1989 coup.

As the earlier economic reforms made its impact and new liberalization initiatives were being put in place during the Ramos administration, the economy began to post positive growth rates starting from 1992 up to the present. The GDP rose by 5.7% in 1996 while Gross National Product (GNP) accelerated by 6.9%. Inflation was stabilized and maintained at below 10% during 1992-1996. Exports continued to accelerate, growing by 20% during the period. The balance of payments registered a \$4.1 billion surplus in 1996, driven by remittances from overseas workers and foreign investment inflows. Unemployment was maintained at below 8.5% from 1994-1996. These positive economic indicators augur well for the human resources development efforts and population and health programs that are crucial to sustainable development.

Many of the benefits of the current climate of economic growth, however, are undermined by rapid population growth of the country which stands at 2.32% annually. Given that GDP growth rates averaged 2.8% annually and GNP grew by 3.5% between 1990 and 1996, per capita GDP and GNP grew modestly during the period. Thus, the gains of economic growth fostered during the period are being dragged down by population growth especially the urban areas.



N.B. Per capita growth rates are calculated using population data.
Source: NSCB database

Despite important progress on the economic front, many problems remain. Poverty and unequal distribution of income, while improving, still persist as problems in the Philippines. The percent of families with incomes below the poverty threshold fell from 44.2 to 35.5 percent between 1985 and 1994, but in rural areas, the drop was very small: from 50.7 to 47.0 percent. Population growth has undoubtedly contributed to the slow decline in poverty, particularly in rural areas. Average family income (in real terms), meanwhile, increased by less than one percent between 1991 and 1994 and the Gini coefficient^b dropped from 0.47 to 0.45, indicating only a very slight improvement toward more equal distribution of income.

The country still needs broader economic participation to improve the quality of life.

The Environment and Basic Needs

The majority of Filipinos who live below the poverty line rely on the forests and coastal areas for food and livelihood. Unsound logging and agricultural practices have decimated the country's old growth forests such that, over the last 40 years, this resource has been reduced by 90 percent. Lack of economic alternatives is leading people to exploit natural resources for short term gain. Only about 5.0 million hectares of forest remain of the 15.0 million in the early 1950s. The clearing of forested watersheds has led to widespread landslides, floods and degradation of marine and freshwater resources that have taken their toll in lives, property, infrastructure and productive capacity. Only six percent of the country's coastal resources, including mangroves and coral reefs, remain in undeteriorated condition, capable of producing sustained yields.

Rapid industrial development, with poor environmental regulation, is causing a deterioration in air and water quality throughout the country, but particularly in urban areas, with serious implications for public health and the quality of the local ecosystems. It is projected that the industrial infrastructure in the Philippines will grow by more than 400 percent over the next twenty years so that the damage potential is enormous if steps are not taken to protect the public from industrial pollution.

Not only is the pressure on the environment building, but the basic needs of Filipinos are also threatened. In the 1980s and early 1990s, rice production grew at 1.9 percent a year--but consumption increased by three percent, driven largely by population growth. For the foreseeable future, Filipinos will have to depend partially on imports to meet their rice needs. Fish accounts for 70 percent of the animal protein intake and 30 percent of the total protein intake of the population. But per capita fish supply availability declined from 30.5 kg in 1987 to 28.5 kg in 1994. In large part due to population growth, per capita fish availability is expected to plummet from 28.5 kg/yr per capita in 1994 to 10.5 kg/yr by 2010. Even under a best-case scenario of vigorous implementation of conservation and management measures, per capita availability

^b The Gini coefficient is an indicator of the degree of equality in income distribution, with 0 indicating total equality and 1 indicating total inequality.

could decline to 24.7 kg/yr.

Population pressures are at the root of these problems, causing rapid depletion of precious natural resources on which Filipinos and the economy are heavily dependent, fueling poorly-regulated industrial development with its harmful side effects and placing Filipinos' basic needs in jeopardy.

Employment

As a result of past high fertility, the labor force is increasing rapidly--by an average of almost 700,000 people per year since 1990. Yet, in recent years, only about 650,000 new jobs have been created each year. The annual labor force growth rate of 2.6 percent per year actually exceeds the population growth rate, creating major challenges in terms of job creation and the maintenance of social and political stability.

Of the population 15 years old or older, 65.8 percent were in the labor force in 1996--a proportion that has not changed dramatically in over a decade. Of this economically active population, 92.6 percent were employed. The employed workforce is dominated by agricultural workers (42.3 percent), with production and related workers comprising the next largest group (22.8 percent) and just a small fraction of the workforce engaged in professional, technical and related work.

Unemployment stood at 7.4 percent in 1996 and has been declining slowly since 1991 but urban areas, in particular, continue to suffer from high unemployment with a rate roughly twice as high as in rural areas. Underemployment is also a serious problem, with 19.4 percent of employed persons desiring additional hours of work.

Education and Literacy

Participation in elementary education is relatively high in the Philippines, with about 99 percent of children aged 7 - 12 enrolled in elementary education in the 1995-96 school year. Enrollment for children of secondary school age was lower, at 77.4 percent^c.

Based on the 1994 figure, literacy is high with 93.9 percent of the population aged 10 or over able to read, according to the DECS and NSO --roughly 4.1 percentage points higher than the rates in 1989. There were significant regional variations, however, with a literacy rate over 98.8 percent in NCR, as compared with 73.5 percent in ARMM. Functional literacy, however, is considerably lower, with 83.8 percent of the Filipinos aged 10 or over able to read and comprehend a simple text in 1994. Functional literacy appears to be improving rapidly, with a 10 percentage point increase between 1989 and 1994.

^c Single age group was derived using proportion method.

Status of Women

The status of women is relatively high by international standards. The Philippines ranks 28th in the world--ahead of some developed countries, including Portugal, France and Singapore--on the U.N. Development Program's Gender Empowerment Measure which reflects women's participation in political decision-making, their access to professional opportunities and their earning power.

National policy is generally favorable to women. Since 1975, there has been a National Commission on the Role of Filipino Women, charged with "moving toward the full integration of women for social, economic, political and cultural development." The 1987 Constitution states that "The State recognizes the role of women in nation-building and shall ensure the fundamental equality before the law of women and men" (Article II, Sec. 14) and recognizes women's maternal and economic role, their special health needs and other matters of concern to women. The 1987 New Family Code of the Philippines also eliminated many discriminatory provisions in the earlier Civil Code of the Philippines. Other supportive policies include the outlawing of sexual harassment in employment, education or training environments (RA 7877); increased maternity benefits for women in the private sector (RA 7322); increased minimum wages for domestic helpers (RA 7655); outlawing "mail order brides" (RA 7688); and providing incentives to public and private health institutions with rooming-in and breastfeeding practices (RA 7600).

A bill (Anti-Rape Bill) that aims to set up rape crisis centers in every city and province nationwide was finally signed into law on February 13, 1998. The legislation (jointly authored by Senators Leticia Ramos-Shahani, Nikki Coseteng, Miriam Defensor-Santiago and Ernesto Herrera) delegates the Departments of Social Welfare and Development (DSWD), Justice (DOJ) and Interior and Local Governments (DILG) the task of establishing crisis centers for victims/survivors of rape and sexual violence by providing counseling, medico-legal examination, legal assistance and other services necessary for their recovery. The law also includes provisions for: complaints of rape against any public official; prohibition against undue publicity; and prosecution and trial of rape cases.

Women are relatively on a par with men in the field of education. Enrollment figures for boys and girls at the elementary and secondary levels are comparable and, in tertiary education, women slightly outnumber men. Literacy rates do not differ greatly by sex (94.0 percent for women, 93.7 percent for men in 1994), but there is a significant urban-rural gap, so that only 91.3 percent of rural women are literate. The problem, rather, is gender-stereotyping in education, which later limits women to lower-paying, less challenging jobs. Women enroll in food and nutrition, nursing and midwifery, teacher education and social work, while men enter the more lucrative professions such as law, engineering and architecture.

It is in the employment arena, then, that the problems become evident. Just 52.3 percent of the female population 15 years and over were in the labor force in 1993, in contrast to 86.0 percent of men. In 1996, women comprise a low 36.0 percent of all employed persons and a high 41.0 percent of all *unemployed*. They tend to hold jobs in lower skill categories--despite their higher educational attainment. For example, in 1995, they represented only 32.8 percent of those holding managerial and executive jobs. And accordingly, they get lower pay. Their earnings were only 47.0 percent of men's earnings in 1992.

Women also have a long way to go in public life. Although the Philippines has had a woman president, politics remain male-dominated, with women occupying just 13 percent of all elective positions in 1995. In Congress, they hold four out of 24 Senate seats and 19 out of 202 House seats. In government, women constitute a majority of career service employees, but only 26.6 percent of senior (third level) positions are held by women.

In short, Filipinas do not suffer the blatant forms of discrimination that are evident in some countries, but there is still a long agenda for them to achieve true equality.

II. PROGRAMS RELATED TO POPULATION, HEALTH & NUTRITION

A. The Health System in the Philippines

The Government Sector

In the past, DOH employed all government health workers and managed a nationwide network of hospitals and health centers around the country. With the enactment of the Local Government Code of 1991 (RA 7160), which decentralized many central government functions, including health, the DOH role no longer centers on the direct provision of health services. Instead, it focuses on the formulation of plans, policies and programs, standard setting, resource allocation, monitoring and evaluation, studies and research, data management and technical assistance to implementing agencies in the field through training and consultation. This is done through the DOH central office in Manila and 16 regional offices. The LGUs, meanwhile, are the primary providers of health services. Within the Central Office, a reporting scheme was adopted pending DOH reorganization.

The LGUs--that is provinces, cities and municipalities--now have primary responsibility for planning, managing and evaluating health services in their jurisdictions and employ most health personnel.

- Provinces provide services directly through provincial and district hospitals;
- Municipalities are responsible for the rural health units (RHUs) and barangay health stations (BHSs) that are the major providers of public health services.
- Cities provide services directly both through hospitals and their main health center networks.

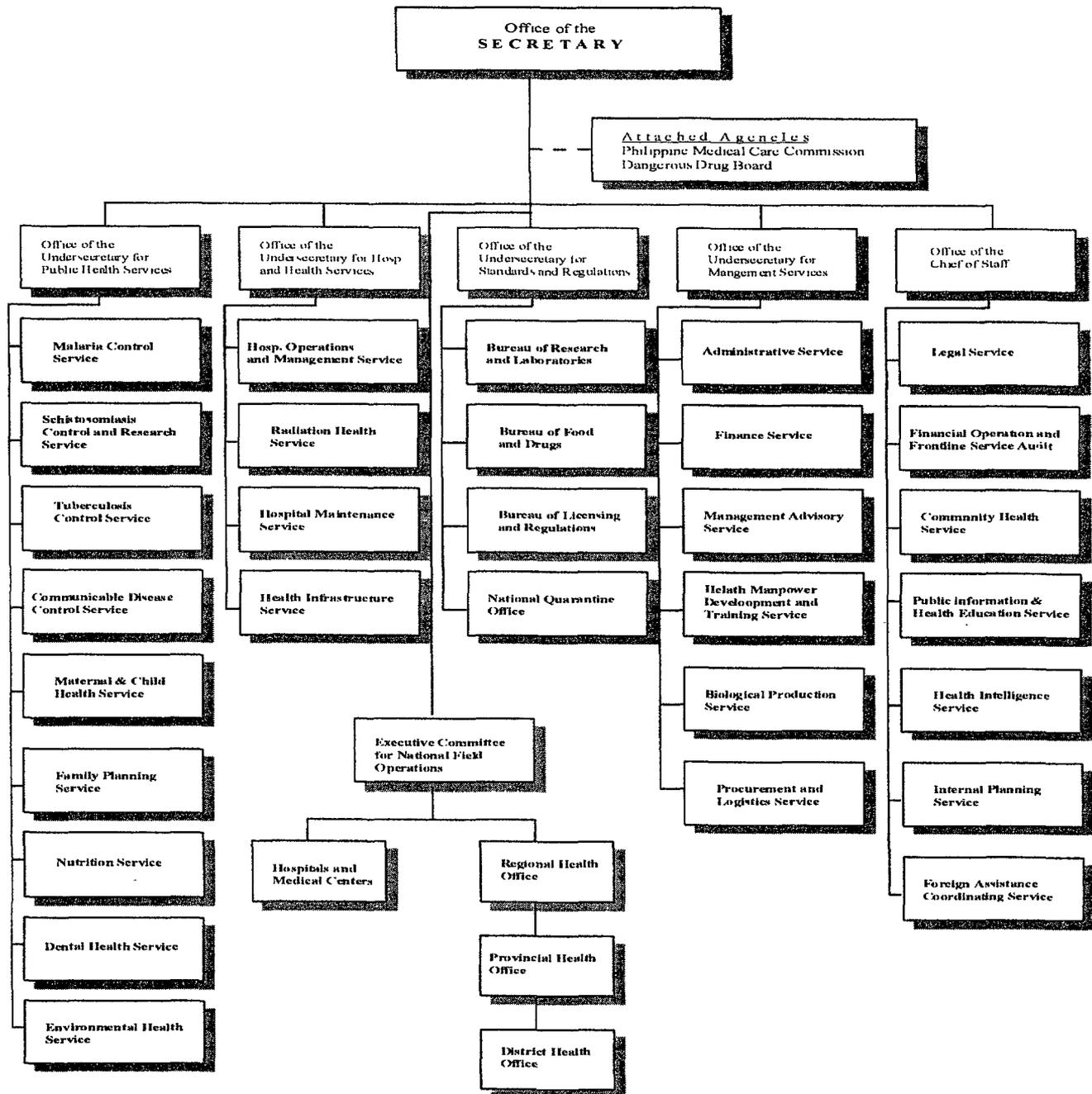
DOH remains involved in service provision only through its retention, even after devolution, of the regional hospitals and medical centers.

The chief link between DOH and the LGUs is a Comprehensive Health Care Agreement (CHCA), undertaken every two years, which sets out the two parties' programmatic and financial contributions to meeting national health goals and provides a framework for collaboration. Where additional funds are made available from donors, a supplemental Memorandum of Agreement is appended to the CHCA.

The government health network is large. In 1994, there were about 2,350 RHUs and 11,500 BHSs and about 500 public hospitals. Prior to the implementation of devolution, in 1993, the government employed 6,900 doctors, 8,850 nurses and

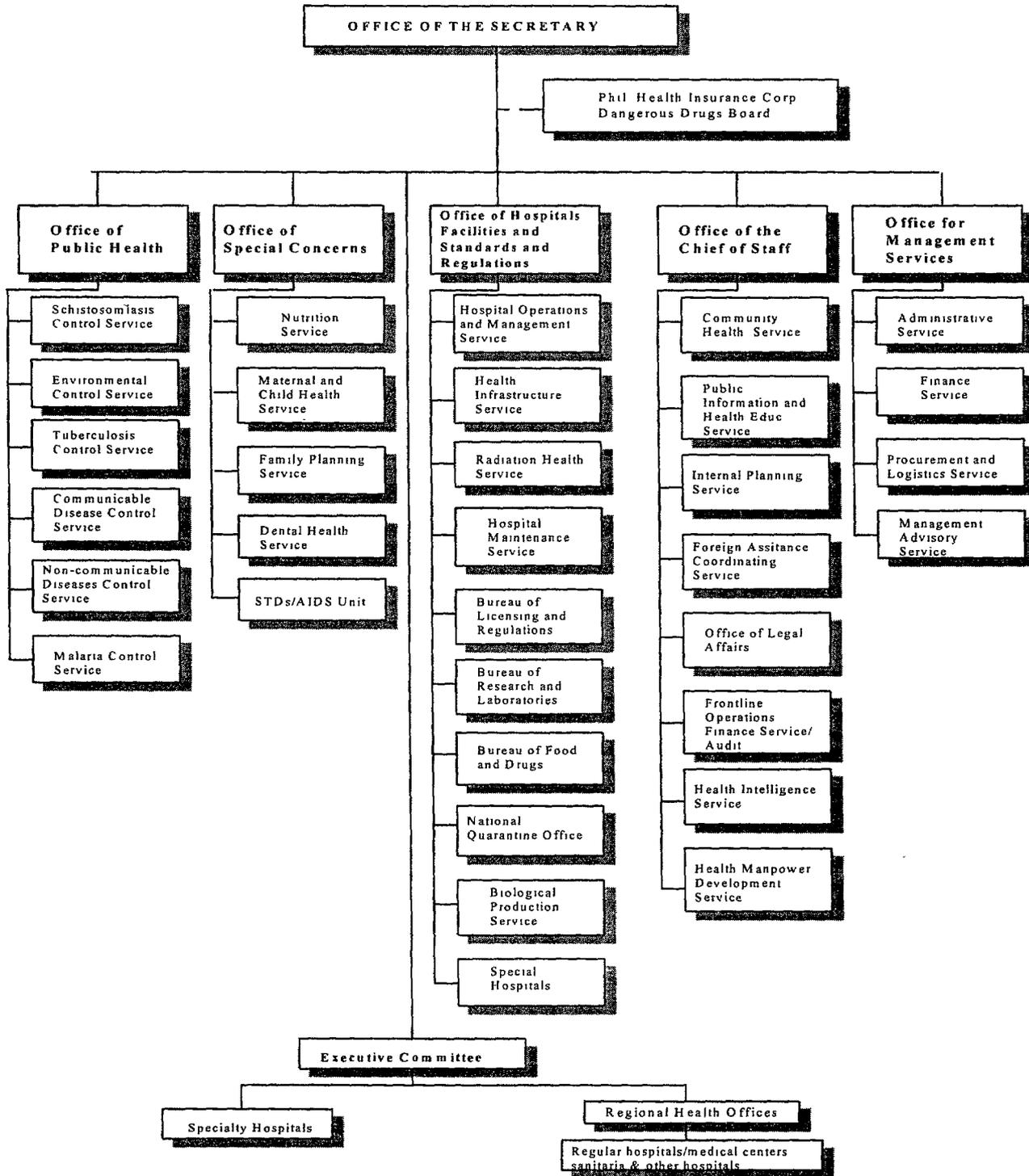
10,800 midwives. With the implementation of devolution a year later, most of these personnel were taken over by the LGUs; DOH retained just 2,500 doctors, 2,700 nurses and less than 100 midwives.

CURRENT DOH ORGANIZATIONAL CHART



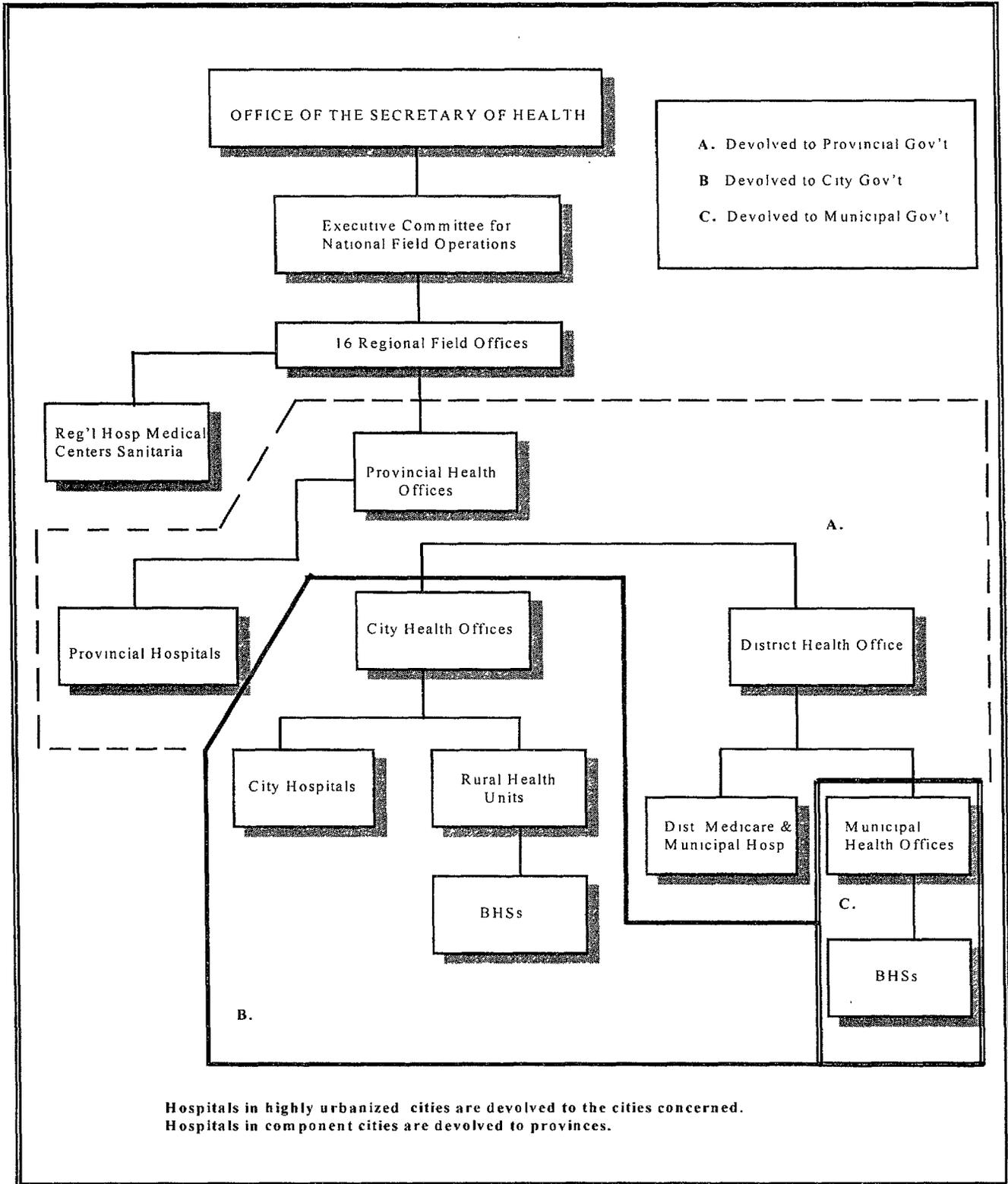
Note: Based on E.O. 119

DEPARTMENT OF HEALTH
REPORTING SCHEME



Memorandum Order 27 s 1992, Streamlining of agency operations and organizations
DOH AO 16 s 1993, Reporting scheme in accordance with the DOH streamlining per MO 27
DOH AO 15 s 1997, DO 44 s 9197, DO 257-A s 1997 on reassignment of service and programs

THE DEVOLVED HEALTH SYSTEM



Hospitals in highly urbanized cities are devolved to the cities concerned.
Hospitals in component cities are devolved to provinces.

The devolution of health services created a host of problems that are now beginning to be resolved. Many health workers received fewer benefits from the LGUs than from DOH and this led to (unsuccessful) moves to renationalize health personnel. Staff in many parts of the country, however, remain demoralized and often refuse to submit data to DOH to show their dissatisfaction with devolution--with sad consequences for DOH's information systems. LGUs often did not budget adequately for health services which, in turn, suffered. Difficulties arose with respect to procurement issues. Links between provinces and municipalities were often disrupted. In short, neither DOH nor the LGUs were properly prepared for devolution. However, rapid assessments conducted under USAID's Governance and Local Democracy Program have found that LGUs are not only overcoming these problems but are developing innovative programs that respond to locally-identified health needs.

In addition to the DOH/LGU network, there are a number of other government organizations that also provide family planning, MCH and nutrition services. These include the Department of National Defense that operates clinics for military personnel and their families, some offices of the Department of Labor and Employment (DOLE), and DOLE-associated industrial clinics, Fabella Memorial Hospital, the University of the Philippines General Hospital and Malacanang Tulungan clinic. The Departments of Agriculture and Social Welfare and Development, as well as other agencies, also provide related, mostly informational and referral, services.

The Private Sector

The private sector plays an important role in providing hospital services, with about two thirds of hospitals and half of beds privately owned in 1990. It plays a very small role in the provision of family planning, MCH and HIV/AIDS/STD services, by contrast, judging from data from the NDS, SMS and NSO's 1995, 1996, and 1997 Family Planning Surveys as well as data from contraceptive distribution and sales.

Non-governmental organizations (NGOs) pioneered the provision of family planning/MCH services in the Philippines and, while they are a very small piece of the pie in terms of CPR, they continue to play a significant role, particularly in program innovation. They have used creative strategies to reach young and unmarried people, men in the workplace and women with health risks. They pioneered the concept of "franchised midwives" and have been active in advocacy on population and family planning issues. The largest NGOs, all national in scope, are the Institute of Maternal and Child Health (IMCH), the Family Planning Organization of the Philippines (FPOP) and Integrated Maternal and Child Care Services and Development, Inc. (IMCCSDI). All three provide family planning training, services and information, education and communication (IEC) in the context of MCH services. There is also an umbrella organization for NGOs in population and family planning, the Philippine NGO Council on Population, Health and Welfare (PNGOC).

Companies with more than 200 employees are required by law to make family welfare services available to their employees and many companies provide family planning and MCH services under this mandate. Although these companies, like the NGOs, don't make a large contribution to CPR, they have found creative ways of reaching men and educating workers about responsible parenthood.

The private commercial sector -- which encompasses private physicians, nurses and midwives; private hospitals and clinics; drug stores and pharmacies and other providers -- contributes modestly to CPR. Table 7 gives a detailed break-out of the contribution of all sectors. It is clear from that table that the private/NGO sector is not keeping pace or increasing its share of contraceptive prevalence.

Health Expenditures

Total national health care expenditures have been estimated at 29.5 billion pesos in 1991--or 2.4 percent of GDP--as can be seen in Table 10. The largest share of these expenditures (39.4 percent) was financed by the national government, with an additional 4.7 percent coming from local governments. After government, households played the largest role, paying out-of-pocket for 38.3 percent of expenditures. Medicare, together with employment compensation, financed 11.8 percent of expenditures, while an additional 5.7 percent was financed by health maintenance organizations (HMOs) and private insurance. Not included in these figures are expenditures by businesses, private schools, community financing schemes and philanthropic organizations.

Table 10: Estimated Total Health Care Expenditures by Source of Financing, 1991

	Millions of Pesos	Percent of Total
Government		
National	11,638.7	39.4
Local	1,379.8	4.7
Social insurance		
Medicare	3,112.6	10.5
Employment compensation	397.4	1.3
Private		
Out of pocket	11,316.3	38.3
Private insurance	1,245.8	4.2
HMOs	450.4	1.5
Total	29,540.9	100

Note: Percentages may not add due to rounding

Source: R. H. Racelis and A.N. Herrin, "National Health Accounts of the Philippines: Partial Estimates as of November 1994," paper prepared for the conference, "Pesos for Health Part Two: Emerging Results of Current Research on Health Care Reform," December 8-9, 1994.

Data are available for 1993 health care expenditures which show the central government contribution declining to 8.7 billion pesos, as might be expected in light of

devolution, while social insurance and HMOs increased their contribution to 4.6 billion and 563 million pesos respectively. Data on local government expenditures in 1993 are not yet available.

Turning to the DOH budget for 1993, researchers at the University of the Philippines School of Economics estimate that the GOP allocated about 1.1 billion pesos and this sum was nearly doubled by over one billion pesos of donor commitments, for a total budget of about 2.1 billion pesos that directly supported DOH programs. The GOP contributed about 52 percent of the direct funding for DOH program.

USAID was the largest contributing donor, committing over 390 million pesos in 1993, or 18.3 percent of the total 2.1 billion peso program budget. The next largest donor was the World Bank, with about 300 million pesos, or 14.1 percent of the total program budget, followed by United Nations Fund for Population Activities (UNFPA) at 6.3 percent of the total. The Canadian International Development Agency (CIDA), Rotary International and Australian government each contributed about two percent. All other donor agencies combined accounted for about four percent of total program budget.

The DOH budget tends to emphasize curative care, rather than cost-effective primary and preventive health care interventions. The 1997 General Appropriations Act, for example, provides an operations budget for the department of which 79 percent of the funds are allocated for health facilities and operations--which, since devolution, means primarily regional hospitals and medical centers--while just 21 percent are allotted for public health services and primary health care. This situation is more skewed than in 1996 when curative care received 77% and public health/primary health care received 23%. It should be kept in mind, however, that external donors tend to support public health programs, bringing a better balance to the overall picture.

B. Philippine Population Management Program

Background

The first official action of the Philippine government on population was the signing by President Marcos of the United Nations (UN) Declaration on Population in 1967, recognizing population as a principal element in long-range national planning. The Commission on Population (POPCOM) was created in 1969 and mandated to conduct studies and recommend population policies and programs. The following year, the National Population Program was launched, with fertility reduction as its major thrust and with POPCOM reorganized to serve as the central coordinating, planning and policy-making body for population and family planning matters. It was in the 1971-74 Four-Year Development Plan that explicit population growth targets were first established. In 1971, RA 6365 was enacted establishing a National Population Policy

that recognized the socio-economic challenges posed by rapid population growth and respecting the religious convictions of individuals. From 1970 to 1988, the history of the population and family planning programs are closely intertwined, as POPCOM took on the direction of the national family planning program. In 1989, however, the responsibility for managing the national family planning program was transferred to DOH.

Over the years, there were repeated moves to broaden the concern of the population program to family welfare. When a new Philippine Constitution was ratified in 1987, after the EDSA revolution, a new population policy was also articulated, broadening population concerns to encompass not only fertility reduction but also family formation, the status of women, MCH, child survival, morbidity and mortality, population distribution, migration and population structure. In 1989, POPCOM's five-year plan identified two major thrusts for the population program: the integration of population into development, for which POPCOM was to have the lead role, and family planning, for which DOH was to be responsible. President Ramos established the policy for the new population program in 1992 when he said "Our Population Management Program aims to help achieve a healthy balance between our population and resources for the welfare of our children, in line with our vision of Philippines 2000." The Philippine Population Management Program is now conceived with a framework of balancing population, resources and environment and "seeks to improve the quality of life of Filipinos through rational population growth and distributrion, balanced with providing the people resource requirements while at the same time ensuring ecological integrity and environmental protection."

POPCOM's mandate, then, is "to formulate policies and to develop, coordinate, and monitor programs aimed at ensuring the effective management of the country's population such that all individuals can be assured of a decent and dignified quality of life." The commission itself is composed of a 15-member Board of Commissioners from 11 government agencies, the University of the Philippines Population Institute and three private organizations. POPCOM has 15 regional offices. There are counterpart offices at the LGU level and a national survey conducted by POPCOM to measure LGU commitment and support to the population program revealed that 144 LGUs have either a population office or a person designated to take care of population-related projects and activities. However, the future of these offices is still uncertain since the Local Government Code (LGC) of 1991 makes the position of population officers at the provincial and municipal levels optional. Meanwhile, efforts are being made to amend the provision under the Local Government Code of 1991 for the mandatory installation and maintenance of population offices in every local government unit.

Another survey to measure LGU commitment to the population/family planning program will be conducted by POPCOM after the May 1998 election.

Program Description

POPCOM is responsible for management of the Philippine Population Management Program (PPMP) which has five component programs:

- *POPDEV Planning*

Population and development (POPDEV) explicitly considers population and development concerns at the macro- and micro-policy and planning levels. POPCOM and NEDA undertake capacity-building activities targeted to national and local executives, legislators and development planners.

- *Family Planning/Reproductive Health (FP/RH)*

Individuals have a basic right to information and services related to family planning and reproductive health. DOH, which has lead responsibility for this aspect of the population program, is reorienting the family planning program using a reproductive health approach. Regional and local population offices work with DOH and local health care providers to ensure that information and services on family planning and reproductive health are accessible. POPCOM takes responsibility for advocacy for family planning/reproductive health. Essentially, this program is designed to effect universal access to quality care, FP/RH information and services.

- *Adolescent and Youth Development*

POPCOM's Adolescent and Youth Development Program brings together key players--service organizations in the social development sector, legislators and local executives, church-based groups, business people, parent groups, media and youth--to develop and implement a national program for youth. An IEC campaign is being developed to communicate core messages for youth on gender equity and women empowerment, population and sustainable development, aging, the environment, reproductive health rights and productivity. This program will contribute in lessening the extent of adverse consequences from risky sexual behavior of adolescents.

Population education (PopEd) is delivered through the basic education system spearheaded by the Department of Education, Culture and Sports (DECS). POPCOM and others participated in the development of an enriched PopEd curriculum covering reproductive health, adolescent health. A major effort undertaken toward addressing youth concerns includes a well-managed and values-focused Population Education Program of the Department of Education, Culture and Sports.

- *Gender*

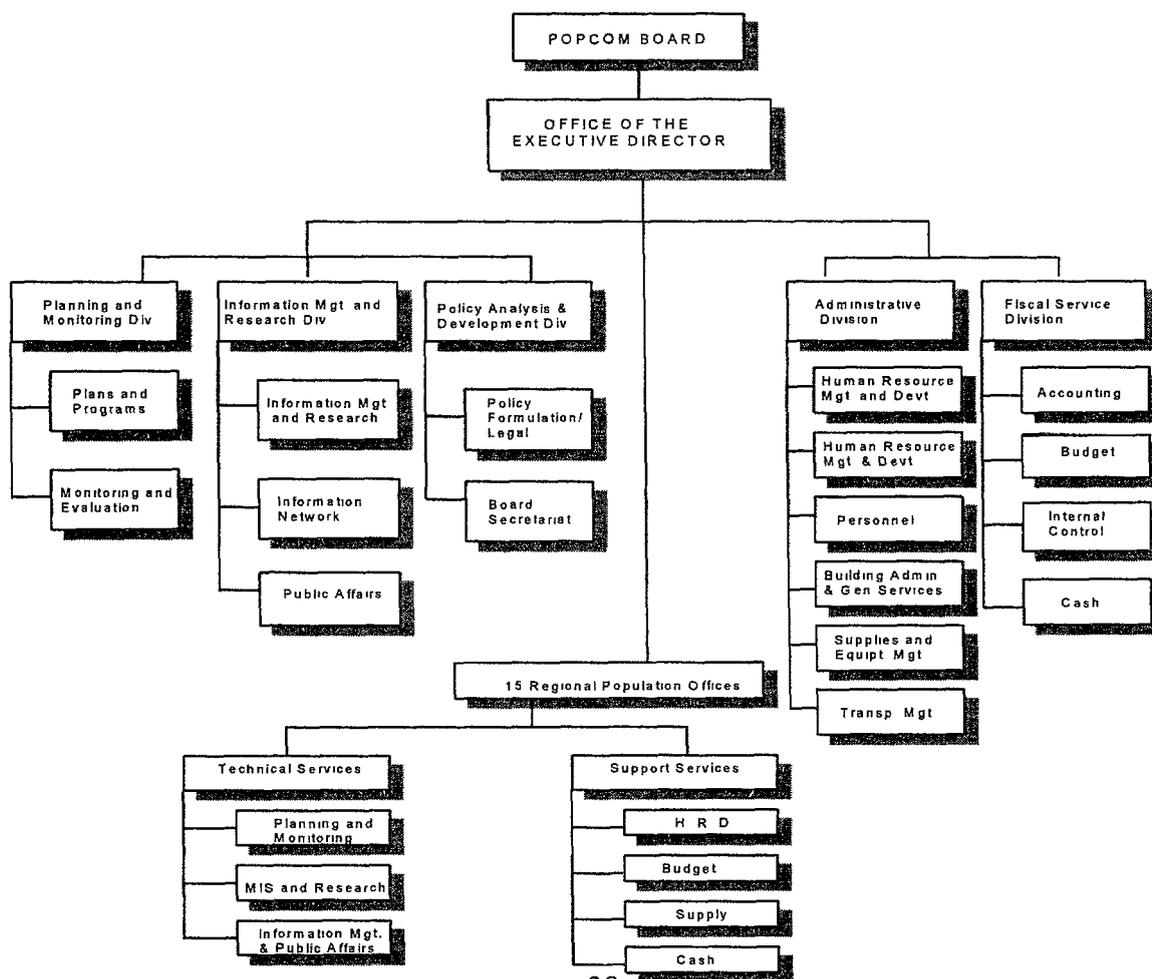
The PPMP promotes awareness of gender issues because women can be an important

driving force towards development if given equal opportunity and access to assistance to groups within and outside government and through policy studies and advocacy. This program will try to measure the extent of male-female sharing in fertility management, child care and household management.

- *Migration and Urbanization*

The PPMP aims to achieve quality of life through rational population distribution given available resources and the carrying capacity of the natural environment. POPCOM advocates “forward planning” particularly regarding population projections and development trends and the corresponding investment programs needed to provide appropriate types and levels of infrastructures, utilities, services and land use patterns. This program can be operationalized through the formulation of POPDEV sensitive development plans and advocacy directed towards concerned individuals and agencies.

COMMISSION ON POPULATION
ORGANIZATIONAL/FUNCTIONAL CHART



The POPCOM Secretariat and a group of population experts are considering whether gender, migration and urbanization, and adolescent and youth development should be subsumed under the first two program areas - POPDEV Integration and FP/RH. This issue will be taken up with the Board later this year,

Across these five program areas, POPCOM is responsible for the following activities:

- *Population Planning*

POPCOM coordinates the formulation of the long-term, medium-term, and annual plans of the population program. It defines the vision, objectives, strategies and the activities of the program for a given planning period. It employs a planning approach in which partner agencies in the program and local government units are heavily involved, e.g., the Pledges of Commitment of the national agencies, and technical assistance (TA) to the LGUs.

- *Policy Formulation and Analysis*

POPCOM is responsible for formulating policies designed to increase the effectiveness and ensure the success of the PPMP. It formulates policies in conjunction with other government agencies to provide direction regarding the agencies participation In the PPMP. It reviews existing policies and makes recommendations for new policies for national, regional, and local bodies to provide guidance in the implementation of the PPMP.

POPCOM is also responsible for policy analysis. It identifies issues for policy action, and conducts research to obtain data. The research findings are widely disseminated to appropriate audiences to either formulate their own policies or to influence other agencies to formulate policies to address problems that are encountered in the implementation of the PPMP.

- *Advocacy*

One of POPCOM's main responsibilities is advocacy. It has developed a five year National Population and Development Advocacy Plan as well as annual implementation plans. Among other issues, POPCOM advocates for creation of a supportive environment for the PPMP, to strengthen the commitment a government and private organizations to the PPMP, and to influence national and local government decision makers to increase funding for the PPMP.

- *Technical Assistance*

POPCOM provides TA to national and local government agencies so they can fulfill their roles in the PPMP. It provides TA in planning, monitoring, advocacy, and policy

analysis and formulation as well as in other- aspects of implementation of the PPMP.

- *Monitoring and Evaluation*

POPCOM undertakes the regular monitoring and evaluation of the five-year directional plan. The Directional Plan includes a monitoring and evaluation plan that lists the five objectives of the plan, and Indicators and data sources where those indicators can be found. It is expected that the monitoring and evaluation plan will be periodically reviewed and updated when necessary.

Major Accomplishments:

- POPCOM has been made a member of the primary committees dealing with socio-economic development including the Philippine Council for Sustainable Development, Human and Ecological Security Councils, the Social Reform Agenda and local reform councils.
- POPCOM along with DILG championed the 1995 Presidential Directive on Human and Ecological Security that directed LGUs to set aside 20 percent of 20 percent of the Internal Revenue Allotment allocated Human and Ecological Security for allocation for population, environment and peace initiatives.
- National government agencies made a Pledge of Commitment in 1996 to integrate population concerns into their plans, programs, projects and activities. This has been translated into commitments by the regional offices to move ahead with population activities. POPCOM is currently working to institutionalize these within the various agencies.
- Collaboration with Congress in the drafting of legislation introduced in both houses to strengthen POPCOM by broadening its mandate and enabling it to better coordinate a revitalized population policy and program.
- POPCOM worked to ensure that access to family planning was incorporated as a Minimum Basic Need and LGUs' progress on this will be assessed regularly,
- POPCOM has conducted two post-election surveys of elected officials to determine their positions on population and family planning issues and thus guide decisions about where to target program activities and how to allocate resources. Two more surveys, one national and one local, will be conducted after the 1998 elections.
- POPCOM has developed national and regional computer-based presentations for policy makers at all levels outlining the relationship of population to development concerns.

- A program has been institutionalized to give annual awards to outstanding LGUs that have contributed in a significant way to local population management programs.

The Philippine Population Management Program (PPMP) has come a long way over the past years since it went through a "paradigm shift" with the adoption of the Population Resources and Environment (PRE) framework and made improved quality of life and sustainable development as its overriding goals. It has gained new capabilities and a new vitality that has led to enhanced credibility among government agencies.

While virtually all government agencies have some role to play in the implementation of the PPMP, it is POPCOM that has been responsible for bringing the PPMP to the forefront. Over the past years, POPCOM continues to perform its mandate as the overall coordinating, monitoring and evaluating, policy-making and advocacy body of the country's population program. Concomitantly, it has strengthened its linkages with the government (national and local) and non-government agencies towards the attainment of its objective which is to achieve a balance between and among population, resources and environment towards sustainable development.

Issues and Constraints

- While POPCOM has shifted from the lead role in the national family planning program to coordinator of the PPMP, POPCOM staff need further skills development in order to undertake the activities that currently fall under its mandate.
- Although legislation clarifying POPCOM's new role has been drafted and introduced in Congress, it has not been enacted. In the meantime, there is still a need to heighten advocacy activities about the agency's new role. At the local level, there is also a need to address the frequent misunderstandings between LGU population and health officers and staff over their roles and functions, and to help them understand the roles of POPCOM and the DOH,
- In the wake of enactment of the Local Government Code of 1991, LGUs have the option of whether or not to have a local population office. This means that POPCOM must conduct continuous training and advocacy activities in an effort to ensure that local chief executives are made aware of population issues and support the maintenance of a local population office.
- The opposition of certain religious groups to population programs remains a serious barrier to program implementation and policy activity. This is because many elected representatives fear that they will lose the support of key constituencies if they support population policies or programs.

Program Funding

In 1996, a total of 108.1 million pesos was spent for POPCOM activities both at the central and regional level. About 75 percent of these expenditures came from the GOP with the remainder provided by external donors namely: UNFPA, USAID, Ford Foundation and JICA.

Approximately 159.0 million pesos was the estimated POPCOM expenditure in 1997. Of this figure, about 63 percent was GOP expenditure, while a significant contribution of 23 percent was attributed to UNFPA, 12% to USAID and about 2 percent came from other donor agencies mentioned above.

Table 11: Estimated Commission on Population Expenditures for 1996 and 1997 (Estimated) (in Pesos)

	1 9 9 6		1997 (Estimated)	
	Pesos (In Million)	% of Total	Pesos (In Million)	% of Total
GOP	81.0	75%	100.3	63%
UNFPA	12.6	12%	36.1	23%
USAID*	11.4	10%	19.4	12%
Ford Foundation	1.5	1%	1.7	1%
JICA	1.6	2%	1.5	1%
Total	108.1	100%	159.0	100%

* Support to PopCom provided by The Futures Group/Policy Project, including TA, workshops, travel, as well as subgrant to PopCom.

USAID support to POPCOM is through the Policy Project. Extensive national and LGU-focused advocacy activities are supported as well as long and short term technical assistance, workshops, and training.

POPCOM receives important support from UNFPA through several projects:

- The National Advocacy Campaign for POPDEV runs from 1995 to 1999 and is budgeted at \$1.3 million. It seeks to enhance public awareness and generate multi-sectoral support for the country's population management program through advocacy activities intended to create a conducive policy and program environment for the country's population and development goals.
- The program to Strengthen the Policy, Planning Coordination and Monitoring of Adolescent Fertility and Youth Development runs from 1995 to 1999 and is budgeted at \$1.4 million.

- POPDEV Planning at the Local Level runs from 1996 - 1998, with a budget of \$1.6 million and aims to assist in the development of sustainable local development plans.
- Population Policy Operations Project runs from July 1996 to March 1999 and is budgeted at \$469,000.

UNFPA also supports population programs in other sectors, for example Strengthening and Revitalizing of the Population Education Program, funded at \$545,000 over the period 1996 - 99. This project works with the Department of Education, Culture and Sport on school-based population education programs.

C. The Philippine Family Planning Program (PFPP)

Background

Family planning services first became available in the Philippines in the 1950s, under the auspices of private voluntary agencies. It wasn't until 1968, however, when the Project Office for Maternal and Child Health was created in the DOH, that the public sector became involved, providing services at government clinics, while NGOs focused on expanding services to areas that government facilities could not cover.

During the 1970s and early 1980s, under the leadership of POPCOM, the Philippines had one of Asia's most successful family planning programs. Established in 1969, POPCOM gradually took on tasks originally carried out by DOH, at the same time as assuming the dominant role in the development of population policy. Concluding that the clinic-based strategy offered inadequate accessibility to services for the majority of people, the Philippine Family Planning "Outreach Project" was launched in 1976. Outreach was initially funded by USAID but, by 1986, nearly 95 percent of local governments had assumed financial responsibility for the program. Although the Outreach Project was highly successful, other sectors suffered from being neglected during its growth. DOH and the NGOs continued to provide clinical services, but received little attention.

Starting in the mid-1980s, serious difficulties arose. There was a drop-off in high-level political support toward the end of the Marcos administration and in the early years of President Aquino, and economic stagnation, growing political discontent and increasingly strong opposition from the Catholic Church crippled the family planning program. Its very existence, strategies and thrusts were questioned. By 1988, the program had withered, with no real services in the public sector and very little in the NGO sector.

A turning point came when President Aquino was shown the rising maternal mortality rates after the withdrawal of family planning services under her administration and she allowed the Secretary of Health to reinstitute services as a health measure. In 1989, responsibility for family planning was transferred to DOH, while POPCOM's mandate was to concentrate on population policy. By that time, the department had to begin almost from scratch, but it moved forward, training large numbers of DOH staff and taking steps to increase service delivery. Nevertheless, it was a weak substitute for POPCOM and, to address these weaknesses, DOH established a Technical Secretariat of the PFPP charged with recommending technical policy, developing program guidelines, coordinating public and private (largely NGO) efforts and assuring compliance with all national program standards. However, the director of the Technical Secretariat had no authority over the head of FPS and the establishment of the secretariat resulted in a family planning program speaking with two voices.

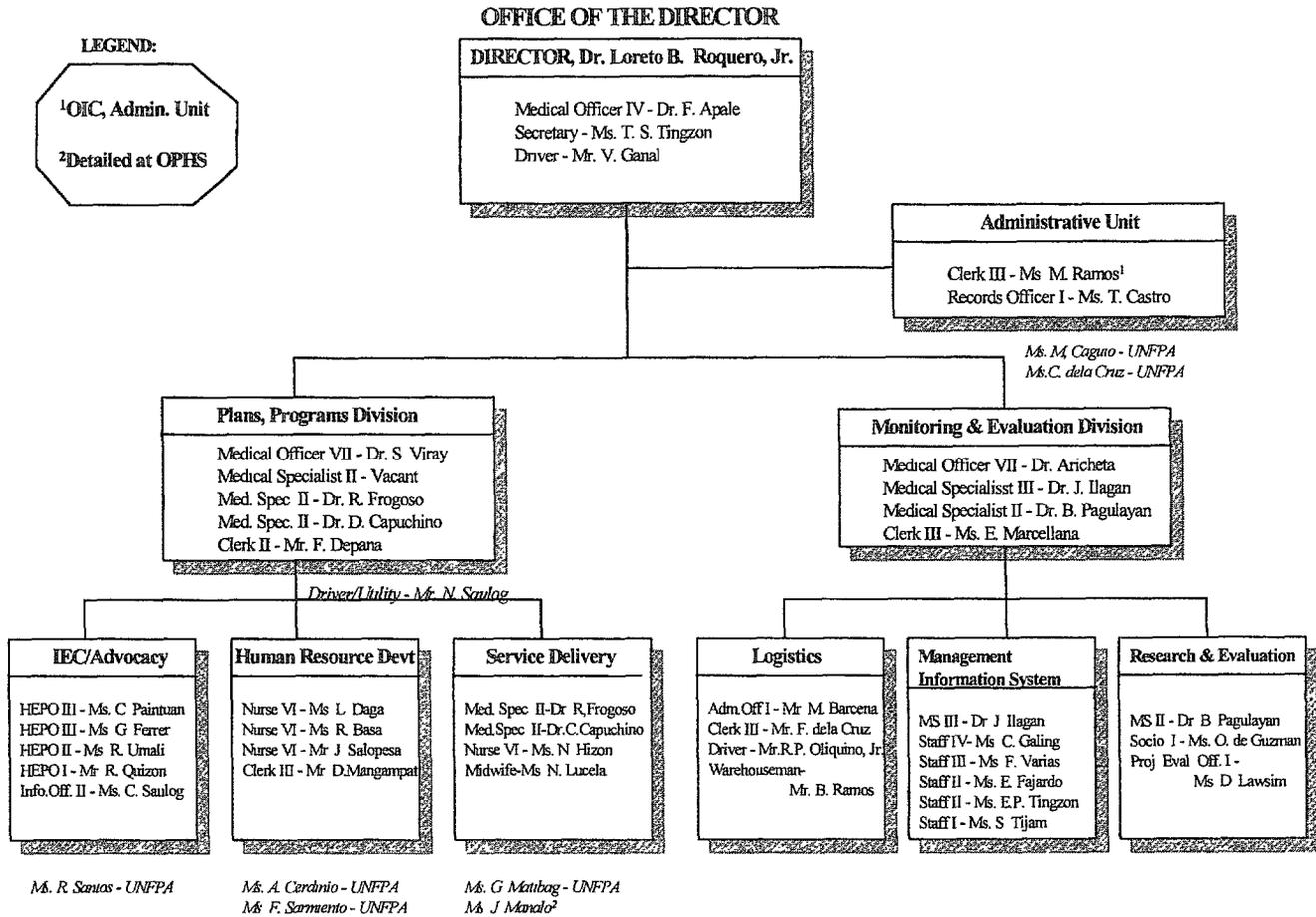
When President Ramos was elected in 1992, the new administration inherited the bifurcated leadership on family planning within DOH, an NGO sector on the verge of collapse, plus a POPCOM still unreconciled to the loss of responsibility for family planning services. However, the President and his Cabinet were open in their support of family planning and population activities and, particularly under Secretary of Health Juan Flavio Velasco (1992 - 95), family planning became a priority program. The Technical Secretariat was disbanded, leadership of the PFPP was consolidated in DOH's Family Planning Service (FPS), private sector participation was encouraged and the program was poised to move forward.

Program Description

The PFPP is one of the nationally mandated priority public health programs that support the country's health and development goals. In accordance with Article XI, Section 3 of the 1987 Constitution, which provides for the right of spouses to found a family in accordance with their religious convictions and the demands of responsible parenthood, the program is strictly voluntary. It rejects abortion as a method of family planning in line with the constitutional prohibition on abortion.

The family planning program's overarching objective is to satisfy the unmet need for services, both among women for whom pregnancy presents health risks and among couples who *desire* to prevent an unplanned pregnancy.

FAMILY PLANNING SERVICE
Position Chart
By Section and Function and Contractual (Internal)



The PFPP is coordinated by DOH's FPS but LGU-operated health centers and hospitals provide the bulk of services, although DOH-retained hospitals also contribute. In some areas, volunteers also play an important role in outreach or community-based distribution. These may be Barangay Service Point Officers (BSPOs) associated with POPCOM or Barangay Health Workers (BHWs) who work with rural midwives in BHSs. A variety of other "Participating Agencies" also provide services:

- **NGOs.** There are national NGOs (known as traditional NGOs), the largest of which are FPOP, the local affiliate of the International Planned Parenthood Federation (IPPF), IMCH and IMCCSDI. Small, local NGOs also participate.
- **Industrial clinics.** Companies with more than 200 employees are required by law to make family welfare services available to their employees.

- Other government organizations. These include the Department of National Defense that provides services to its employees and their families, UPPGH, Malacanang Tulungan Clinic, provincial and city population officers who manage a network of volunteers, the Department of Labor and Employment that encourages private industries to open clinics and a variety of other government organizations that offer services to their employees.

It is estimated that, at the end of 1995, there were some 15,400 outlets around the country providing family planning services--excluding agencies that do not provide a full range of services (e.g. NFP providers or information providers only) and volunteer health workers.

In addition to government health centers and hospitals and the other Participating Agencies, the commercial sector also provides services--though to a limited extent. The "true" commercial sector sells products or provides services at unsubsidized rates, through pharmacies, private practitioners, private hospitals and clinics and elsewhere. Within the commercial sector, "social marketing" provides some measure of subsidy or support for certain sales, with a view to promoting purchases in the lower middle-income groups.

The main components of the PFPP are:

- *Logistics*, which ensures that contraceptives are available in government health centers and hospitals as well as other Participating Agencies of the PFPP such as NGOs, industrial clinics and other government organizations. This system is known as the Contraceptive Distribution and Logistics Management Information System, or CDLMIS.
- *Information, Education and Communication (IEC)*, which seeks to heighten awareness of the benefits of family planning services and encourage utilization of services. It uses a variety of strategies, including an annual National Communications Campaign, the development of printed materials, interpersonal communications and other means. There is also a special effort to work with LGUs in the development of their own IEC programs.
- *Human Resources Development*, which provides training for frontline health workers (doctors, nurses and midwives), field supervisors and program managers, volunteers and the staff of NGOs and other government organizations. Courses are offered in clinical skills, IEC, program monitoring, quality assurance and other subjects.
- *Service Delivery*, which focuses on the provision of safe, effective and legally acceptable family planning methods, providing standards and guidelines to the field, overseeing the accreditation of family planning providers and monitoring new

developments in the medical arena. In addition to contraception, relevant laboratory examinations, such as Pap smears, wet smears, gram staining, pregnancy testing and urinalysis are also provided.

- *Research and Development*, which encompasses clinical, community and operational studies, many conducted in collaboration with research institutions. There is a special focus on operations research to improve programs at the national and local levels.
- *Evaluation*, which focuses on the quality of care, using monitoring and supervision as tools.
- *Management Information Systems (MIS)*, which track the accomplishments of the agencies participating in the PFPP in terms of services provided, training, IEC and other facets of the program.

The range of methods provided by DOH and LGUs are one combined oral contraceptive pill (Lo Gentrol), a condom, the TuC 380A IUD, the DMPA injectable, modern NFP and the lactational amenorrhea method (LAM) as well as male and female VSS. The DMPA injectable was re-introduced to the program in 1994/95, after having been introduced in the late 1980s and then withdrawn because it had not been approved for general use by the Bureau of Food and Drugs (BFAD). While the PFPP has been providing NFP for a number of years, the methods included were calendar, rhythm and withdrawal. Modern NFP is only beginning to be introduced in an organized way. VSS is provided almost entirely in hospitals and the IUD is generally available only at the RHU level, in hospitals and some NGOs. A wider range of brands and methods, most particularly of pills and condoms, is available in the private sector.

In line with the recommendations of the 1994 International Conference on Population and Development and the 1995 International Women's Conference, DOH has recently created a "Philippine Reproductive Health Program." The following primary health care services have been identified as the elements of Reproductive Health Care package.

1. Family Planning
2. Maternal and Child Health and Nutrition
3. Prevention and Management of Abortion Complications
4. Prevention and Treatment of Reproductive Tract Infections (RTIs) including STDs, HIV and AIDS
5. Education and Counseling on Sexuality and Sexual Health
6. Breast and Reproductive Tract Cancers and other Gynecological conditions
7. Men's Reproductive Health
8. Adolescent Reproductive Health
9. Violence Against Women

10. Prevention and Treatment of Infertility and Sexual Disorders

The DOH is currently developing its Medium Term Plan and 1998 Operational Plan for this Program.

Couple-Years of Protection (CYPs) Provided

For years, DOH has collected data on new acceptors and current users of family planning served by government and other Participating Agencies. In response to the virtual collapse of DOH's service statistics system in the wake of devolution, and concerns about the accuracy of the data generated by that system, the FPS introduced couple-years of protection as a measure of annual program accomplishment in 1996³. It is thought that the CYP data based on CDLMIS contraceptive distribution figures and on commercial sales of contraceptives are relatively reliable, although they do have some limitations. CYPs based on DOH's service statistics on VSS, NFP and LAM, however, are thought to have a number of weaknesses and are based to a great extent on estimates.

In 1996, the organized family planning program--meaning government facilities operated by the DOH, the LGUs and other government organizations, by NGOs and other Participating Agencies that receive free contraceptive supplies from DOH--provided 1.88 CYPs. Of these CYPs, 39.8 percent came from pills and 28.1 percent from IUDs. Other methods played a much smaller role: 9.4 percent from injectables, 7.7 percent from VSS, 7.8 percent from condoms, 4.7 percent for NFP and 2.5 percent for LAM.

Compared with 1995, the organized program provided 1.0 percent less CYPs in 1996, with decreases for all major methods except injectables. There was a 12.6 percent increase in the injectable, which is to be expected given DOH's initiatives to reintroduce the method since 1994-1995. NFP and LAM appear to have increased substantially, but the figures may also include traditional methods, such as withdrawal and rhythm, in addition to modern NFP. VSS decreased by 10.0 percent from 1995 to 1996. There was also a drop of 11.4 percent in CYPs from the IUD, possibly due to

3 CYPs provide a measure of family planning program accomplishment. They are calculated from the number of contraceptives distributed and sold in a one-year period and, for methods that do not depend on contraceptive supplies (i.e. VSS, NFP and LAM) from service statistics. The conversion factors used to calculate CYPs in the Philippines are:

15.39 cycles of pills	=	1 CYP
91.2 condoms	=	1 CYP
1 IUD	=	3.56 CYPs
4.55 vials of 3-month injectables	=	1 CYP
7.2 vials of 2-month injectables	=	1 CYP
105 foaming tablets	=	1 CYP
1 trained user of natural family planning	=	1.55 CYPs
1 user of LAM	=	0.25 CYPs
1 VSS procedure	=	8.11 CYPs

One CYP is equivalent to one imaginary couple using a method consistently over a one year period.

public misperceptions of this method, to women shifting from IUDs to the injectable, to providers' lack of confidence in inserting IUDs or other reasons. These decreases in long term modern method use negatively impact on the effectiveness of the program.

Within the organized program, government facilities provided almost nine out of 10 CYPs in 1996, with NGOs accounting for 9.2 percent and industry-based facilities for 1.2 percent. Government facilities provided virtually the same number of CYPs in 1996 than in 1995. Their share of the CYPs provided by the organized program also remained about the same as in 1995. NGOs appeared to provide fewer CYPs in 1996 than in 1995, while industrial clinics increased slightly.

Compared to the organized program, the commercial sector played a small but increasing role, accounting for about 290,000 CYPs, with almost 56 percent of these coming from social marketing, as opposed to the "other" commercial sector. The method mix in the commercial sector was different from that in the organized program: condoms were the leading method (62.4 percent of CYPs), followed by pills (35.9 percent), with injectables playing a very small role. The commercial sector overall provided 22.4 percent more CYPs in 1996 than the previous year. There was growth in both the social marketing sector as well as in the true (unsubsidized) commercial sector.

Combining the contribution of the organized family planning program and the commercial sector, close to 2.17 million CYPs were provided in 1996 -- 1.6 percent more than in 1995 (see Tables 12 and 13). This figure does not include some family planning methods and services provided through the private sector, however, so it understates the full contribution of the PFPP. The largest share of CYPs in 1996 came from pills (39.3 percent), followed by IUDs (24.3 percent), condoms (15.1 percent), injectables (8.4 percent) and VSS (6.6 percent). Other methods each accounted for less than four percent of CYPs.

Tables 12 and 13 present the percentage share of CYPs provided by government and by the private sector. However, because of weaknesses in the CYP data on VSS, NFP and LAM, it is better to compare commodity-dependent methods only. Using this measure, government facilities provided the great majority (74.4 percent) of CYPs, while the private sector contributed 25.6 percent. The picture was much the same in 1995. Within the private sector, the commercial sector played the largest role (15.3 percent of CYPs), followed by NGOs (9.1 percent) and industry (1.2 percent). For most family planning methods, government was the major provider. However, only about 39 percent of CYPs from condoms came from government, with the commercial sector providing a large share (55 percent); with respect to pills, the commercial sector also contributed a significant number of CYPs (12 percent); and NGOs contributed 19 percent of CYPs from IUDs.

Table 12: Total CYPs,^a by Sector and Method, Philippines, 1996

	Government ^b		Private								Total	
			Total Private		NGOs		Industry		Commercial			
	CYPs	%	CYPs	%	CYPs	%	CYPs	%	CYPs	%	CYPs	%
Pills	677,559	79.6	173,687	20.4	56,435	6.6	13,520	1.6	103,732	12.2	851,246	100
Injectables	172,442	94.8	9,559	5.2	4,374	2.4	240	0.1	4,945	2.7	182,001	100
Condoms	128,799	39.4	197,719	60.6	11,337	3.5	6,047	1.9	180,335	55.2	326,518	100
IUDs	425,544	80.7	101,887	19.3	99,623	18.9	2,264	0.4	-	-	527,431	100
Subtotal	1,404,344	74.4	482,852	25.6	171,769	9.1	22,071	1.2	289,012	15.3	1,887,196	100
VSS	142,790	99.3	1,022	0.7	1,022	0.7	-	-	-	-	143,812	100
NFP	87,337	99.4	496	0.6	496	0.6	-	-	-	-	87,833	100
LAM	47,425	99.3	354	0.7	354	0.7	-	-	-	-	47,779	100
Subtotal	277,552	99.3	1,872	0.7	1,872	0.7	-	-	-	-	279,424	100
GRAND TOTAL	1,681,896	77.7	484,724	22.3	173,641	8.0	22,071	1.0	289,012	13.3	2,166,620	100

Source: DOH, "1996 Family Planning Maternal and Child Health and Nutrition" June 1997, Table 30.

^a Excludes VSS, NFP and LAM provided by private hospitals and clinics and private practitioners; also excludes sales of IUDs and foam tablets from the commercial sector.

^b Excludes VSS, NFP and LAM from DOH regional hospitals and medical centers.

Table 13: Total CYPs^a, by Sector and Method, 1995

	Government ^b		Private								Total	
	CYPs	%	Total Private		NGOs		Industry/		Commercial		CYPs	%
			CYPs	%	CYPs	%	CYPs	%	CYPs	%		
Pills	732,800	80.5	177,320	19.5	60,270	6.6	13,090	1.5	103,960	11.4	910,120	100
Injectables	76,150	91.5	7,080	8.5	1,900	2.3	190	0.2	4,990	6.0	83,230	100
Condoms	153,060	51.2	146,010	48.8	12,400	4.1	6,400	2.2	127,210	42.5	299,070	100
IUDs	494,070	83.0	101,530	17.0	98,090	16.4	3,440	0.6	-	-	595,600	100
Subtotal	1,456,080	77.1	431,940	22.9	172,660	9.2	23,120	1.2	236,160	12.5	1,888,020	100
Foam. Tablets	0	0	430	100	430	100	-	-	-	-	430	100
VSS	150,593 ^c	94.0	9,610	6.0	9,610	6.0	-	-	-	-	160,203	100
NFP	71,710	90.6	7,430	9.4	7,430	9.4	-	-	-	-	79,140	100
LAM	3,510	84.6	640	15.4	640	15.4	-	-	-	-	4,150	100
Subtotal	349,940	95.1	18,110	4.9	18,110	4.9	-	-	-	-	243,923	100
GRAND TOTAL	1,681,893	78.9	450,050	21.1	190,770	8.9	23,120	1.1	236,160	11.1	2,131,943	100

Source: DOH, "1996 Status Report: Family Planning, MCH and Nutrition Status Report," June 1997, Table 31

^a Excludes VSS, NFP and LAM provided by private hospitals and clinics and private practitioners; also excludes sales of IUDs and foam tablets from the commercial sector.

^b Excludes VSS, NFP and LAM from DOH regional hospitals and medical centers.

^c Adjusted figure based on 1995 FHSIS annual Report

Issues and Constraints

- Prevalence of modern contraceptive methods is very low in the Philippines and is growing only slowly. This, despite a large unmet need for services and high use of traditional methods which would indicate strong interest in fertility regulation. Major efforts are needed to make women and couples aware of the benefits of modern family planning, to explore and address barriers to use of modern methods and to ensure that services are accessible. Also contributing to low prevalence are high levels of contraceptive discontinuation, with one in three users of contraception (35.4 percent) discontinuing the method within a year of starting it, according to the 1993 NDS.
- Misinformation is an important issue, with women who discontinue their method most often saying they did so because of method failure or side effects/health concerns, according to the NDS. Concern about side effects was also the leading reason given by non-users of contraception in the NDS. Clearly, the general public has much misinformation about contraception and even women who use a method often have not received adequate information to help them select a method whose side effects they are prepared to accept.
- Data from the NSO indicate that there has been a drop in use of VSS in recent years. This is believed to be attributable in part to the discontinuation of subsidies to providers of VSS services since 1992. Services are also thought to be less available than in the past. Given the traditional popularity of VSS in the Philippines and the considerable unmet need for family planning services among women who want to limit their childbearing, major efforts are needed to make services more available and to reduce any barriers that may exist.
- The incidence of high risk childbearing remains high--although it is declining--with 56.2 percent of births being to women in a high risk group in 1997. The PFPP has not yet devised effective strategies to reach women for whom pregnancy presents health risks and these are needed to accelerate the decline in high risk childbearing and thus help improve MCH.
- Much work remains to be done to improve the sustainability of the program. Although the government has increased its appropriation for family planning in the last few years, GOP funds covered only 3.8 percent of 1996 expenditures for the national family planning program. Furthermore, frequent changes in staffing at DOH's FPS complicate the task of building a strong and sustainable program. GOP and LGU budgetary support needs to be significantly increased to assume a major share of the cost of running the program. At the same time, a cadre of skilled and experienced staff are needed to manage the program on the DOH side.

- The PFPP is dominated by the public sector and, even though DOH and USAID would like to see the private sector play a larger role, the private sector contribution has actually declined in recent years. It is also unclear who the target "market" is for the public sector, for NGOs and other types of providers. The family planning "market" needs to be segmented into groups needing free services, needing some level of subsidy and groups that can afford to pay the full cost of care. Then, different types of providers should be encouraged to target their services to certain segments of the public. Market segmentation efforts along these lines need to be undertaken with a view to increasing the private sector's role and targeting limited government funds to those truly in need, thus enhancing the sustainability of the PFPP.
- Devolution presents a special challenge where family planning is involved. Chief executives in a few LGUs are opposed to the program and have made it extremely difficult for their health staff to continue providing care--to the point where regional staff have had to take over certain LGU functions in order for family planning services to be maintained. Much advocacy work is needed at the local level to convince current and potential public officials that family planning is a highly beneficial preventive health service and that there is strong public support for the service. Senior GOP officials also need to move faster and more strongly to ensure that local chief executives understand their responsibility to offer family planning services.
- The activism of certain religious groups against family planning remains a serious obstacle to a stronger PFPP. Even though religion has been shown to be a minor factor in individual decisions on whether or not to use contraception, many public officials, and particularly elected officials, are concerned that support for family planning could antagonize key constituencies and jeopardize their career in public life. Thus, they hesitate to back the program. Likewise, there is considerable anecdotal evidence that service providers are being told they are committing a mortal sin when offering artificial methods of contraception and therefore are not providing services. Clearly, stepped-up advocacy efforts are still needed and the people themselves should be given a voice on this issue.
- The scope of reproductive health services has been recently defined by DOH. It remains to be seen whether the broader mandate will draw financial and human resources away from family planning which is already not receiving sufficient priority attention from the GOP/DOH.

Program Funding

In 1996, approximately 652.4 million pesos was spent by the central government and donors for family planning services. Table 14 shows the breakdown of these

expenditures by funding source. While the bulk of funds came from foreign donors, with the Philippine government allocating only 3.8 percent, it should be pointed out that the GOP figure covers only FPS central office expenditures. It does not include expenditures by the LGUs for the government network of health facilities and staff that are the backbone of the family planning program, DOH regional staff and their activities. The table includes some programs and projects that do not have family planning as their primary focus. The amount of resources devoted specifically to family planning is an estimate. Out of pocket expenditures by individuals and families are also not included in the total.

Table 14: Estimated Family Planning Expenditures for 1996 (in Pesos)

	<u>Amount In Pesos</u>	<u>% of Total</u>
GOP Funds:		
Personnel Services/MOOE Of the Family Planning Service	25,073,000	3.8
Foreign Assisted Activities		
IFMPHP (USAID) ¹	470,951,080	72.2
Fourth Country Programme of Assistance	135,134,922	20.7
Expansion of Family Planning and Women Enhancement Project in Selected Urban Poor Areas (UNFPA/AusAID)	4,108,942	0.6
Sustainable Community-based FP-MCH Project with Special Focus on Women (UNFPA/JOICFP)	595,863	0.1
Mobilizing Barangay FP-IECM teams in 10 Pilot Areas (AusAID)	860,020	0.2
Barangay Health Center and Other Volunteer Workers Training in ICS in FP and Integrated Health (AusAID)	8,491,572	1.3
Women's Health and Safe Motherhood Project (ADB)	4,465,734	0.7
Women's Health and Safe Motherhood Project (World Bank)	2,691,237	0.4
Total	652,372,370	100

Note: Figures may not add due to rounding

¹Fiscal Year October 1995 to September 1996

Source: DOH, "1996 National Family Planning, MCH and Nutrition Status Report."

While USAID is the largest donor to the PFPP, other important donors include:

- UNFPA, whose Fourth Country Programme of Assistance (1994-1998) is budgeted at \$22.6 million and is designed, among others, to strengthen the management and field implementation of the family planning service program in the DOH central and regional offices and 52 DOH-retained hospitals; two other government offices; 27 provinces/highly urbanized cities; and 1,317 NGO service outlets through facility upgrading, training, MIS/computerization and other forms of technical assistance. The programme operates on three tracks: DOH, LGU and NGO and has a major emphasis on reproductive health. UNFPA also contributes the DMPA injectable to the PFPP.
- A consortium of donors, including The World Bank, The Asian Development Bank (ADB), Australian Agency for International Development (AusAID), the European Community and the Kreditanstalt fuer Wiederaufbau (KfW), are financing the Women's Health and Safe Motherhood (WHSM) project. This project runs from 1995 - 99 and is expected to cost \$136.4 million. It focuses on improving the quality and range of women's health and safe motherhood services; strengthening the capacity of LGUs to manage these services; strengthening DOH's provision of policy, technical, financial and logistical support; and enhancing the effectiveness and sustainability of health interventions through the participation of local communities and NGOs in the project. The health services component of the project focuses on maternal care and other women's health services, including family planning, diagnosis and treatment of reproductive tract infections (RTIs) and STDs, and detection and treatment of cervical cancer. About 40 provinces are targeted for intensive coverage for maternal care, 10 provinces for RTIs and STDs, and 15 provinces for cervical cancer.
- The World Bank and AusAID, through the Urban Health and Nutrition Project (UHNP), seek to address the increasing health and nutrition problems affecting the growing populations of rapidly urbanizing areas of the country. The project is focused on Metro Manila, Metro Cebu and Cagayan de Oro City which, together have over 70 percent of the slum population of the country. The service delivery component of the project focuses on the most cost-effective health services, including maternal and child care, family planning, nutrition, STDs, acute respiratory infections and diarrheal diseases. UHNP runs from 1994 - 1998 and is estimated to cost \$82 million.
- The Japanese International Cooperation Agency (JICA) provides family planning/MCH assistance in the province of Tarlac and works with DOH's Public Information and Health Education Service on the production of audio-visual materials on family planning/MCH. The project budget is \$4.4 million for the period 1992 - 97.

- AusAID supports the Expansion of Family Planning/Safe Motherhood and Women Enhancement Program with \$600,000 (1994 - 96) focused on selected urban areas.
- The Kreditanstalt fuer Wiederaufbau (KfW) provides funds to DKT International for social marketing of donated contraceptives at a subsidized price in the private commercial sector.
- IPPF supports its local NGO affiliate, FPOP, with contraceptives and a grant for other operating costs.

D. The Maternal and Child Health (MCH) Program

Background

Prior to the 1986 EDSA Revolution, a division under the Bureau of Health Services managed the Expanded Program for Immunization (EPI), the Maternal Care Program (MCP), and the Undersix Clinic Program. Control of Diarrheal Diseases (CDD) was under the Office of the Secretary of Health. In 1986, the Maternal and Child Health Service (MCHS) was created and all four programs consolidated within it. MCHS was also charged with developing two new programs: Control of Acute Respiratory Infections (CARI) and the Breastfeeding and Weaning programs (BF/W).

Program Description

The six national programs managed by MCHS collectively aim to reduce death and illness among mothers, pregnant women, and children under five years of age. The main strategy is to provide basic prenatal, delivery and postnatal care to mothers and preventive and early health interventions against the most common and most serious diseases among children, such as measles, pneumonia, diarrhea, undernutrition, neonatal tetanus, poliomyelitis, diphtheria and pertussis. Each of the six programs is described briefly below.

- *EPI* aims to (1) reach more than 90 percent of infants with a complete series of primary immunizations against seven vaccine-preventable childhood killer diseases, namely: tuberculosis, pertussis, diphtheria, poliomyelitis, tetanus, measles and Hepatitis B; and (2) reach 80 percent of pregnant women with immunization to prevent neonatal tetanus. Eventually the program aims to achieve polio eradication, neonatal tetanus elimination and measles.

- The *CDD* program seeks to reduce mortality and morbidity from diarrhea particularly among children under five years of age through the following health care interventions: (1) effective case management in health facilities and in the home, e.g., use of home fluids at the first sign of diarrhea, oral rehydration therapy (ORT) for dehydration, continued feeding during diarrhea, intravenous therapy for severe dehydration and selective antibiotic therapy; and (2) prevention of diarrhea by breastfeeding exclusively for four to six months and continuing through one year, improved weaning practices, use of safe water, hand washing, use of latrines, proper disposal of stools of young children, and measles immunization.
- The *CARI* program is aimed at reducing infant and child mortality due to pneumonia. The primary strategies of the program include early detection and proper management or treatment of children with acute respiratory infections (ARI).
- The *Under-Five Care/Growth Monitoring Promotion (UFC/GMP)* program aims to deliver a basic package of preventive, promotive and curative health care services focused on those children under age five who are most vulnerable to diseases and other infirmities. The package of services includes immediate care of the newborn, growth and health monitoring, breastfeeding counseling and supplementary feeding, immunization, micronutrient supplementation, dental care services, early diagnosis and management of common childhood diseases like diarrhea and acute respiratory infections, identification and referral of child abuse cases, the provision of emergency care, education for families on child health management and referral and follow-up. Thus, the program is to a great extent the glue that brings together and coordinates other child health programs. Strategies for UFC are currently being re-evaluated, however.
- The *MCP* aims to improve the well-being of mothers during pregnancy, parturition and lactation. Services include prenatal care, tetanus toxoid immunization, delivery care, postpartum care and identification of risk factors and danger signs for early referral.
- The *BFW* program conducts IEC and advocacy activities to promote breastfeeding and proper weaning practices. The program also trains health care professionals, to familiarize them with the scientific aspects of breastfeeding, as well as community support and volunteer groups, to counsel new mothers and encourage them to continue breastfeeding until the infant's second year of life. Hospitals are also encouraged to promote breastfeeding among their clients and those that meet certain criteria are certified as Mother-Baby Friendly. The latter component of the program, however, has been transferred from MCHS to DOH's Hospital Operations and Management Service (HOMS).

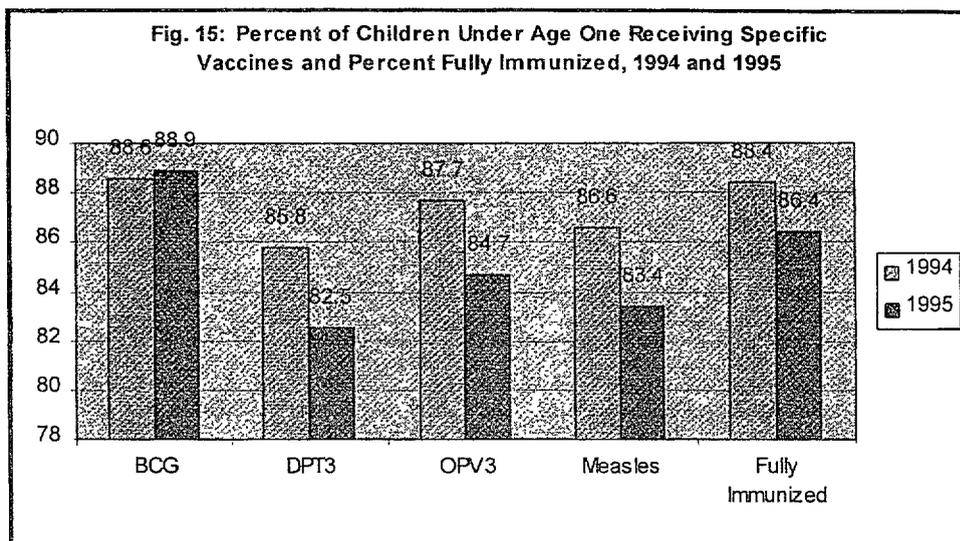
Services Provided

There are three main sources of data on utilization of MCH services:

- *Service Statistics:* DOH's HIS, through its Field Health Service Information System (FHSIS) gathers statistics on public health services provided by DOH and the LGUs. Since devolution, however, FHSIS data reported to the central level have been late and incomplete. Service statistics may also overstate the services provided for a variety of reasons, including the fact that service providers' performance is often measured by their achievement of targets with respect to the provision of public health services. Nevertheless, FHSIS data are the generally-used DOH/LGU measure of accomplishment.
- *Cluster Surveys:* DOH's MCHS conducts cluster surveys to validate data from service statistics. The MCHS conducted a program-wide cluster survey in 1994 and covered eight provinces and eight cities, including 3,360 mothers with children under age five. Different subsets of the mothers were surveyed for different program services. While these data are valuable, it should be noted that they are not nationally representative and that cluster surveys have large variances. In 1996, a multiple indicator cluster survey (MICS) for MCH programs was commissioned by UNICEF and conducted by the NSO. For EPI, although it covered the various antigens, it did not use fully immunized child concept.
- *National Surveys:* Two major national surveys provide what are generally considered to be reliable data on the need for and utilization of MCH services. These are the NDS and the SMS conducted by NSO and Macro International in 1993. Data on breastfeeding are also available from the National Nutrition Survey (NNS) last conducted in 1993 by the Food and Nutrition Institute (FNRI). In addition, a 1997 MCH Rider Survey was conducted by NSO.
- *EPI*

MCHS reported that 90.6 percent of the estimated number of children under age one were fully immunized in 1996, based on DOH service statistics – an improvement from the 1995 coverage level of 86.4 percent. Unfortunately, starting in 1996, coverage by antigen is no longer reported at the national level. These data are only available at the LGUs. We do know that between 1994 and 1995, coverage for individual vaccines, except BCG, slipped according to DOH services. DPT-3, OPV-3 and measles coverage all declined by three percentage points (see Fig. 15). DOH attributed the drop largely to the impact of devolution which it says reduced outreach services, as well as under-reporting of immunization accomplishment; the DOH also reports that children who receive polio vaccine during National Immunization Days (NID) often do

not return for routine immunization, especially if the schedule is close to NID.



Source: DOH, 1995 National Family Planning, MCH and Nutrition Status Report, Table 20

Survey data, while less up-to-date, indicate that vaccination coverage may not be quite as high as the DOH service statistics indicate.

Cluster surveys conducted by MCHS in 1994 in 16 areas show somewhat lower coverage for the different vaccines, even though one might expect higher coverage since the cluster surveys included children aged 12 - 23 months, while the service statistics are limited to those under age one. Average coverage for BCG was high, at 93 percent, but dropped to less than two thirds for the third doses of oral polio vaccine and DPT and somewhat over half of children for measles vaccine. Moreover, coverage rates for all vaccines varied substantially from one province/city to another. For BCG they ranged from virtually universal coverage to a low of 88 percent, while for OPV3 and DPT3 they went from over 80 percent to less than 40 percent. Measles coverage varied from a high of 74 percent to a low of 28 percent.

The 1993 NDS, which was a nationally representative sample and, while old, is reliable, showed 71.5 percent of children aged 12 - 23 months fully immunized, with the coverage rates highest for BCG (91.2 percent) and the first doses of DPT and polio (about 91 percent each). Only about eight out of 10 children had received all three doses of DPT and OPV, while a somewhat higher proportion received measles vaccine. Children in urban areas were more likely to be fully immunized than those in rural areas and there were significant variations between regions in this indicator. The region with the best immunization coverage was CAR, with over 85 percent of children fully immunized and less than three percent with no immunizations. Southern Mindanao also had high coverage. At the other end of the spectrum, Central and

Western Mindanao had almost one in five children without any immunizations—well over twice the national figure. And Ilocos, Metro Manila and the Cagayan Valley had only about six out of 10 children fully immunized (See Annex 6).

In June 1996, a multiple indicator cluster survey, commissioned by UNICEF, revealed coverage levels for various antigens, but not for fully immunized child. In 1997, a MCH rider survey was done in conjunction with the Labor Force Survey, and individual antigen as well as fully immunized child data were obtained.

Looking across the various data sources (see Table 15), it is remarkable how close the results of the 1996 UNICEF MICS and the 1997 national MCH rider survey. BCG appears to be stable from 1993 to 1996 and 1997. There has been some improvement in measles vaccination. DPT 3 and OPV 3 appear to have declined somewhat since the 1993 NDS. For fully immunized children, there is an indication from the 1993 NDS and 1997 MCH Rider Survey that immunization coverage is slipping. However, a BuCen analysis indicates that the difference between 1993 and 1997 FIC rates may not be statistically significant.

Table 15: Percent of Children Immunized, Various Data Sources

	Service Statistics (under age 1)			1997 MCH Rider Survey (12-23 mos.)	1996 UNICEF MICS (12-23 mos)	1994 MCHS Cluster Survey (12-23 mos.)	1993 NDS (12 – 23 mos.)
	1996	1995	1994				
BCG	NA	88.9	88.6	86.7	89.2	93	88.3
DPT 3	NA	82.5	85.8	70.7	71.4	62	77.3
OPV 3	NA	84.7	87.7	69.8	68.3	62	75.5
Measles	NA	83.4	86.6	74.5	74.5	56	70.9
Fully Immunized	90.6	86.4	88.4	58.2	-	-	61.9

Source: 1993 NDS Report Table 8.7, page 100
 DOH, 1995 National Family Planning, MCH and Nutrition Status Report, Table 20
 DOH, 1996 Family Planning, MCH, Nutrition Status Report, Table 34
 NSO, 1996 UNICEF MICS (unpublished results)

In terms of tetanus toxoid immunization, MCHS statistics show that 47.0 percent of the estimated number of pregnant women received at least two tetanus toxoid vaccinations (without regard for timing of vaccine) in 1996. The comparable figure for

1995 was 57.6 percent and in 1994, 69.3%. This sharp drop in tetanus toxoid coverage may be related to the widely-publicized claims by some religious organizations, right before the 1995 NID, that the tetanus toxoid vaccine contains an abortifacient.

The 1993 NDS provides data on the percent of live births in the last five years in which two or more TTV doses were received during the corresponding pregnancy. This is a different coverage measure than the service statistics. The result was 42.2 percent. A comparable figure from the 1997 MCH Rider Survey was 36.1% (except it was derived from children under 3 rather than under 5). A measure from the 1997 Rider Survey more closely corresponding to DOH service statistics which focuses on the mother was 67.4%. A new measure using a more complete criteria for TT protection indicated that 51.2% of surviving children under 3 years of age are protected against neonatal tetanus according to the 1997 Rider Survey.

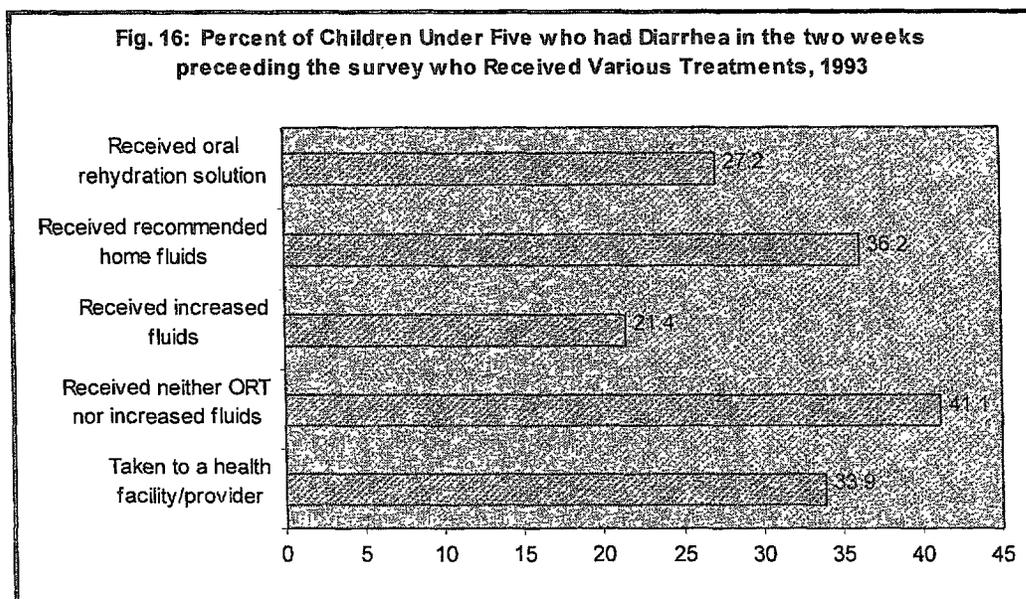
- *CDD*

The most recent DOH service statistics are for 1996 and show that DOH/LGU facilities treated with ORS 34.6 percent of the estimated 2.9 million diarrheal cases expected that year^d. Regional variations were apparent, with facilities in some regions treating with ORS less than 25 percent of the expected cases (Region 10, 11), while Region 7 reported treating 68 percent of the expected number of cases. These statistics, of course, do not capture home treatment of diarrhea.

The 1993 NDS probably provides a more accurate picture. The survey reported 10.1 percent of children under five having had an incident of diarrhea in the last two weeks, with 58.9 percent of them receiving oral rehydration solution or increased fluids. Of the sick children, 27.2 percent received oral rehydration solution and 36.2 percent received recommended fluids (Fig. 16). The NDS found less drastic regional variations than the service statistics, with between 4.7 and 15.4 percent of children having a recent episode of diarrhea and between 45.1 and 78.6 percent of mothers having ever used ORS packets.

Cluster surveys in 1994 found a somewhat similar situation with respect to treatment. About 29 percent of children under five were reported to have had an episode of diarrhea in the last two weeks. On average, 43 percent of the sick children were treated with oral rehydration solution and, when other recommended treatments are taken into account, oral rehydration therapy was used in 55 percent of the cases. Both the incidence of diarrhea and use of oral rehydration therapy varied dramatically around the country.

^d DOH estimates the number of cases on the basis of 2.8 diarrheal episodes per year among children under age five, who are assumed to be 14.5 percent of the population.



Source: NSO and MACRO International, NDS 1993, Table 8, 12 and 14

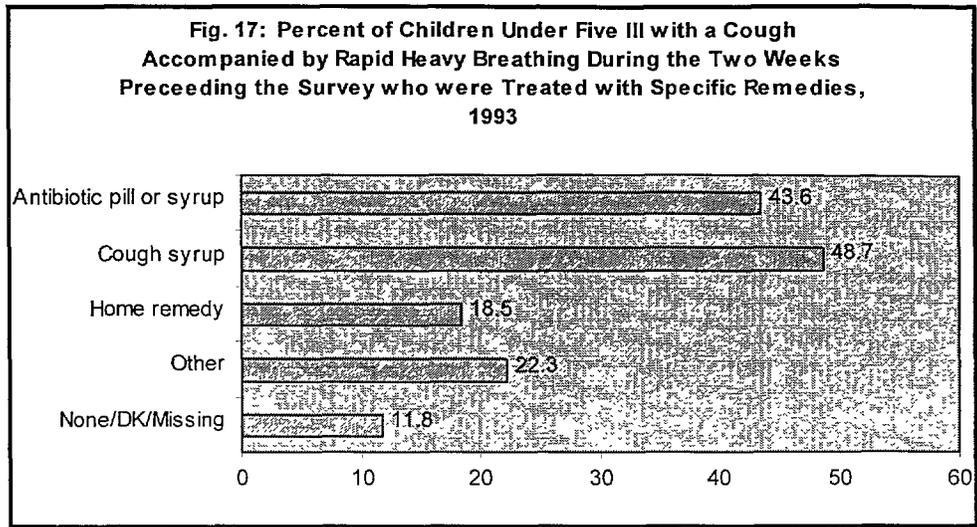
The 1996 UNICEF Multiple Indicator Cluster Survey found 89.9 percent of children under five years of age who had diarrhea within two weeks prior to the survey and who had received oral rehydration therapy or other recommended fluids. Urban children were more likely to receive ORT/fluids (92.1 percent) than rural (88.4 percent).

- *CARI*

1996 DOH service statistics estimate a total of 1.04 million cases of ARI^e. Of these, the DOH estimates that 75 percent were seen and 89 percent of those seen received treatment.

Data on the incidence and treatment of acute respiratory infections are also available from the 1994 MCH cluster surveys and the 1993 NDS. According to the NDS, almost nine percent (8.7 percent) of children under five experienced a respiratory infection and 51.3 percent of these children were taken to a health facility or provider. The cluster surveys found a similar percentage (53 percent) of sick children had been taken to a health facility. As for treatment, in the NDS, 43.6 percent of sick children were given antibiotic pills or syrup (Fig. 17) -- a similar finding to the 37 percent found in the cluster surveys. The cluster surveys also found that an average of only 57 percent of mothers had proper knowledge of pneumonia.

^e The estimate is derived from the total population x 14.5 percent x 100/1000.



Source: NSO and Macro International, NDS 1993, Table 8.11

- *UFP/GMP*

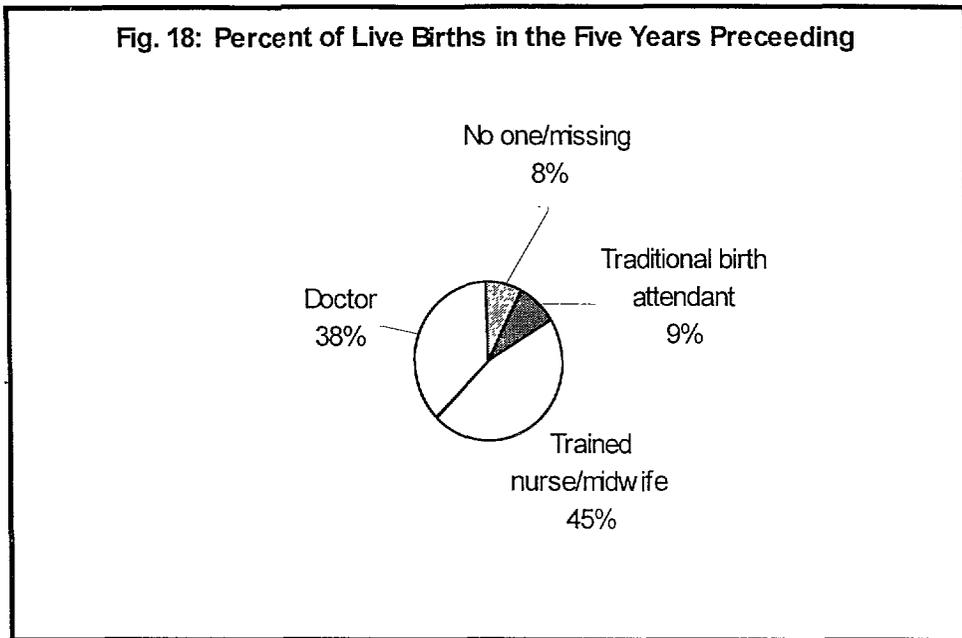
The Under-Five Care program served 87.1 percent of the targeted population of children under age one in 1994, according to DOH service statistics. More current statistics are not available from MCHS. Thirty-three percent of these children were identified as being risk children in need of special attention.

On average, 4.8 follow-up visits to Under-Five Clinics were made for each risk child. In reality, however, many of the follow-up visits were made by healthy children, so that it is clear that even risk children did not make the recommended *monthly* visits that *all* children should make, whether or not they are at risk.

- *MCP*

DOH service statistics for 1996 showed that more than one half (54.7 percent) of the estimated number of pregnant women made at least one prenatal visit to trained DOH/LGU personnel (including trained hilots). This is an increase over 1994 where 46.4 percent made the recommended minimum of three visits.

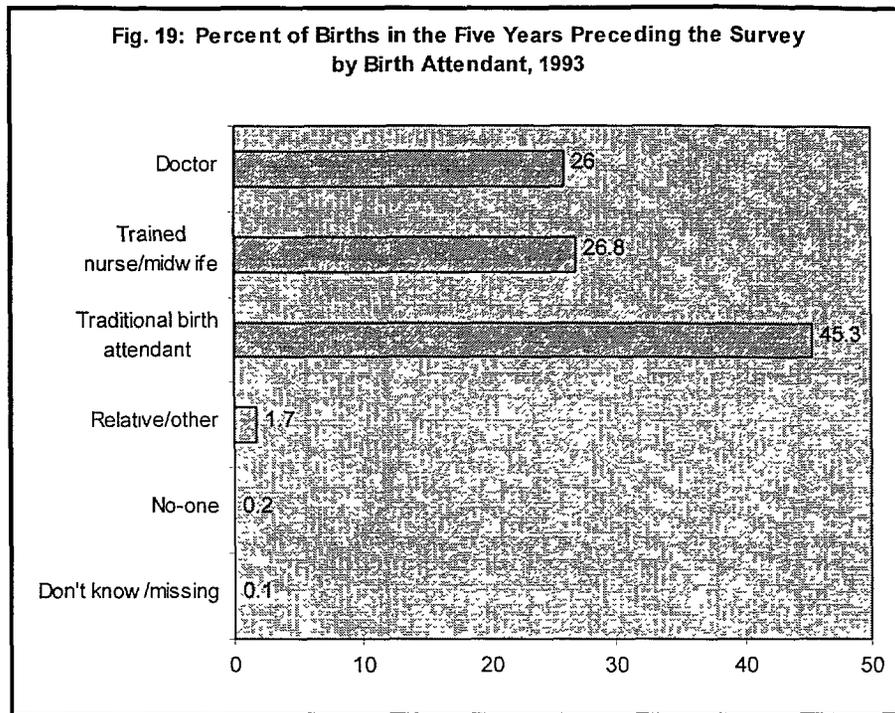
The 1994 MCH cluster surveys found higher utilization of prenatal care, with an average of 93 percent of mothers with children under five having made at least one prenatal visit, and 73 percent making three or more visits. Only seven percent received no care.



Source: NSO and Macro International, 1993 NDS, Table 8.1

The 1993 NDS and SMS, both of them with large nationally representative samples, probably provide the most accurate picture. In the NDS (see Fig. 18), 83.1 percent of births in the five years preceding the survey were to mothers who received prenatal care from a medical professional, while nine percent consulted a traditional birth attendant (TBA or hilot). Mothers in urban areas and those with higher education were more likely to receive medical attention during pregnancy than others. Less than eight percent of the births were to respondents who did not receive prenatal care from anyone. A somewhat similar pattern emerges from the SMS. There, only 6.2 percent of the births were to women who did not receive prenatal care from anyone. Midwives were the main providers of care (58.6 percent), followed by doctors (35.0 percent) and hilots (28.3 percent). However, respondents to the SMS could name more than one provider of prenatal care, so that it is difficult to determine the main provider of care.

Of the women who saw a doctor, nurse or midwife for prenatal care, 81.3 percent saw the health professional for at least three prenatal visits, with the median number of visits being 3.8, and 48.0 percent of the women had their first visit in the first trimester according to the SMS. The NDS found 52.1 percent of women with three or more prenatal visits-and a median number of 4.5--with half initiating prenatal care at 4.3 months.

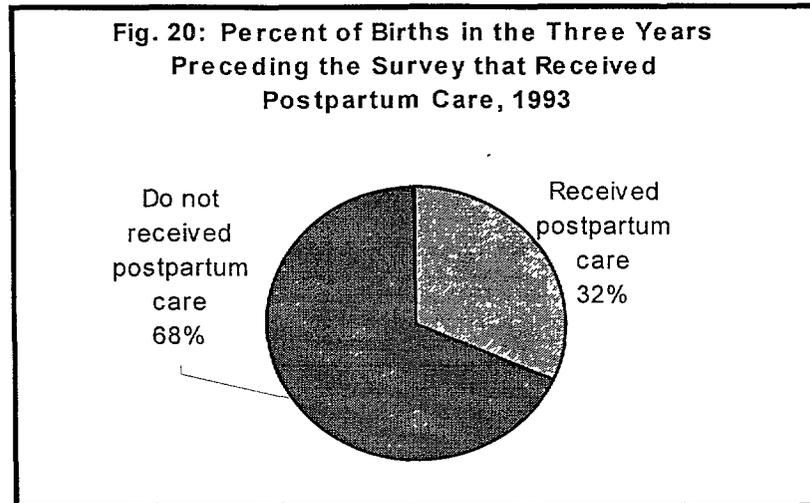


Source: NSO and Macro International, NDS 1993, Table 8.5

The recently conducted 1997 MCH Rider Survey used a different measure, focused on percent of women with surviving children, 0-35 months of age, who received pre-natal care during pregnancy of youngest surviving child. A total of 42.4 percent of the women were seen by a doctor, 67.0 percent by a trained nurse/midwife, and 23.9 percent by a hilot. (The women could have been seen by more than one care provider.)

About seven out of 10 births occurred at home, while the other three were in a health facility, according to the SMS and NDS. The 1994 MCH cluster surveys showed almost two-thirds of the women who gave birth did so at home. Close to half (45.3 percent) of births were delivered by hilots. In contrast, medical assistance at delivery was provided by doctors for 26.0 percent of births and by nurses and midwives for 26.8 percent of births. Medical assistance at delivery--particularly by a doctor--was more common among women in urban areas than in rural areas.

Over two thirds of the population estimated by DOH to be eligible for postpartum care (67.2 percent) received at least one postpartum visit in 1996 according to service statistics. Data from the 1993 SMS are thought to be a more accurate reflection of the situation around the country, however, showing 32.2 percent of births receiving postpartum care (Fig. 20).



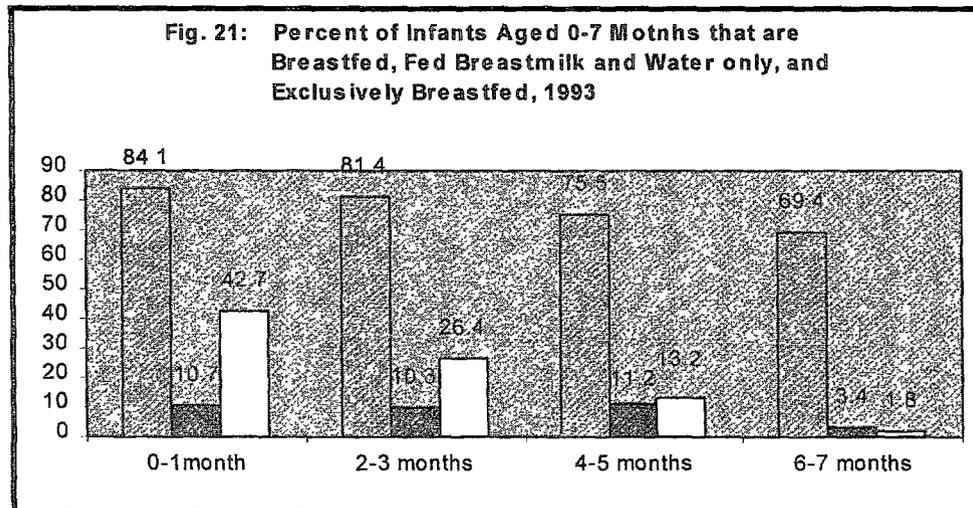
Source: NSO and Macro International, SMS 1993, Table 5.15

- *Breastfeeding*

1996 DOH service statistics indicate that 62.5 percent of postpartum women initiated breastfeeding. There was some regional variation with Regions 9, 10 reporting the lowest (31.0 and 34.1 percent, respectively) and Regions 2 and 4 reporting the highest (70.3 and 70.7 percent, respectively).

According to the MCH cluster surveys conducted in 1994, an average of 92 percent of infants under age one were breastfed at some time. The NDS found a relatively compatible figure of 87.2 percent of infants having been breastfed at some time for the five-year period ending in 1993, although the figure was significantly lower (82.3 percent) in urban areas.

Breastfeeding lasted more than 14 months, in most cases, according to the NDS, but the benefits of extended breastfeeding were mitigated by the extremely short duration of exclusive breastfeeding, exposing infants to the risk of contamination from other liquids and foods. Infants received nothing but breastmilk for just a little over half a month, instead of 4 - 6 months. Both with respect to the initiation of breastfeeding and its duration, infants in rural areas fared better than their urban siblings. The 1993 National Nutrition Survey also found low levels of exclusive breastfeeding, with only six out of 10 infants aged 0 - 3 months exclusively breastfed and just 15.7 percent of those aged 4 - 6 months. DOH cluster surveys show much higher levels of exclusive breastfeeding: an average of 41 percent of infants under age one.



Source: NSO and Macro International, Inc., NDS 1993, Table 9.2

Children were introduced to supplemental foods very early, according to the NDS. Among newborns under two months, 15.9 percent were not breastfed and 30.7 percent were receiving supplementary foods, with only 42.7 percent exclusively breastfed. At age 4 -5 months, the majority of infants (51.1 percent) were receiving supplementary foods, 24.5 percent were no longer breastfed and the percentage exclusively breastfed dropped to 13.2 percent (Fig. 21).

Issues and Constraints

- Childhood immunization coverage needs continued attention to maintain the DOH target of 90% (using service statistics definition). With respect to tetanus toxoid immunization, service statistics show even more serious declines between 1993 and 1996: from 70.0 to 47.0 percent of pregnant women immunized with two or more doses of TTV. Urgent steps need to be taken to raise coverage levels for all the childhood immunizations and tetanus toxoid.
- Data from both DOH cluster surveys and the NDS show that 55 - 60 percent of diarrhea cases reported by mothers were treated with oral rehydration therapy. The percentage using oral rehydration therapy varied considerably, indicating that oral rehydration therapy is not uniformly practiced. These uneven patterns could indicate problems with the program in some areas of the country. There is a need to learn more about why oral rehydration therapy is less used in some areas than in others, so that its promotion can be given better focus.
- Pneumonia is the leading cause of infant deaths, yet data from the 1994 MCH cluster surveys showed that only 57 percent of mothers had proper knowledge of pneumonia, with the percentage varying from 32 to 73 percent among the clusters.

More efforts are needed at the grassroots level to teach mothers to recognize pneumonia and seek early treatment.

- While use of prenatal care is relatively high, there is still a need for greater IEC efforts to inform and convince pregnant women--particularly those with less education and those living in rural areas--to obtain care from trained personnel in the first trimester of pregnancy. This needs to be accompanied by a continuing program to train hilots on proper delivery procedures and timely referrals.
- Use of postpartum care is the exception, rather than the rule, in the Philippines. Efforts are needed to reach more women with postpartum care and, at the same time, advice on family planning for birth spacing and on infant care.
- Considerable work is still needed on the promotion of breast-feeding. In particular, *exclusive* breast-feeding *for longer periods* needs to be encouraged for proper infant nutrition and to lengthen postpartum amenorrhea.
- There is considerable evidence of poor weaning practices among mothers. There are low levels of exclusive breastfeeding and IDA among infants aged six months to a year is high. Wasting among infants is also probably due to a considerable extent to poor weaning practices. Clearly, messages about proper weaning practices need to be directed toward new mothers whenever they are in contact with the health care system and supplemental feeding needs to be targeted on the neediest infants during the months when they are weaned.

Program Funding

An estimated 400 million pesos were spent by the central government and donors for MCH activities in 1995 (Table 16), with by far the largest share (72 percent) devoted to immunization. Next in line in terms of expenditures was maternal care (16 percent) mainly due to the Women's Health and Safe Motherhood Project. CDD and CARI received less than 6 percent each.

LGU expenditures from their own budgets are not included in this table.

Table 16: Estimated Expenditure for Maternal and Child Health Services for 1996

<u>Activity</u>	<u>Amount in Pesos</u>	<u>% of Total for Each Program</u>	<u>% of Total Expenditure</u>
Expanded Program on Immunization (EPI)	287,260,150	100.0	71.8
GOP	276,964,050	94.6	
IFPMHP/LPP (USAID)	8,775,000	3.1	
UNICEF	989,300	0.3	
WHO	531,800	0.2	
Control of Acute Respiratory Infection (CARI)	23,685,534	100.0	5.9
GOP	19,074,000	80.5	
IFPMHP/LPP (USAID)	4,387,500	18.5	
UNICEF	224,035	1.0	
Control of Diarrheal Diseases (CDD)	22,825,150	100.0	5.6
GOP	17,984,400	78.8	
IFPMHP/LPP (USAID)	4,387,500	19.2	
UNICEF	453,250	2.0	
Under-Five Care Program (UFC)	3,872,831	100.0	1.0
GOP	3,000,001	77.5	
WHSMP (AusAID)	872,830	22.5	
Maternal Care	68,682,421	100.0	15.7
GOP	1,920,000	3.0	
WHSMP (AusAID)	39,707,640	63.3	
WHSMP (ADB)	4,465,734	7.1	
WHSMP (World Bank)	2,691,237	4.3	
UNICEF	13,897,810	22.2	
TOTAL	400,326,087		100.0

Note: Figures may not add due to rounding.

Source: DOH, 1996 National Family Planning, MCH and Nutrition Status Report, June 1997.

Using only these DOH expenditures, the GOP financed 80 percent of MCH expenditures overall, but the GOP share varied significantly by program. For EPI, 96 percent of expenditures were from the GOP, for CARI 80 percent, for CDD 79 percent, for UFC 78 percent and for maternal care, it was far smaller, at 3 percent .

Apart from the GOP, the United Nations Children's Fund (UNICEF) Fourth Programme of Cooperation for Child Survival, Protection and Development in the Philippines (CPC IV) provides major funding support to DOH's MCH program. The program consists of five projects, namely women's health and safe motherhood; breastfeeding, weaning and growth monitoring; EPI; CDD; and CARI. The focus is on 27 provinces and 18 urban areas, with 15 provinces supported substantially by AusAID. Inputs consist of capacity-building activities such as personnel training, program reviews and conferences, development of IEC materials, provision of essential drugs and supplies, support for advocacy and social mobilization, community empowerment activities, program monitoring, research and evaluation studies. Over the first two years of the project, EPI received 42 percent of expenditures, followed by women's health and safe motherhood with 37 percent, CDD with 11 percent, seven percent for CARI and four percent for breastfeeding. CPC IV runs from 1994 - 1998 and is estimated to cost of \$16 million.

Other major projects that support activities in these areas are WHSM and UHNP (see page 55). In addition, the Early Childhood Development Project to be funded by The World Bank and ADB will have a major health component and is expected to begin in 1998.

E. The Nutrition Program

Background

The Philippine government has been involved in nutrition activities since 1947, when President Manuel Roxas established the Institute of Nutrition, and the first National Nutrition Program was submitted to the president in 1948. The focus in these early days was on the reduction of beriberi and iron deficiency anemia. The Institute on Nutrition became the Food and Nutrition Research Center (FNRC)--the precursor of the current Food and Nutrition Research Institute--in 1958 and was charged with coordinating scientific research and development activities of government agencies and private enterprise. The FNRC, in 1960, organized the National Coordinating Committee on Food and Nutrition to coordinate nutrition activities and this body evolved over the years into the present National Nutrition Council.

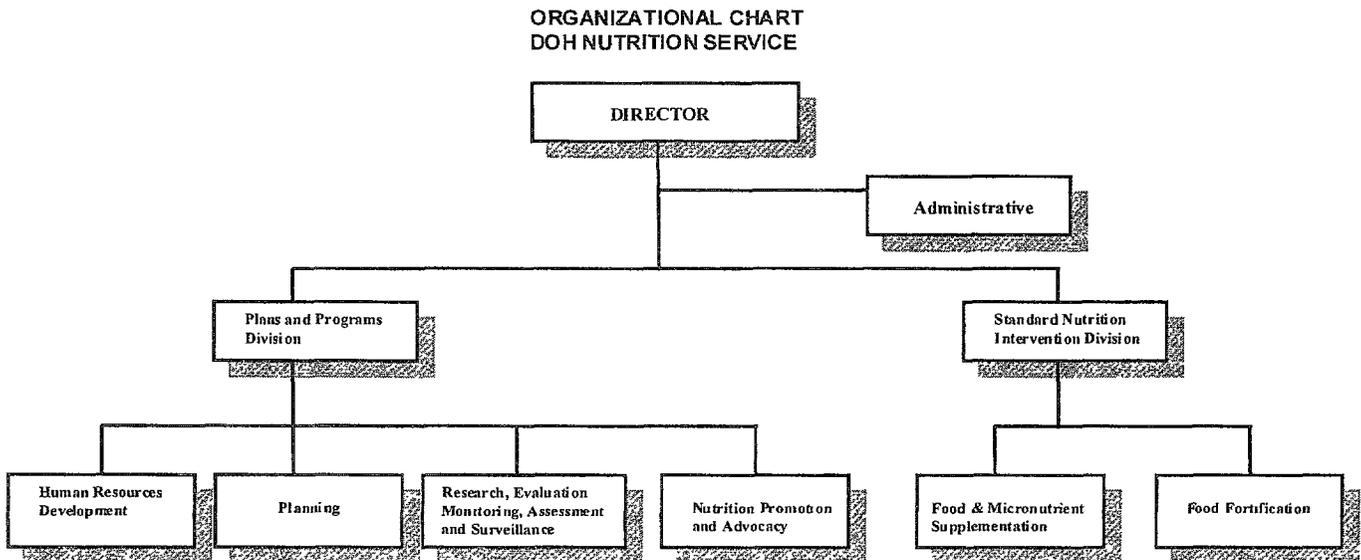
In 1960, the Secretary of Health established the Division of Nutrition in the Bureau of Health Services to manage rice enrichment and nutrition activities. The President of the Philippines launched the National Nutrition Program in 1967, a comprehensive health/nutrition program that started operations at DOH the following year, with assistance from USAID. The plan placed high priority on the development of locally available, highly nutritious, low cost food combinations, but throughout the 1970s and 1980s the nutrition program relied heavily on feeding activities using P.L. 480 commodities.

In the mid-1970s, DOH consolidated all its nutrition and dietetic services into the National Nutrition Services, later renamed the Nutrition Service (NS). In 1983, under a DOH reorganization, the service reoriented its activities toward the development of innovative approaches for application by field health units in identifying nutritional problems and providing nutrition interventions. Since 1987, NS has been one of the services under DOH's OPHS. In 1989, the strategic plans for prevention and control of VAD, IDA and iodine deficiency disorders (IDD) were approved by the DOH and thereafter the program's focus shifted to micronutrient malnutrition.

Program Description

The National Nutrition Council is the nation's coordinating body that provides overall policy and program direction on nutrition. It is chaired by the Secretary of Agriculture and co-chaired by the Secretary of Health, with a membership drawn from government agencies and NGOs. The council has adopted a Philippine Plan of Action for Nutrition and oversees its implementation. The current plan covers the period 1993 - 98 and focuses on VAD, IDD and to a certain extent IDA and PEM.

DOH plays a leading role in the national nutrition program, with responsibility for the micronutrient program, growth monitoring, nutrition education and supplementary feeding for pregnant and lactating women and children under age four. As with other health programs, however, local governments are the main actors in nutrition since devolution.



The activities of DOH's NS are geared toward the reduction of mortality and morbidity due to avitaminoses and other nutritional deficiencies, particularly among infants, preschoolers, pregnant and lactating women. Specifically, it aims to achieve the following:

- Reduction of PEM among preschoolers by 0.5 percent per year to cut the 1990 PEM level by half by the year 2000;
- Reduction of VAD prevalence by 0.02 percent per year, using Bitot's spots as the indicator, to achieve virtual elimination of clinical VAD among preschoolers by the year 2000;
- Reduction in the prevalence of goiter as a manifestation of IDD by one percent per year in endemic areas to achieve virtual elimination of IDD by the year 2000;
- Reductions in the prevalence of IDA in the following population groups:

Infants	1.4 percent per year
Preschoolers	0.8 percent per year
Pregnant women	1.2 percent per year
Lactating women	1.2 percent per year.

The standard nutrition intervention programs implemented by the DOH are:

- *Nutrition Promotion and Advocacy*

The purpose of this activity is to generate awareness and motivate the population to adopt desirable nutrition practices, including exclusive breastfeeding, introduction of proper complementary foods for infants, consumption of a balanced diet, maintenance of home food security and consumption of fortified foods, such as iodized salt, fortified rice and wheat flour. Initiatives supporting these objectives include social marketing communication programs, nutrition education programs (diet counseling) and the Child Growth Project which supports training for midwives and BHWs in nine provinces.

- *Food and Micronutrient Supplementation*

This program is geared toward the reduction of PEM and IDA and the virtual elimination of VAD and IDD.

The Vitamin A program focuses on the provision of high dose capsules, with a preventive regimen targeted to mild, moderate and severely underweight preschoolers, those with chronic diarrhea, measles and ARI, and postpartum women within one month after delivery. The preventive regimen is also given when outbreaks of measles, diarrhea and natural calamities occur. Areas with prevalence of night blindness and Bitot's spots in excess of one percent and 0.5 percent respectively are given priority. A treatment dose is given to identified VAD cases. Moreover, on major

public occasions such as Araw ng Sangkap Pinoy (ASAP), NID and Knock Out Polio, Vitamin A capsules are distributed universally.

The iron supplementation program seeks to reach all pregnant women with iron supplements, starting in the fifth month of pregnancy up to two months postpartum, and low birthweight infants are given ferrous sulfate drops.

The priority preventive measure for IDD is iodized salt which is promoted for household consumption nationwide. Iodized capsules are used, however, to prevent and treat IDD, while food fortification activities are put into place. In IDD endemic areas, where more than five percent of the population have goiter or more than 10 percent of 6 - 12 year olds have goiter, the target populations are women aged 15-40, young people aged 6 - 14 and other adult males. In very hard-to-reach areas that are not regularly visited by health workers, an iodized oil injectable is given, due to its long period of action.

The Targeted Food Assistance Program (TFAP) has, for years, been DOH's intervention to address the problem of PEM. TFAP targets preschool children under age seven, women in their second and third trimesters of pregnancy as well as underweight anemic mothers and lactating mothers in the first year after delivery. The program involves the provision of food commodities provided by the U.S. government under P.L. 480. These consist of bulgur wheat and green peas for preschoolers, pregnant and lactating women. With the complete phase out of the P.L. 480 commodities, the government is now developing a food supplement or complementary food mix to be used as a supplement for rehabilitative feeding, starting at age six months to twenty four months. This being piloted in Masbate.

Operation Timbang (OPT) is a massive nationwide program carried out in the first quarter of each year to weigh children under age seven and determine their nutritional status. Through OPT, beneficiaries for food supplementation are identified.

The NS also believes that the reduction/elimination of micronutrient deficiencies will contribute to the reduction of PEM.

- *Food Fortification*

The National Food Fortification Program was launched by President Ramos in 1993 with a call to all sectors to support the Fortification for Iodine Deficiency Elimination (FIDEL) and FVRice (iron-fortified rice) programs. In 1994, a nationwide social marketing campaign was launched to promote daily consumption of iodized salt. An Act on Salt Iodization Nationwide (ASIN) was approved by President Ramos on December 20, 1995 and mandates that all salt for human and animal consumption be iodized.

The FVRice program concentrates on communications activities and the refinement of rice enrichment technology at the rice mill. DOH has forged a strong partnership with the private sector, particularly the food industry, in its food fortification program and it also works on the legislative front to encourage the food industry's participation in food fortification program.

In 1996, DOH launched the Sangkap Pinoy Seal Program which involves the issuance of the seal of acceptance on the product label of fortified foods that meet DOH requirements.

- *Araw ng Sangkap Pinoy (ASAP)*

DOH launched the National Micronutrient Day (popularly known as "Araw ng Sangkap Pinoy – ASAP), in October 1993 and has continued the event for the last five years. The target populations have expanded over the years of ASAP implementation and, by 1995, included children aged one to four who receive a Vitamin A capsule and all women of childbearing age (15 - 40 years) who receive an iodized oil capsule (IOC). In addition, seeds, seedlings and cuttings of different varieties rich in Vitamin A, iron and iodine are also distributed to promote and encourage household and community gardening as well as to help meet the need for these micronutrients. In 1996 and 1997, only women 15-40 years old in IDD endemic areas were given iodized oil capsules. Also in 1996, iron supplements were distributed to pregnant women for the first time as part of ASAP. This was continued in 1997.

Services Provided

As with other DOH services, the NS is also unable to obtain prompt and reliable data from health centers on the services they provide on a regular basis. Thus, it relies largely on data about services provided during the special campaigns organized by the NS: OPT and ASAP. OPT data on food supplements are reported by service providers. And, for ASAP, two sets of data are used: reports from health centers on the services they provided during ASAP and the results of cluster surveys conducted by the Field Epidemiology Training Program (FETP). The cluster surveys are thought to be the more reliable source because the service statistics tend to overstate accomplishment--probably because of some combination of errors in estimating the target population and the tendency of service providers to over-report the services they provide.

- *Food Supplementation.* As its main intervention against PEM, the Nutrition Service provided bulgur wheat and green peas as food supplements to 331,452 severely underweight preschoolers, to selected moderately underweight preschoolers identified during OPT and to underweight anemic pregnant and lactating women in 1995, according to the OPT Report. This was a drop as compared to 1994 when 640,000 received services and is due to a great extent to the start of the phase-out of P.L. 480 donated commodities.

- *Vitamin A.* The 1997 Post-ASAP coverage surveys found that 78 percent of the children aged one to four had received a Vitamin A capsule during ASAP. Nationally, this was a decrease as compared to 1995 and 1996, when 88 percent of children received the vitamin. This is thought to be due to the delayed arrival of the supplements in-country and to limited LGU budgets that restricted the ability of health personnel to reach far-flung areas, as demonstrated by the reduced percentage of house visits undertaken in 1997. The NID cluster surveys conducted earlier in the year when the first dose of Vitamin A was administered, showed somewhat higher coverage, at 91 percent--although the denominator was a younger group of children. Since NID and ASAP were held six months apart, the results of the two surveys are not inconsistent. It should be kept in mind, however, that the cluster surveys only measure the administration of a single Vitamin A capsule to a child, while a dose of two is required. Thus, it cannot be concluded that about 90 percent of children have received the requisite dosage of Vitamin A.

Based on reports from health providers, NS reports that 98.8 percent of the estimated target population of 7.8 million children aged one to four received a Vitamin A capsule during the 1996 ASAP.

- *Iron.* The 1997 Post-ASAP Coverage Survey found that iron tablet coverage was 58%. This is a steep decrease from the 1996 survey where the percent was 67%. This is a further decline from the MCHS integrated cluster surveys conducted in 1994 which found that an average of 78 percent of mothers of children under age five in 16 provinces and cities had received an iron tablet during their most recent pregnancy. This percentage ranged from 61 percent in Camarines Sur to 93 percent in Cebu City and Iloilo Province. It is unclear from these surveys which women are actually taking the full number of tablets needed to prevent anemia during pregnancy.

The 1993 SMS found that, among pregnancies in the previous three years of which prenatal care was received from a doctor, nurse or midwife, 68 percent received iron tablets. Though comparisons among the surveys should be made with caution, it appears there is a decreasing trend from 1993 to the present.

- *Iodine.* The 1997 Post-ASAP coverage surveys found 54 percent of women aged 15-40 had received iodized oil capsule during ASAP. The national figure would appear to be a drop from the 1995 and 1996 figures of 81 and 80 percent respectively but, in reality, the target population grew larger over the three-year period: from pregnant women only in 1993, to married women of childbearing age in 1994 and all women 15 to 40 years in 1995. However, in 1996 and 1997, the targets were women 15 to 40 years in endemic areas only.

Reports from service providers indicate that 84.8 percent of the estimated 15.6 million women aged 15 - 40 received iodized oil capsules (IOC) during ASAP 1995. Even though the target population for IOC was expanded from *married* women aged 15 - 40 in 1994 to *all* women in this age group in 1995--an increase of 40 percent--coverage dropped by only about one percentage point. Accordingly, the absolute number of women reached increased by more 38.5 percent, almost keeping pace with the substantially increased target population.

Issues and Constraints

- With the complete phase out of P.L. 480 donated food commodities in 1997, a substitute must be found to supplement the nutritional needs of vulnerable populations and, at the same time, strategies developed to target food supplements to the most nutritionally vulnerable populations.
- Efforts to reduce PEM are not receiving the same priority as those to reduce micronutrient malnutrition. Moderate malnutrition remains an important problem and its reduction could save thousands of lives among infants and young children. Possible strategies to improve this situation involve a revitalization of the growth promotion program targeted primarily on children in the first two or three years of life; a re-targeting of supplemental feeding on the neediest women and children; and the redirecting of funds from a generalized food subsidy to a nutrition security program for the food-insecure.
- The prevalence of underweight, stunting and severe chronic malnutrition among young children declined between 1987 and 1993. Wasting, however, which measures active malnutrition, increased slightly from 5.5 to 6.2 percent between 1987 and 1993 and needs to be addressed. Vigorous efforts and prompt services are needed, with greater focus on specific areas and population groups most in need: rural areas and their preschool-age children and urban areas and their school children, including teenage pregnant women.
- Important progress has been made in reducing micronutrient malnutrition, but anemia levels are still high among infants, pregnant and lactating women--with the high rate among infants attributable to a great extent to anemia in their mothers. Strategies to address anemia in infancy, through fortification of complementary foods and/or supplementation, are needed; iron supplementation among pregnant women still needs to be strengthened; and interventions aimed at improving the iron status of adolescent girls prior to pregnancy should be considered. A sustained commitment at the policy and program level is also needed to prevent and control anemia.
- The incidence of goiter appeared to increase between 1987 and 1993 and afflicts large numbers of people, especially women, and most particularly pregnant and

lactating women. In light of the consequences of iodine deficiency in women for any children they may bear, this is an important concern.

- The distribution of some micronutrients, particularly Vitamin A, seems to be slipping and the DOH attributes this largely to the impact of devolution, due to reduced outreach activities. The reasons for the declining coverage should be investigated and prompt action taken to reverse this troubling trend.

Program Funding

Central government expenditures for nutrition services targeted to women and children, in 1996, are estimated at about 121.6 million pesos (see Table 17), with 61 percent coming from the GOP. It should be noted that it is difficult to obtain a good estimate of expenditures for nutrition activities targeted to women and children because the nutrition program serves a much broader population group.

Table 17: Estimated Expenditure for Nutrition Service for 1996		
<u>Activity</u>	<u>Amount in Pesos</u>	<u>% of Total</u>
GOP funded activities	74,230,000	61.1
Donor-assisted activities		
IFPMHP (USAID)	8,775,000	7.2
Country Program for Children (UNICEF)	1,820,000	1.5
UHNP Nutrition Project	10,688,000	8.8
Women's Health and Safe Motherhood Project (ADB)	14,280,000	11.7
Opportunities for Micronutrient Intervention Project (USAID)	2,730,000	2.2
Helen Keller (USAID and other sources)	9,100,000	7.5
TOTAL	121,623,000	100

Note: Figures may not add due to rounding.
Source: DOH 1996 National Family Planning, MCH and Nutrition Status Report.

The table does not include expenditures by the DOH regional offices, the LGUs which finance many nutrition activities or donated food commodities from the U.S. Also, projects included in the table are only those with a major focus on nutrition. Other

projects, where nutrition is one of a range of health interventions, are not presented. Finally, expenditures for nutrition services in other sectors, such as agriculture, social welfare and education, are not included.

USAID supports the NS programs not only through IFPMHP but also with funds from its Global Bureau in Washington for Helen Keller International and Opportunities for Micronutrient Interventions (OMNI).

Apart from the GOP, UNICEF's CPC IV provides major support for nutrition programs in various sectors, including those of DOH. Components are: food production for household food security; micronutrient supplementation and food fortification; the Child Growth Project; nutrition advocacy; capability-building; community assessment, nutrition surveillance and operations research; and program planning, coordination, monitoring and evaluation. The focus is on 16 provinces, 11 cities and 10 urban municipalities. AusAID supports nine disadvantaged provinces through the Child Growth Project which integrates nutrition and MCH services to help care-givers ensure proper growth and development of young children. It also supports the Salt Iodization Project, with additional funds from other donors. The UNICEF project runs from 1994 - 1998 and is estimated at \$14 million for all sectors of the program, with approximately \$10.6 million of this planned for the health sector, including the child growth and salt iodization projects.

UHNP, while not focussed exclusively on nutrition, provides important inputs in the sector (see page 55). In addition, the Early Childhood Development Project to be funded by The World Bank and ADB is expected to begin in 1998 and will have a major nutrition component.

F. The National AIDS/STD Prevention and Control Program

Background

A year after the first case of AIDS was diagnosed in 1984, the DOH initiated serosurveillance through the Research Institute for Tropical Medicine (RITM) and the Bureau of Research and Laboratories (BRL) in collaboration with the U.S. Naval Medical Research Unit-2 (NAMRU). In 1986, AIDS was declared a reportable and notifiable disease and, in 1988, the National AIDS Registry was created.

The first programmatic steps were taken early in 1987 when the government established the National AIDS Prevention and Control Committee under the DOH's Office of the Undersecretary for Public Health Services--a committee that was to undergo several transformations over the years--and appointed a National AIDS Coordinator. The DOH gained visibility on the issue when the Secretary of Health spearheaded the holding of the First International Conference on AIDS in Asia in

Manila in November 1987. The Department approved the National Medium-Term Plan for the Prevention and Control of AIDS (1989-1993) in 1988 and the National AIDS Prevention and Control Programme was officially launched in August of that year to implement the plan.

During the 1990s, the AIDS program gained status. It was designated a priority program for the DOH when the AIDS/STD Unit was integrated into the Office of Special Concerns that fast-tracked the implementation of priority health concerns. With the completion of the First Medium-Term Plan, a second-generation plan was drafted.

Increasing concern about the AIDS problem drew attention to STDs and, in 1993, the National STD Control Program was integrated with the AIDS program.

Program Description

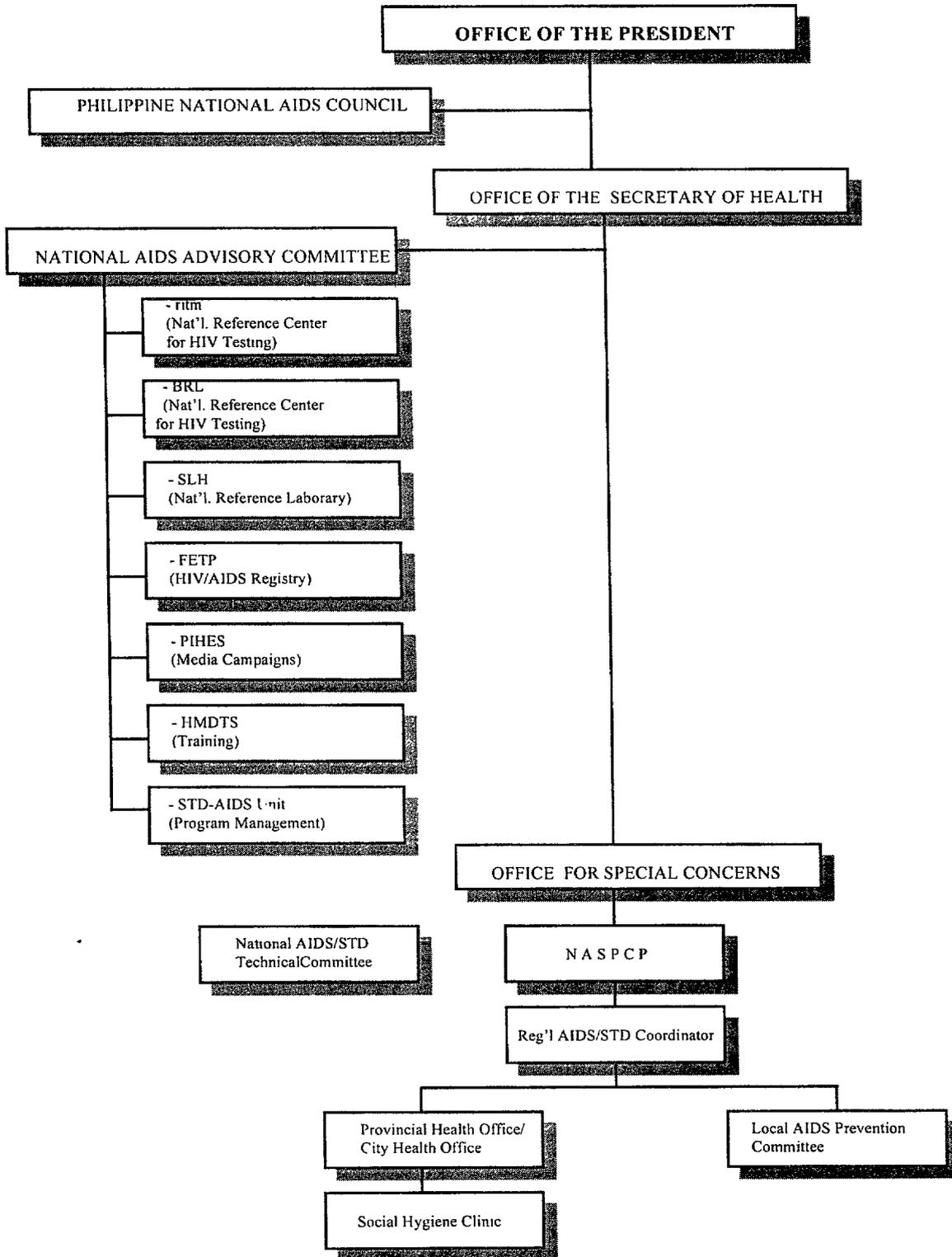
The National AIDS-STD Prevention and Control Program (NASPCP), Medium-Term Plan 2 (1994-1999) governs program activities at this time. The objectives of the program for the medium-term are:

- To continue to monitor STD and HIV infection among identified sentinel groups and the general population;
- To institute HIV screening of all blood administered through the government's health care system;
- To promote health education to encourage safe behavior among vulnerable groups as well as the general population;
- To promote the use of condoms among those who practice high-risk sexual behaviors;
- To develop and propose to government specific guidelines for the screening of all blood products used in the private sector, including private hospitals;
- To enforce appropriate sterilization practices for skin piercing instruments, including syringes and needles; and
- To reduce the impact of HIV/AIDS and STD on individuals, groups and society through education, counseling and social support.

To achieve its objectives, the program has four main strategies:

- Prevention of sexual transmission;
- Prevention of transmission through blood;
- Prevention of perinatal transmission; and
- Reduction of the impact to individuals, families, communities and society.

**ORGANIZATIONAL STRUCTURE
NATIONAL AIDS/STD PREVENTION AND CONTROL PROGRAM**

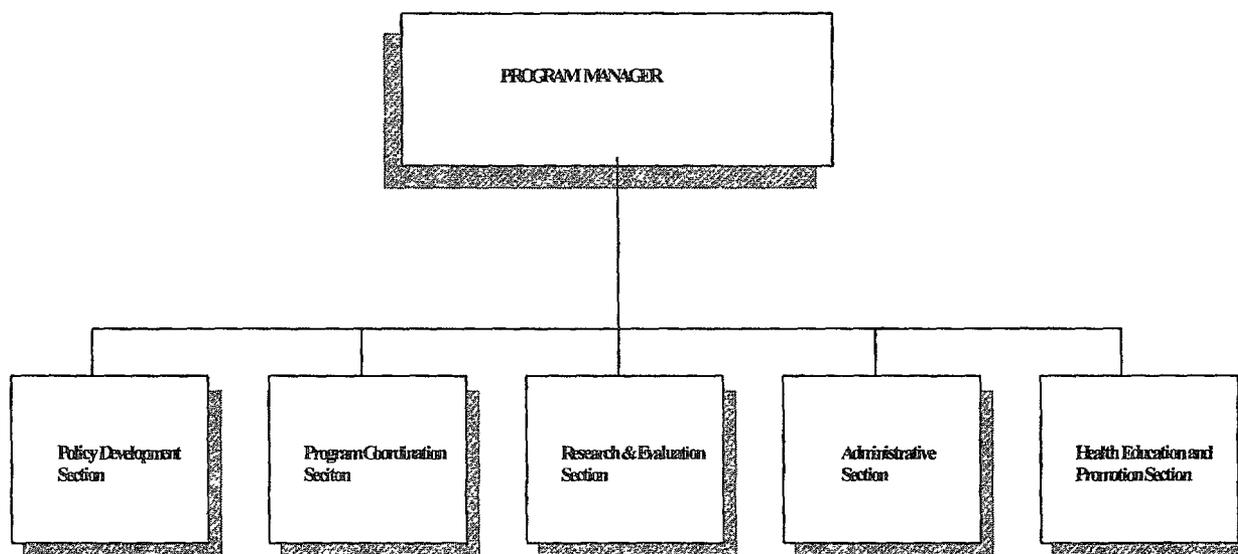


Two bodies provide policy direction and coordination for the national HIV/AIDS prevention program. The Philippine National AIDS Council (PNAC), created by President Ramos in 1992, and chaired by the Secretary of Health, consists of top-level officials from 13 government departments/agencies and seven NGOs including a representative of Pinoy Plus, a local organization of people living with HIV/AIDS (PLHA). The PNAC advises the President on policy developments for AIDS prevention and control and is supported by a technical working group comprised of the technical staff of the Council members. The National AIDS-STD Advisory Committee, comprised of DOH services and bureaus, including RITM and San Lazaro Hospital, provides oversight for DOH's AIDS/STD prevention and control activities. It is supported by a technical working group composed of the technical staff of the committee members.

In 1994, the National STD Technical Committee (NSTC) was convened, to provide technical and policy-related adviser to NASPCP. Members of this committee are experts, both from the government and private sector in various disciplines – public health, social and behavioral sciences, clinicians, pharmacists, and the likes.

The AIDS/STD Unit in DOH's Office of Special Concerns serves as a secretariat for the PNAC and the National AIDS-STD Advisory Committee. Although the unit has a small cadre of permanent staff, most of the personnel are either contractual (including two USAID-financed positions) or are seconded from other DOH services.

ORGANIZATIONAL CHART DOH AIDS/STD UNIT



The NASPCP works in six main program areas:

- *Surveillance and Research*

DOH's FETP manages the National AIDS Registry, to which all testing laboratories--both public and private--are required to report all cases of HIV infection and AIDS. It is known, however, that there are some problems with this data base.

Thus, in addition to the above "passive" surveillance system, FETP and selected LGUs, with support from USAID through a grant to the WHO/WPRO, conducts sentinel surveillance to actively monitor the spread of HIV/AIDS in high risk groups. The system now focuses on four population groups: registered female sex workers, freelance female sex workers, men who have sex with men and injecting drug users. (See page 109 for more detail about the sentinel surveillance system.)

- *IEC*

The communications strategy, developed in 1992 and revised in 1994 for the period 1994-99 details three main target audiences:

- Influentials such as policy makers, health professionals, religious leaders, media practitioners and others;
- "Gatekeepers" such as teachers, media practitioners, health care workers, religious leaders and civic organizations
- Individuals at risk, such as overseas contract workers, commercial sex workers, men who have sex with men and injecting drug users.

Of these, the program currently prioritizes emphasizes commercial sex workers, injecting drug users and men who have sex with other men.

NGOs conduct the bulk of IEC activities, undertaking educational programs for high risk groups to promote behavioral change, as well as mass media programming targeted to the broader population. LGUs meanwhile, focus primarily on counseling for clients who come to the social hygiene clinics. USAID supports IEC activities for high risk groups, through an American NGO, Program for Appropriate Technology in Health (PATH).

IEC activities promote condom use and, in some cases, distribute condoms. For the most part, however, condoms are made available through social hygiene clinics, health centers, hospitals and other agencies participating in the PFPP. In addition, DKT International, with funding from KfW, operates a social marketing program which sells condoms at subsidized prices through pharmacies, drug stores, supermarkets, bars, brothels and elsewhere. It also undertakes community education activities, such as street theater, and targeted marketing to high risk groups, with USAID support.

- *STD Prevention and Care*

DOH has had a longstanding program of STD control centered on a network of 130 social hygiene clinics. These clinics, now managed by the LGUs, cater largely to registered sex workers who are required to undergo regular examinations in order to obtain a "pink card." Efforts are under way to strengthen this program and help it provide policy guidance to the LGUs that are the primary providers of STD services. In the last three, an STD-AIDS Manual of Operations, a National STD Case Management Guide and a Manual for Training in STD care and prevention have been completed and an STD strategy is currently being prepared. Family Health International/AIDS Prevention and Control Project (AIDSCAP) supported the program in this task, with funding from USAID.

DOH is giving a new emphasis to implementation of the syndromic approach to case management. Model sites are being set up in eight cities where health workers are being trained in the syndromic approach, linkages between LGUs and NGOs are being built and strengthened around STD prevention and care, and public service announcements are being broadcast to encourage persons with STDs to seek treatment.

- *Blood Safety*

Recognizing the threat to transmission of HIV and other infections, DOH is seeking to develop a national voluntary blood donation program.

A 1994 USAID-supported study estimated that the blood supply falls short of yearly requirements by as much as 33 percent and confirmed that most of the blood is provided by commercial blood banks with pay donors, increasing the risk of disease transmission as much as three times compared to a voluntary system. This study led to enactment of a legislation requiring commercial blood banks to close by December 1996 -- which was postponed until December 1997--and also created a multisectoral National Blood Program Committee and a National Voluntary Blood Services (NVBS) Program. A NVBS Unit was tasked to manage the program and draft a national strategic plan. The plan was developed, with USAID financial support, and accepted and endorsed by DOH in 1996. The goal of the new voluntary program is to establish a safe, adequate and efficient voluntary blood transfusion service in the country over the next five years.

- *Laboratory Services*

Diagnostic facilities are available in strategically designated hospitals and social hygiene clinics. Initial HIV screening, on a voluntary and confidential basis, is done by government and private laboratories accredited by the Bureau of Research and Laboratories (BRL). Confirmatory testing is done by BRL and RITM. Work is under

way to upgrade selected laboratory facilities, through training and new equipment financed largely by USAID and JICA.

The STD/AIDS Cooperative Control Laboratory (SACCL) is also being established, to serve as a referral center for STD/HIV diagnosis as well as training and research. This is mainly funded by the Government of Japan through JICA.

- *Care and Support*

There are three government hospitals that provide care and support to people living with HIV and AIDS: San Lazaro, RITM and Ospital ng Maynila. They offer clinical care and support, counseling and laboratory services. In the regional hospitals, HIV/AIDS Core Teams, have been created (and adequately trained) to cater to the needs of PLHA in their local area. DOH shoulders the costs of care at the hospitals it operates, including care for further infection, but it does not provide anti-HIV drugs.

Counseling before and after HIV testing is provided by DOH/LGU facilities and NGOs, primarily in selected urban areas.

Major Accomplishments

Among the major accomplishments of the NASPCP in recent years are:

- Development of a National AIDS Strategy;
- Establishment of the National AIDS Registry;
- Establishment of a National HIV Sentinel Surveillance System to monitor HIV transmission among high risk groups
- Integration of HIV/AIDS education into the curriculum for secondary and college students as well as medical, nursing, midwifery, dental and medical technology courses;
- Generation of a body of research data on clinical, laboratory, social and behavioral variables;
- Formation of the Philippine National AIDS Council as a multi-sectoral advisory body on HIV/AIDS;
- Raising HIV/AIDS awareness in the general population to the point where the first health issue mentioned by Filipinos (43 percent of them) in surveys is HIV/AIDS;
- Creation of the National AIDS Advisory Committee and its working group within DOH;
- Formation of the HIV/AIDS Network of NGOs;
- Integration of AIDS information and education in the school curricula nationwide (DECS Circular 445, S.1997);
- Development of a National Policy and Strategy on AIDS in the Workplace; and
- Passage of AIDS Bill (February 1998).

Issues and Constraints

- There has been no “explosion” of HIV infection thus far in the Philippines. The number of geographic sites for HIV/AIDS surveillance may not need to be expanded to a larger number of urban areas. However, high risk behaviors are widespread among those groups where the potential for STD/HIV infection is greatest. The number of groups delivering IEC prevention activities may need to be expanded.
- Surveillance has found high prevalence rates of STDs in a number of risk groups, raising concern for STDs as a co-factor in the spread of HIV/AIDS. Substantial inputs will be required to strengthen DOH’s capacity to treat STDs and other HIV/AIDS-related diseases. For example, there is an acute shortage of drugs to treat STDs.
- In the wake of devolution, advocacy activities are needed to convince local officials of the importance of HIV/AIDS/STD programs and the need to fund them. Capacity-building is also needed to help them plan, manage and evaluate effective programs.
- There is a dearth of national policies, standards and guidelines on safe sex and HIV/STD prevention and care programs that makes for a patchwork of policies and programs that are not always as effective as they might be.
- Opposition to the promotion of condoms by some religious groups presents a major problem because of the unwillingness of many public officials, NGO leaders, health workers and others to participate in this highly effective preventive strategy.
- Ensuring the safety of the blood supply is another area of concern. The current system for procuring blood is principally through paid donors and suppliers and poses risks of contamination. The changes proposed by DOH involve a massive revamping of the system over the next few years. Until these changes are fully implemented, the blood supply as a co-factor in the spread of HIV/AIDS remains a cause for concern.

Program Funding

An estimated 185 million pesos was spent for the NASPCP in 1997, with USAID providing almost 42 percent of this amount. (See Table 18.) The DOH budget provided 32.6 million pesos or 18 percent of estimated program expenditures, but this figure excludes expenditures by: the DOH regional offices; DOH facilities for testing and care for persons with HIV/AIDS/STDs; and support provided by the LGUs for social hygiene clinics, which provide most AIDS/STD services. Total expenditures also include only donor support from projects that have AIDS/STDs as their major focus,

even though a number of other projects with a broader health care agenda also contribute in important ways to the NASPCP.

Table 18: Estimated Expenditures for the National AIDS/STD Prevention and Control Program, in Pesos, 1997

	<u>Pesos</u>	<u>% of Total Expenditure</u>
GOP	31,654,436*	18
USAID/ASEP*	69,601,450	38
USAID/AIDSCAP	7,250,000	4
AusAID	9,454,000	5
JICA	66,000,000	35
TOTAL	184,959,886	100%

* October, 1996 – September 1997.

Note: US dollars converted into pesos at a rate of 29 P to \$1 (1997 Average Forex rate)

Source: DOH, AIDS/STD Unit, USAID, AusAID, JICA.

The NASPCP is supported by a patchwork of projects. USAID is the largest contributor to the program but other donors play a critical role in supporting a large and complex program.

- Establishment of an HIV sentinel surveillance system among high risk population groups at strategically located geographic sites is supported by USAID and supplemented by the Japanese government. USAID focuses on financing and providing technical assistance to the surveillance system itself, while JICA provides laboratory, office and communications equipment.
- In HIV/AIDS education, USAID focuses on high risk groups, while other donors support educational activities directed toward the broader population. Both AusAID and the European Union support NGO-based IEC activities, with JICA also providing small-scale grants to local NGOs. In addition, AusAID provides funding for developing curricula for students of medicine, nursing and allied professionals. The Japanese government, through an Embassy-managed program, also provides IEC equipment for these NGOs.
- Various UN and multilateral agencies, with the UN Programme on HIV/AIDS (UNAIDS) as a coordinating body, concentrate on support for infra-government activities on HIV/AIDS prevention, e.g., pilot initiatives in various GOP agencies; projects to strengthen NGO/LGU partnerships; advocacy activities for public officials; and work on the integration of AIDS education into school curricula.

UNAIDS assists the GOP in the areas of policy making, program management, human resource development and IEC. It also develops models and strategies for improving public and private STD treatment and management.

- Condom distribution and sales are supported by various donors, with USAID supplying most of the condoms used in the DOH program under SO 3 (WHO has phased out its provision of condoms), while KfW provides assistance to DKT International for social marketing of condoms below cost in the private commercial sector.
- A number of donors are upgrading selected public sector services for STD/HIV/AIDS diagnosis and treatment. USAID, through the AIDSCAP project, has strengthened the national STD program, particularly at the social hygiene clinic level. USAID and AusAID through its syndromic approach training programs, support model sites for the implementation of the syndromic approach to STD case management. The Netherlands Embassy provides drugs to treat STDs through local NGOs in selected cities. The European Union is upgrading public sector sites and emphasize integration of STD/HIV/AIDS services into primary health care. A number of donors are placing special importance on diagnosis and treatment of STDs and reproductive tract infections. These include the World Bank through UHNP, the World Bank and other donors through WHSM, and UNFPA through its family planning and reproductive health project.
- JICA supports the establishment of a national AIDS/STD referral laboratory and training for regional personnel in HIV laboratory diagnosis and treatment.
- In the effort to promote a safe blood supply, USAID has supported development of a study of blood practices and development of a national blood program strategy. JICA supports the provision of laboratory equipment for DOH and the Philippine National Red Cross.

III. USAID/PHILIPPINES PROGRAM

A. Brief History and Background

The U.S. has provided economic assistance to the GOP since 1946, having an important impact on development and touching the lives of millions of Filipinos.

- One in every 20 villages in the nation has a primary schoolhouse financed by USAID; Tens of thousands of farmers have been exposed to new farming techniques and technologies that were developed with USAID assistance;
- The safety and efficiency of the country's air transport system was improved through USAID-financed training of key technical personnel in the use of new air navigation equipment;
- The GOP established a build-operate-transfer (BOT) mechanism with USAID technical assistance when crippling power shortages hit Metro Manila in 1992-93. This permitted NAPOCOR to turn to the private sector and get power projects on stream, virtually eliminating power outages;
- Many Philippine institutions of excellence were either created or developed with USAID assistance, including the University of the Philippines at Los Banos, the International Rice Research Institute, the Asian Institute of Management, the DOH and Siliman University;
- USAID has been the major donor in helping develop private voluntary organizations in the Philippines--a community that has become a significant force for change;
- The U.S. was one of the four lead donors in the highly successful Multilateral Assistance Initiative (MAI) which directly supported much of the macroeconomic reform program now pushing the Philippine economy to new heights.

U.S. government support for the health sector began in 1952 with funding for the national malaria control and eradication program. In the 1960s, the focus shifted to nutrition and later included support for innovative primary health care programs in the Bicol region and on Panay Island. In the 1980s and continuing into the 1990s, USAID provided technical assistance, training and financial resources to help develop an economical primary health care system nationwide. It also supported the government's efforts to promote child survival programs to combat infant mortality. For many years, USAID also provided food assistance to the Philippines, particularly for infants, school children and mothers, through the Food for Peace (P.L. 480) program.

USAID has supported family planning in the Philippines since 1967, beginning with assistance to NGOs engaged in family planning and going on to support POPCOM, DOH and NGOs that made available culturally acceptable, safe and effective contraceptives to couples desiring them. Abortion, which is illegal in the Philippines, is not encouraged or financed by USAID. In 1991, AID/Washington's Office of Population designated the Philippines as a priority country to receive population assistance funding, based on a three-factor index of unmet need for services, number of high risk births and number of new users needed to track the UN low fertility population projection.

B. Country Strategy

Philippines 2000: A Model NIC Democracy

At the time of the EDSA Revolution, in 1986, nearly two decades of crony capitalism had left the Philippine economy in a shambles. The people were poor and had been largely cut off from international commerce. Once abundant forest and fishery resources had been decimated. Most of the few remaining core institutions of a once-proud democratic society were corrupt. The Philippines had been dubbed the Sick Man of Asia. The new Aquino government began the arduous journey of returning the country to democracy and reestablishing connections to the global marketplace. USAID played a key role through the MAI, launched in 1989 with pledges of some \$3.5 billion in annual assistance from 22 donors.

The orderly election of President Ramos in 1992 underscored the commitment of the Philippines to both democratic principles and free markets--the only country in S.E. Asia to make that commitment. Under the banner of Philippines 2000, the Ramos Administration set its goal on achieving newly industrialized country (NIC) status through global excellence and people empowerment. The government hopes to enable the Philippines to compete effectively in a global marketplace while empowering its people to take control of every aspect of their lives. The GOP has established ambitious targets to be achieved by the year 2000. Principal among these are the increase in per capita income to \$1,200 per year (from \$730 in 1990), reducing the incidence of poverty to 30 percent and substantially slowing the population growth rate.

To that end, the Philippines has been pursuing an aggressive program of economic liberalization. Over the past decade, the economy has undergone considerable reform and appears to be approaching the levels of growth necessary to support the Philippines 2000 goals. Now the Philippines has acquired the sobriquet of Asia's most active tiger cub. However, economic growth must go hand in hand with increased access to the benefits of growth, social justice and an improved quality of life for the many living in poverty. Through its Social Reform Agenda, the government seeks to improve the lives of the majority of Filipinos and create a greater stake for them in

determining their own future.

While impressive progress is being made, democracy and development remain fragile. Political and social unrest, particularly in Mindanao, remain serious problems. Public confidence in the judiciary and in law enforcement is weak. Stubbornly high poverty rates have yet to fall dramatically. And large numbers of people in marginalized groups, such as the urban poor, fisherfolk and tribal groups, are still excluded from political processes.

USAID/Philippines' goal is to support the effort of the GOP to achieve the status of a newly industrialized, democratic country by the year 2000 by supporting both democracy and development as essential components of this goal. As of 1997, the Mission completed the shift from a program focused on macro-level policy reform and infrastructure to a more targeted technical assistance program. Infrastructure activities were completed and the Food for Peace program (P.L. 480) was also phased out.

Mission Goal:

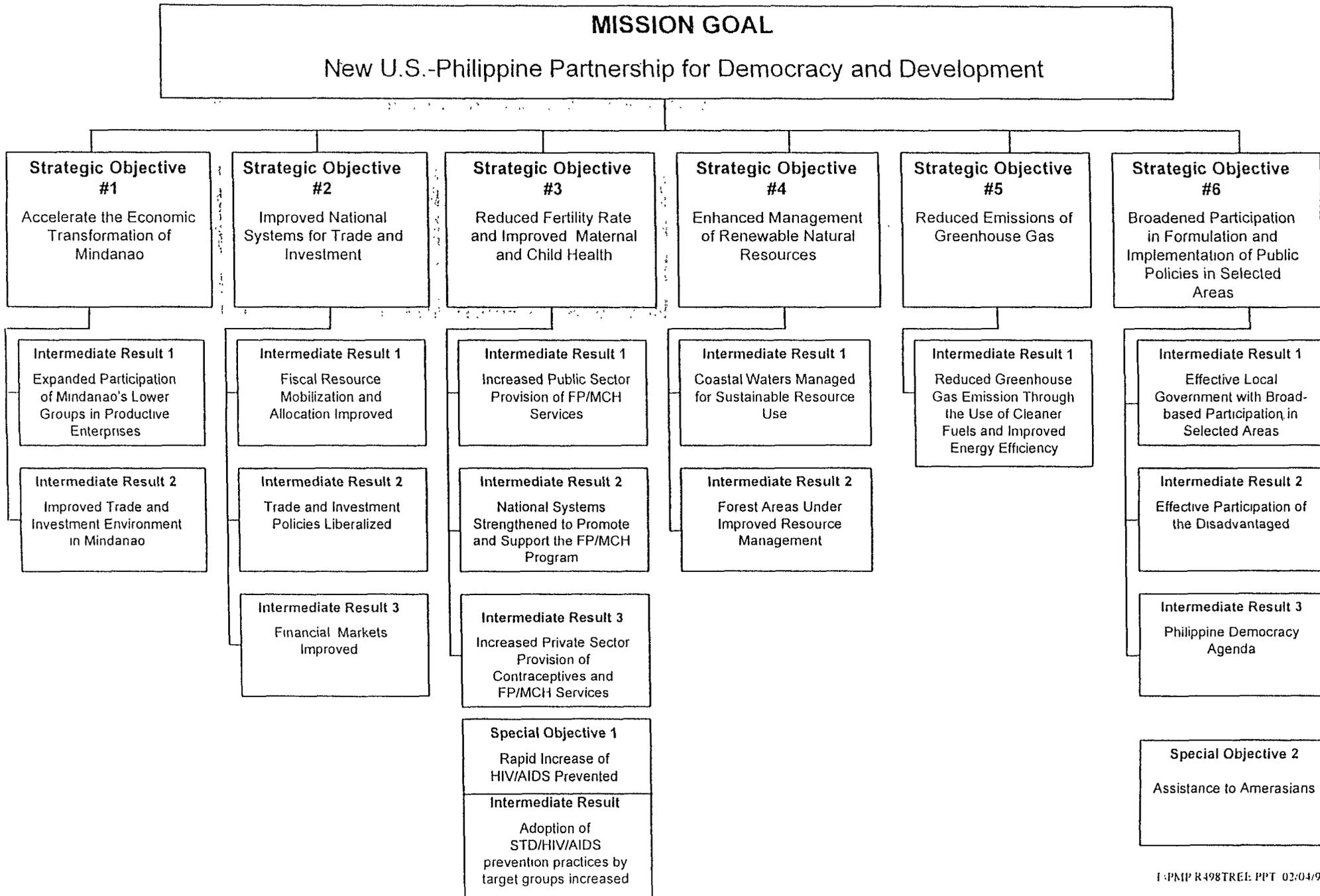
New U.S.- Philippine partnership for democracy and development

The Philippine Mission is also on the leading edge of USAID's worldwide reengineering effort, having served as a successful experimental laboratory for the new results-oriented program approach. The Mission has shifted from a project to a program orientation and has developed a country strategy based on strategic objectives (SOs) that lead to achievement of the Mission's goal and intermediate results that lead to achievement of the strategic objectives.

The Mission's strategic objectives are outlined below. The themes of devolution to LGUs and NGO involvement run through all of them.

1997-2000
1990-1997
1980-1989
1970-1979

USAID/PHILIPPINES OBJECTIVE TREE



SO 1: Accelerate the Economic Transformation of Mindanao

This strategic objective seeks to maximize people's participation in and benefits from increased public and private investments in the economy of Mindanao—an island where the quality of life is well below the national average and where there is potential for peace and substantial economic growth. USAID focuses on a broad-ranging enterprise development program aimed at facilitating maximum participation of small farmers/fisherfolk, and small and microentrepreneurs in the economy. It also supports efforts to assist Mindanao's leaders identify and bring about modifications to governmental policies that will stimulate economic progress, and to assist leaders to take actions to help assure the continued flow of appropriate levels of public infrastructure development resources and private investment. Assistance will be provided to finance institutions in Mindanao to develop their capacity to provide viable and sustainable services to small and microenterprises.

USAID partners in this initiative are Presidential Assistance for Mindanao, LGUs, the private sector and a contractor for the Growth with Equity in Mindanao (GEM) program.

SO 2: Improved National Systems for Trade and Investment

This SO aims to create an environment conducive to trade and investment through liberalized policies, improved financial markets, and improved mobilization and allocation of fiscal resources. It includes programs designed to promote domestic competition in selected key sectors of the economy. Reforms focus on reducing barriers to entry in domestic industries, improving transportation and communications services, improving tax planning, administration and collection, and facilitating the movement of investment capital. USAID assistance is provided through advisory services in the review, analysis and formulation of policies, and through support for policy reforms by coalitions of interested groups. USAID will also support the implementation of these reform policies to upgrade the capability of local institutions to implement and sustain policy reform efforts.

This SO is being undertaken together with the Bureau of Internal Revenue, the Securities and Exchange Commission, the National Telecom Commission, the Bureau of Treasury, the National Credit Council, Philexport and other NGOs.

SO 3: Reduced Population Growth and Improved Maternal and Child Health

SO 3 seeks to improve the health of women and children by expanding access to quality family planning and selected other reproductive health services in the public and private sectors as well as fostering the continued provision of selected child survival interventions at the LGU level. USAID releases a "tranche" of funds each year provided that DOH and participating LGUs meet a series of performance "benchmarks" concerning the delivery of family planning and MCH services.

Collaborating agencies assist DOH and POPCOM, NGOs and the private commercial sector to strengthen systems for IEC, logistics, policy formulation, applied research, family planning and MCH service delivery and social marketing. Funds are also used to procure contraceptives from the U.S. and to support surveys to monitor key indicators of progress. This program is described in more detail on pages 95 to 106.

SO 4: Enhanced Management of Renewable Natural Resources

This SO is designed to enhance and sustain the management of natural resources by communities and businesses and thereby prevent environmental collapse while the opportunity still exists. It works in three areas: forestry resources management, coastal resources management and industrial environmental management. In the forestry sector, USAID assists upland communities to secure management authority and responsibility for at least 500,000 hectares of the country's public forest lands. This forest land will be converted from open access conditions into community-managed enterprises. By applying sustainable management systems, program beneficiaries will provide approximately 10 percent of domestic demand for solid wood products by 1999. In coastal resources management, USAID's efforts will lead to communities controlling access to, and practicing management for, sustainable harvests in coastal waters along 3,000 kilometers of shoreline. In return, these communities are expected to supply 25 percent of national harvest from coastal waters by 2002. In the industrial sector, USAID's efforts will lead to increased private investment in pollution-abatement practices. As of 1996, these investments reduced pollution discharges by participating industries by 29 percent.

Partners in SO 4 are the Department of Agriculture, the Department of Environment and Natural Resources, LGUs, U.S. and local NGOs and U.S. contractors.

SO 5: Reduced Emission of Greenhouse Gasses

SO 5 aims to mitigate emissions of greenhouse gases from the power industry through the use of cleaner fuels and improved energy efficiency. Efforts will target the development of natural gas, renewable energy, clean coal and greater end-use efficiency by industrial and commercial enterprises. Targeting these areas for additional funds not only greatly enhances the likelihood of achieving this objective's targets, but also supports the three highest priority policy areas of the GOP. Annual performance-based monitoring will allow USAID and the GOP to adjust activities for maximum impact.

Partners with USAID in this effort are the Department of Energy, the National Electrification Administration, the National Power Corporation, US contractors, NGOs and the private power sector.

SO 6: Broadened Participation in the Formulation and Implementation of Public Policies in Selected Areas

This strategic objective aims to broaden participation in the formulation and implementation of public policies in selected areas. USAID is providing assistance to LGUs of 10 provinces and their municipalities and cities. Premised on "assisted self-reliance," the assistance uses participatory mechanisms to innovate and implement service delivery systems that establish new performance standards. These include resource mobilization, investment prioritization and environmental planning and management. Participatory processes will revolve around the Local Government Code provision for local special bodies wherein not less than 25 percent of membership should come from NGOs. USAID is also assisting disadvantaged groups to unite into coalitions of member-controlled associations working to promote under-represented interests. The coalitions will be linked to centers of power and strengthened to the point where they are able to analyze and debate public policy issues and to participate in the public policy arena. Illustrative of the respective critical issues are: repeal of inappropriate laws, land rights and tenure, and equitable management of resources. In a special initiative, USAID is assisting pro-democracy groups to formulate a Philippine democratic action agenda leading to a better articulated and broadly supported policy recommendation for the protection and promotion of the democratic process.

Partners in this effort are U.S. and Philippine private consulting firms, U.S. and local NGOs and the Philippine Leagues of city, provincial and municipal governments.

Special Objective: Rapid Increase of HIV/AIDS Prevented

This special objective seeks to prevent a rapid increase of HIV/AIDS infection by monitoring the prevalence and transmission of HIV infection and encouraging behaviors that reduce HIV transmission. A sentinel surveillance system for monitoring HIV seroprevalence is being implemented under the program. Mass media and IEC programs, which help reduce HIV transmission among individuals at risk, are being implemented under the education component of the program. USAID is assisting DOH to develop a strategy and plan of action for a safe blood supply system. With USAID support, the GOP and NGOs will develop, implement and evaluate a set of STD interventions among groups with high prevalence of STDs in selected sentinel sites. This special objective is described in detail on pages 107 to 113.

Special Objective: Assistance to Amerasians in the Philippines

This special objective will facilitate the socio-cultural and economic integration of Filipino Amerasians by enhancing their skills and productivity, and that of their families, by helping them secure access to jobs or capital for small business ventures and providing them access to health and psycho-social services.

USAID's partners will be a coalition of NGOs led by the Pearl S. Buck Foundation.

USAID/Philippines' Regional Role

In addition to managing an ambitious country program, the Mission's regional responsibilities have been steadily increasing over the last couple of years. With the closure of the Regional Mission in Thailand, USAID/Philippines now provides program and project support as well as contracting, finance, administrative and legal support to USAID programs in Mongolia, Vietnam, Laos, Cambodia and the Regional Inspector General's office.

C. SO 3: Reduced Population Growth Rate and Improved Maternal and Child Health

Program Objectives

SO 3, also known as the Integrated Family Planning/Maternal Health Program (IFPMHP), runs from 1994 to 2000 and, as the major program supporting the PFPP, seeks to contribute in an important way to achieving some ambitious, but attainable, results by the turn of the century:

- The population growth rate will decline from 2.35 percent a year in 1990 to 1.93 percent;
- Fertility will fall from 4.1 children per woman in 1991 to 3.1;
- The infant mortality rate will be reduced from 57 per 1,000 live births in 1990 to 41;
- Maternal mortality will drop from 209 deaths per 100,000 live births in 1990 to 190;
- High risk births will decline from 62.4 percent of all births in 1993 to 56.0 percent;
- Contraceptive prevalence for modern methods will increase from 25.2 percent in 1993 to 35.7 percent and, for all methods, from 40.0 to 50.5.

The achievement of these results will support the Philippine government's and USAID's objectives for the year 2000 by reducing the pressures of rapid population growth on sustainable development and improving MCH.

USAID's Partners in SO 3

A number of GOP institutions are working collaboratively with USAID in implementing the strategic objective and attaining the desired results:

- The DOH, as the GOP agency with the major responsibility for overseeing public health services, providing strategic leadership on health matters and giving technical assistance to the field, is the major USAID partner in implementing SO 3. The DOH has designated a project management team headed by the Assistant Secretary of the Office of Special Concerns, and supported by a Project Management Office, to manage the program on the GOP side.
- POPCOM, as the government agency with overall responsibility for the Philippine Population Management Program, is another key partner, particularly on policy and advocacy issues.
- The NSO conducts an annual family planning rider survey for the program as well as the Demographic and Health Survey. In 1997, it added a MCH rider survey.
- LGUs now have the primary responsibility for providing health services, including family planning, and SO 3 places a major emphasis on helping them expand and upgrade their family planning, population and child survival programs.

USAID has entered into agreements with several collaborating agencies, some American and some Filipino, which have front-line responsibility for carrying out the activities envisioned under SO 3 (See Annex 7 for a list of agencies with brief sketches of each one's role in the program).

Challenges Addressed in SO 3

There are a number of major challenges that USAID and the GOP seek to address through SO 3. In the area of population/family planning, they are the following:

- There is a large gap between knowledge of contraception, which was shown to be close to universal in the 1993 NDS, and contraceptive use which stood at 30.9 percent of married women using a modern method (including modern NFP) according to data from NSO's 1997 family planning survey. There is also a substantial unmet need for family planning, with 26.2 percent of married women saying they would like to postpone or avoid a birth but not using family planning. SO 3 seeks to raise contraceptive prevalence, by strengthening and expanding virtually every facet of the public program (logistics, training, IEC, operations research, etc.) and significantly increasing the role of the private sector.
- The private sector still plays a small role in the provision of family planning services. It was the source of contraception for only 27.0 percent of users of modern contraceptive methods in 1993. Under SO 3, strategies are being developed to increase this role by identifying segments of the "market" for family planning services that can afford to pay the cost of care, or some of the cost of care, in the private sector and focussing public sector resources more effectively on the poorest

and most underserved segments of the population. Collaborating agencies working with the private sector will be held accountable for increasing the number of CYPs they provide and catering to identified segments of the market. Overall the private sector will increase its share of the market for modern methods to 34.0 percent by the year 2000.

- With 62.4 percent of births occurring to women in high risk groups in 1993 (56.2 percent in 1997), there is also a need to reach these women with family planning information and services in order to improve MCH. SO 3 expects to reduce the incidence of high risk childbearing to 56 percent by reaching high risk women and their partners with family planning services.
- Of women adopting a modern method of contraception, 30.8 percent discontinue their method in the first year for reasons other than the desire to become pregnant--implying that the quality of services still leaves something to be desired. SO 3 places a major emphasis on training and on program monitoring to address quality issues.
- With the implementation of the Local Government Code of 1991, the planning, management and evaluation of health services have been devolved to LGUs and they, DOH and POPCOM are still seeking to define functional relationships. Two of SO3's three Intermediate Results are concerned with achieving this, by providing technical assistance to DOH and POPCOM at the central level as well as to the LGUs.
- If the future of the family planning program is to be assured in the face of well-organized opposition, a network of support must be built among decision-makers in central government and at the LGU level. SO 3 provides for technical assistance to POPCOM and the LGUs to ensure that a base of support is laid.
- Much remains to be done to institutionalize the family planning program which is still almost entirely donor-supported and heavily dependent on contractual personnel for program direction and operations. USAID and the DOH have developed a series of indicators to ensure increasing financial support for family planning at the central and LGU levels and increased responsibility on the part of DOH personnel for core program functions.

In MCH, the following challenges are being addressed:

- Reducing sickness among infants who account for more than two-thirds of the deaths among preschoolers. SO 3's family planning and child survival interventions address the leading causes of death among infants.

- Raising immunization coverage which appears to have slipped since devolution. At a minimum, the 90 percent of children fully immunized achieved in the early 1990s is to be maintained; and tetanus toxoid coverage among pregnant women is to be almost doubled from the 1990 level of 42.4 percent;
- Reducing VAD among young children which stood at more than twice the WHO cut-off level of five percent in 1993. Like immunization coverage, Vitamin A distribution, too, appears to be dropping in the wake of devolution. Under this program, Vitamin A coverage is to be maintained at 1993 levels, at a minimum; and
- Reducing IDD. Prevalence of goiter among pregnant women increased between 1987 and 1993, from 12.4 to 22.8 percent of pregnant women aged 21-49; and among lactating women from 10.0 to 17.2 percent. SO 3 will support DOH's campaign against iodine deficiency among women.

Increased contraceptive prevalence is fundamental to achieving all the SO indicators. If the anticipated 35.7 percent CPR (modern methods) is reached by the year 2000, then, based on worldwide experience, the desired total fertility rate (TFR) will follow and population growth will slow. If services are successful in reaching women in high risk groups, then the percent of births to women in these groups will also be reduced.

Increased contraceptive prevalence, particularly among women in high risk groups, will also contribute to reducing infant and maternal mortality. However, in order to ensure that the infant and maternal mortality indicators are achieved, as well as because improved child survival is key to couples' decisions to have fewer children, the provision of selected child survival services in the public sector will also be increased.

In order to achieve the desired end-of-program results, three Intermediate Results have been designed:

- Intermediate Result 1: Increased public sector provision of family planning/MCH services.
- Intermediate Result 2: National systems strengthened to promote and support the family planning/MCH program.
- Intermediate Result 3: Increased private sector provision of contraceptives and family planning/MCH services.

USAID and the DOH have agreed to adopt a performance-based approach to the program, based on successful experiences with the Child Survival Program and the Health Finance Development Project. Under this approach, DOH, POPCOM, NSO and the collaborating agencies must achieve certain benchmarks, or major accomplishments under Intermediate Results 1 and 2 (the public sector components of the program) each year in order for the GOP to receive an annual tranche of funds from USAID. This tranche is then available for grants to LGUs that have achieved their

benchmarks and for DOH activities in family planning and MCH. Over the life of the program, \$29.2 million are budgeted for tranche disbursements. Tranche funds are not conditional on achievement of benchmarks under the private sector component of the program, Intermediate Result 3.

Intermediate Result 1: Increased public sector provision of family planning/MCH services.

The public sector provided contraceptives to 71.4 percent of users of a modern method in 1993 (and 72.9 percent in 1997) and will remain the backbone of the national family planning/MCH program in the near future. This component of the program will support the attainment of SO 3 by increasing the provision of family planning and MCH services in *public sector* facilities, most of which are operated by the LGUs, to achieve the following core indicators by the year 2000:

- The number of CYPs provided will increase from 1.67 million in 1994 to 2.55 million;
- The percent of children fully immunized will remain at least at 90 percent;
- The percent of pregnant women immunized against tetanus will have increased from 70.0 percent in 1993 to 80.0 percent in 2000; and
- The proportion of children receiving Vitamin A capsule supplements will remain at least at 90 percent.

In addition, in order to enhance the sustainability of LGUs' population/family planning/child survival activities, a new mechanism is being sought, as the previous requirement to allocate increasing proportions of their Internal Revenue Allotments from the central government for programs in these areas proved to be difficult to implement.

A performance-based grant program to the LGUs, known as the LGU Performance Program (LPP), has been established as the primary vehicle to achieve Intermediate Result 1. Under LPP, LGUs (provinces and cities) that achieve certain benchmarks receive a grant to expand and improve their family planning/population/child survival programs. LGUs are brought into LPP in batches, usually consisting of 20 LGUs per year, starting with the most populous and those with the strongest political commitment to family planning/population and child survival activities. The first 20 entered the

INDICATORS

- Pop. Growth Rate - 2.35 (1990) to 1.93 (2000)
- Total Fertility Rate - 4.1 (1991) to 3.1 (2000)
- Infant Mortality Rate - 57 (1990) to 49 (2000)
- Maternal Mortality Ratio - 209 (1990) to 190 (2000)

STRATEGIC OBJECTIVE #3**Reduced Population Growth Rate and Improved Maternal and Child Health****INDICATORS (Cont.)**

- Contraceptive Prevalence Rate (all methods) - 40.0% (1993) to 50.5% (2000)
- Contraceptive Prevalence Rate (modern methods) - 25.2% (1993) to 35.7% (2000)
- Percent of births in high risk groups - 62.4% (1993) to 56% (2000)

Intermediate Result 1

Increased public sector provision of FP/MCH services

INDICATORS

- Percent of Children Fully Immunized - 90% (1993) to 90% (2000)
- Percent of Women Immunized Against Tetanus - 70.0% (1993) to 80% (2000)
- Percent of children receiving vitamin A capsule supplement 90% (1993) to 90% (1998)
- Modern method couple years of protection (CYP) from a public sector source - 1.67 million (1994) to 2.55 million (2000)
- Aggregate no of LGUs ever enrolled in LPP - 20 (1994) to 100 (1998)
- Aggregate no of LGUs that have achieved the LPP annual benchmarks - 20 (1994) to 75 (1998)
- FP/MCH sustainability enhanced by: [new indicator under preparation]

Activities

- 1 LGU integrated teams develop annual plans and budgets for FP/MCH/Population activities
Benchmark Not less than 75 LGUs have developed comprehensive annual plans and budgets for FP/MCH/Pop programs by December 1998
- 2 LGUs expand FP/MCH service delivery
Benchmarks 1) All LPP LGUs will provide all reversible program methods at appropriate service facilities 41 (1997) to 75 (2000), 2) No of LPP LGUs meeting the annual FIC targets set by DOH 41 (1997) to 75 (2000), 3) No of LPP LGUs meeting the TT targets set by DOH 41 (1997) to 75 (2000), 4) No of LPP LGUs meeting DOH annual VAC supplementation targets 60 (1997) to 75 (1998), 5) No of LGUs where voluntary sterilization services are available 53 (1997) to 75 (2000), 6) No of LPP LGUs that have implemented the DOH-approved IEC annual plan 41 (1997) to 75 (2000)
- 3 LGUs improve the quality of FP services
Benchmark Percent of LPP LGU public sector service sites that have personnel trained in basic FP/Compre FP or integrated FP/RH 60% (1997) to 80% (2000)

Intermediate Result 2

National systems strengthened to promote and support the FP/MCH program

INDICATORS

- PFPP sustainability enhanced by DOH assuming full operational responsibility for the following support functions: contraceptive dist'n and logistics mgmt.; FP/IEC, training, research and evaluation, service delivery technical support; and program monitoring - 10% (1996) to 100% (1999)
- PFPP sustainability enhanced by increased allocation of budget for Family Planning Service by at least 50% per year: P25 1M (1996) to P127 1M (2000)
- DOH release of annual LPP grants for LGU programs by June of the following year 0 (1994) to 75 (1999)
- Updated National PFPP strategy reviewed and jointly approved by DOH and POPCOM Board by November 1996
- Quality of FP/RH services improved through establishment of competency-based training system in LGUs participating in LPP. 0 LGUs (1993) to 75 LGUs (1999)

Activities

- 1 Nationwide contraceptive distribution system strengthened
Benchmarks: 1) DOH assumes full responsibility for FP contraceptive logistics management for the PFPP by the end of 1998; 2) 80% of FP clinics (delivery sites) maintain at least a one-month supply of oral contraceptives and condoms by the second quarter of 1999.
2. FP IEC program strengthened in DOH
Benchmarks 1) Revised communications strategy focusing on LGUs produced and approved by June 1996; 2) National communications programs executed on a yearly basis
- 3 National FP training program strengthened
Benchmarks: 1) By Sept 1996, DOH will have developed and approved a training strategy for 1996 - 1999; 2) By June 1997, DOH will have initiated implementation of revised Basic FP/RH curriculum using a competency-based teaching approach, 3) By Dec 1997, enriched, integ FP/reproductive health curriculum for midwifery developed and implemented in 90% of midwifery schools, 4) By Dec 1997, enriched, integrated FP/reproductive health curriculum for nursing developed and implemented in 90% of nursing schools.
- 4 Research and technical support programs strengthened at the national level
Benchmarks 1) National FP/MCH guidelines and service standards/protocols reviewed, updated and disseminated by Dec 1996, 2) 30 LPP/LGUs have developed capacity to manage and utilize OR studies on service delivery issues by Dec 1999, 3) 6 OR studies on cross-cutting issues conducted and their results disseminated by December 1999, 4) DOH will develop a system by April 1996 and implement the system by June 1996 for FP/MCH assistance to LGUs
- 5 National program monitoring system strengthened
Benchmarks 1) Yearly population-based FP survey conducted by NSO, 2) Yearly National FP/MCH Status Report produced by DOH/OPHS, 3) A national management information system to monitor FP/MCH performance in place by 1998
- 6 PFPP advocacy program strengthened at POPCOM
Benchmarks 1) National pop and devt advocacy plan (1996-2000) developed and implemented, including advocacy for PFPP among professional assns., 2) 1995 and 1998 post-election surveys conducted to measure commitment to PFPP at the LGU level, 3) No of professional assns supporting FP increased from 1 (1993) to 7 (1999)

Intermediate Result 3

Increased private sector provision of contraceptives and FP/MCH services

INDICATORS

- Percent of family planning services provided by the private sector - 27% (1993) to 34% (2000)

Activities

- 1 Contraceptive social marketing (CSM) program expanded
Benchmarks 1) CSM implemented in 33 urban areas by December 1999, 2) Annual CYPs provided by current CSM project expanded from 28,837 in 1993 to at least 212,306 in Oct 1998
- 2 The provision of FP services in private/NGO hospitals and clinics expanded
Benchmarks 1) 135 industry-based clinics have Responsible Parenthood-MCH programs by December 1999; 2) Between January 1997 and December 1999, USAID-assisted NGO-affiliated services (PCPD, JSI, CARE) will provide at least 601,171 CYPs (cumulative), including CYPs for completed referrals
- 3 The role of the private sector on the PFPP enhanced
Benchmarks: 1) Situational analysis on the involvement of the private commercial sector in FP services developed by June 1996, 2) Studies conducted on factors that affect private sector participation including market segmentation, legal and regulatory issues, and the feasibility of re-targeting public sector facilities on low income and underserved areas, 3) At least 2 policy reforms identified in the studies are adopted by December 1998

DATA BASELINES

- * Demographic Health Surveys 5 yrs
- * Safe Motherhood Surveys 5 yrs
- * Annual Population Surveys 1 yr.
- * Population Census 10 yrs.
- * Intercensal Surveys 5 yrs.

program in 1994 and, when the LPP ends in 1999, at least 75 LGUs are expected to be implementing LPP-funded programs. DOH's Office of Special Concerns manages the program, providing technical assistance to LGUs to help them hone their skills in managing results-oriented, cost-effective, accountable programs. Technical assistance for Intermediate Result 1 is provided by Management Sciences for Health (MSH) and other collaborating agencies. (See Annex 8 for LGUs in which USAID is working.)

The benchmarks under LPP are geared toward helping LGUs improve their program management capabilities, expand the delivery of services and upgrade the quality of care. Specifically, the LGUs:

- Assess their own local needs to strengthen and improve their family planning, MCH and population programs and, based on the assessment, develop an annual plan and budget for these programs. The plans vary dramatically from one LGU to another, but can address needs for equipment, drugs and supplies, training, activities in service delivery, IEC, research and other areas. The plans are approved by DOH before they are funded.
- Expand their delivery of family planning and MCH services. They must provide all reversible methods of contraception at the appropriate types of service facilities; must improve the availability of VSS services; must achieve national immunization and Vitamin A coverage targets; and undertake IEC activities to make the public aware of services.
- Improve the quality of family planning services, by ensuring that at least 80 percent of service sites have personnel trained in family planning by the end of the program.

Intermediate Result 2: National systems strengthened to promote and support the family planning/MCH program.

Even in a devolved health care setting, central government has an important role to play and, in order to achieve SO 3, DOH, POPCOM and the NSO, with technical assistance from several collaborating agencies, will:

- Provide technical support to the LGUs to help them achieve the results expected of them and essential to attaining Intermediate Result 1;
- Provide national leadership for the family planning, MCH and population programs, including performing certain national functions, such as contraceptive procurement and distribution, national IEC activities, standard-setting, research, etc.;
- Advocate for these programs at the national level, so as to build a base of support among opinion leaders in government and outside; and
- Conduct surveys to measure program impact.

It is expected that the following results will be achieved:

- The DOH and POPCOM will develop a national family planning strategy;
- The sustainability of the family planning program at the DOH will be enhanced by institutionalizing major functions in the department and increasing the GOP budget for family planning;
- The quality of services will be improved through the implementation of competency-based training in family planning and reproductive health.

Given the demographic trend of increasing urbanization in the Philippines, an urban strategy will guide all facets of IFPMHP to accelerate the expansion and improvement of services in urban areas where more than 50 percent of the population now resides.

Under this component of the program, the core functions of national services are being strengthened:

- *Logistics*

The Contraceptive Distribution and Logistics Management Information System (CDLMIS) is implemented by FPS with technical assistance from John Snow, Inc./Family Planning Logistics Management. CDLMIS is credited with virtually eliminating the widespread stock-outs that hampered the provision of family planning services in the early 1990s. With the system running smoothly nationwide, two activities are receiving priority: (1) work with LGUs to ensure that the system operates smoothly in all LGUs and (2) institutionalizing the system within DOH, with a view to ending long term technical assistance by the end of 1998.

- *Information, Education and Communications (IEC)*

The IEC program of the FPS undertakes a wide variety of activities, encompassing audience research, the conduct of national communications campaigns, the development of publications and support for interpersonal communications. In undertaking these functions, FPS receives technical assistance from Johns Hopkins University/Population Communication Services. With devolution, the thrust of the program is shifting to place a major emphasis on helping LGUs to develop and implement their own IEC programs in support of local needs and priorities.

- *Training*

Family planning training has experienced many problems in recent years, ranging from a lack of trained personnel to unduly long training programs that discourage participation by health care providers. Under SO 3, the basic family planning curricula

has been revised to make them more effective and cost-effective, and competency-based training.

The content of training has been broadened to encompass reproductive health. These tasks have been undertaken with the assistance of Development Associates, under a subcontract with MSH. There is also substantial support for actual training of personnel in the field, under an MSH subcontract with Educational Development Foundation.

A second focus in the area of training is on the integration of family planning and reproductive health into the pre-service training programs of nurses and midwives. This was being undertaken by the Association of Deans of Colleges of Nursing and the Association of Deans of Colleges of Midwifery, with technical assistance from the Johns Hopkins Program for International Education in Reproductive Health. By the end of 1997, 90 percent of schools were implementing the new curricula and USAID support has phased out.

- *Research and Technical Support*

In its post-devolution role, DOH should be concentrating on policy-making, standard-setting, research, program monitoring and the provision of technical assistance to the LGUs. Under SO 3, MSH is helping DOH adapt to this new role. Among the major tasks undertaken in the policy arena was the updating of guidelines and service standards for family planning and MCH services. Using the LPP program to leverage change, MSH is also helping the DOH services and regional offices make the shift from a top-down management approach to helping LGUs plan, manage and evaluate their own family planning and MCH programs.

In research, the focus is on operations research to improve family planning and reproductive health programs. Studies are being conducted at the national level to help guide DOH's management of the family planning/reproductive health program and, consistent with the shift to the LGUs of program management responsibility, LGUs are receiving technical assistance to help them appreciate the value of operations research and use it to strengthen their programs. The Population Council is helping DOH implement these research efforts.

- *Program Monitoring*

A new MIS strategy for the FP, MCH and nutrition programs was approved by the DOH in December 1996. This strategy emphasizes the important roles of both local and national governments in monitoring and evaluating the FP, MCH and nutrition programs.

At the local level, the LGUs make use of a variety of data-gathering mechanisms—the FHSIS, situational analysis, barangay-based masterlisting of clients, cluster surveys and the CDLMIS. Assisting the DOH in ensuring that the LGUs develop the skills for program monitoring and consequently, data-based decision-making are MSH, the Population Council and various university-based institutions around the country.

At the national level, the CDLMIS and national surveys are the primary mechanisms for monitoring program performance and outcome. JSI/FPLM provides technical assistance to the DOH and the LGUs in implementing the CDLMIS. The national surveys are conducted by NSO, with technical assistance from the U.S. Bureau of Census. Since 1995, the NSO has been conducting a large annual survey to monitor key program indicators such as contraceptive prevalence, the incidence of high risk childbearing and the public-private sector split in the provision of family planning services. In 1997, the annual survey collected both family planning and MCH data. In 1998, NSO will undertake a National Demographic Survey (NDS) in collaboration with Macro International. Based on these and other data, the DOH, with assistance from MSH, prepares an annual National FP/MCH/Nutrition Status Report to help program managers around the country evaluate the success of their programs and chart future directions.

- *Advocacy*

POPCOM has a key role to play in helping opinion leaders at the national level and around the country appreciate the link between population and development and the importance of family planning to sustainable development. Under SO 3, POPCOM is developing and implementing a population and development advocacy plan, with a special focus on advocacy among professional associations. It is also conducting post-election surveys to measure the commitment of newly-elected political officials to population and family planning issues. POPCOM is being assisted in these tasks by The Futures Group/The Policy Project.

Intermediate Result 3: Increased private sector provision of contraceptives and family planning/MCH services.

Although the private sector currently plays only a modest role in the provision of family planning/MCH services, providing only 24.4 percent of modern contraceptive methods in 1997, USAID and DOH consider it a high priority to increase the role of this sector. A larger, more vibrant private sector will contribute to the sustainability of the program in the face of scarce public resources and the ever-present possibility of the advent of a pro-natalist administration in the Philippines. Under SO 3, the private sector will not only maintain its share of an increased CPR by the year 2000, but it will *increase its share* of users from 27.0 percent in 1993 to 34.0 percent in 2000. That means that the

private sector will increase the number of CYPs it provides from 642,208 in 1993 to 1.31 million by the year 2000.

It is anticipated that each *subsector* of the private sector--social marketing, private/NGO hospitals and clinics, and the private commercial sector--will increase its CYP contribution over the life of the program.

- *Contraceptive social marketing*

The USAID-supported social marketing program does not subsidize contraceptives. Rather, the implementing agency, The Futures Group/Social Marketing for Change (SOMARC), enters into agreements with pharmaceutical companies to reduce their profit margin in return for advertising and promotional support, using the Couple's Choice name. Prices are maintained in the affordable range for mid to lower ("C and D" out of a scale from A, very rich to E, very poor) socio-economic groups. SOMARC made pills and injectables available nationwide in 1997 but promotion focused on 23 urban areas. The range of products is expected to expand under SO 3 and promotional activities will be conducted in 35 urban areas by the end of 1999.

- *Private/NGO hospitals and clinics*

Companies with more than 200 employees are required by law to make family planning services available to their employees in their health clinics. For many years, the Philippine Center for Population and Development (PCPD) has assisted a number of industrial clinics to provide these services. Under this program, 135 industry-based clinics are to have Responsible Parenthood-MCH programs by the end of 1999.

John Snow, Inc./Research and Training Institute (JSI/RTI) supports the provision of family planning services in NGOs and SO 3's focus will be on helping NGOs serve populations that can afford to pay part of the cost of care. JSI has refocused its efforts to work with traditional family planning NGOs to develop a more cost-effective and sustainable model, using performance-based payments to deliver family planning services through franchised midwives. CARE, however, works with nontraditional NGOs in fewer targeted areas, using an outreach model. Its program is designed to augment the government services through outreach efforts in hard-to-reach areas. Its focus will not be on sustainability as much as serving the underserved.

- *The Private Commercial Sector*

More work is needed to identify and address the reasons why the private commercial sector plays such a small role in the provision of family planning services in the Philippines. Several steps are envisioned to increase the role of this sector.

Financing of the Program

USAID expects to invest about \$126 million for SO 3 between fiscal years 1994 and 1999: \$65 million from bilateral funds and \$61 million from USAID/Washington's Global Bureau (Table 19).

Table 19: USAID Budget for SO 3, FY 1994 – FY 1999

	Bilateral (\$000s)	Global Bureau (\$000s)	Total (\$000s)
Intermediate Result 1			
Tranche	29,240		29,240
Other	7,400	9,200	16,600
Intermediate Result 2	14,360	40,100*	54,460
Intermediate Result 3	12,900	11,600	24,500
Evaluation & Audit	1,100	-	1,100
TOTAL	65,000	60,900	125,900

* Includes an anticipated \$13 million in contraceptives.

Source: USAID/OPHN

The bulk of the funds will finance the activities of the collaborating agencies, but \$29.24 million is earmarked for the tranche to be awarded to the GOP, subject to achievement of the agreed benchmarks. \$13 million in global funds is budgeted for purchase of contraceptives.

In addition to the funds provided by USAID, the GOP will provide at least \$26 million in counterpart contribution over the life of the program, primarily in the form of personnel, office space and other in-kind contributions as well as local currency for LPP grants and value-added tax offsets.

Program Evaluation

Three mid-term evaluations of all three immediate results are being conducted in January-March, 1998 to assess progress to date in achieving results to the year 2000 and the need for continued USAID assistance to the PFPP beyond the current SO3 planning period (1994-2000). A final evaluation will be conducted towards the end of the program.

D. Special Objective: Rapid Increase in HIV/AIDS Prevented

Program Objectives

Prior to the commencement of the AIDS Surveillance and Education Project (ASEP), USAID provided over \$3.5 million to the National AIDS/STD Prevention and Control Program (NASPCP) of the DOH. This assistance was used to fund activities in Metro Manila, Cebu, Olongapo and Angeles City which included training in AIDS counseling, support for an AIDS hotline, general AIDS education, upgrading social hygiene clinics, upgrading regional blood centers, and the completion of a market feasibility study for condoms.

Recognizing the need to do more in HIV/AIDS control and the requirement to support more focused efforts, USAID authorized the ASEP on July 20, 1992. Activities under the ASEP support USAID's program of preventing the rapid increase of HIV/AIDS as articulated in the "Special Objective (SpO): Rapid Increase of HIV/AIDS Prevented." Current and new activities under this program are expected to be completed by September 30, 2000.

The overall goal of the SpO is to prevent the rapid increase of HIV/AIDS within the Philippines population by institutionalizing public and private sector mechanisms for: (1) monitoring HIV prevalence and risk behavior; and (2) encouraging behaviors which reduce individual risk for contracting and transmitting HIV. The surveillance component is monitoring HIV seroprevalence among high risk groups (HRGs), namely, registered female commercial sex workers, men who have sex with men, and injecting drug users. To date, annual surveillance HIV-testing and surveillance for risk behavior among HRGs has been established in 8 cities (Quezon, Cebu, Pasay, Davao, Angeles, Iloilo, General Santos and Zamboanga). The education component is aimed at information, education and communication (IEC) activities targeting high risk "groups" in 8 sentinel surveillance sites.

USAID's Partners in the Special Objective

USAID's chief partner responsible for implementing the Special Objective is the DOH – specifically an Assistant Secretary who has recently been appointed as the Project Coordinator who reports directly to the Secretary of Health. The DOH's STD/HIV/AIDS Unit is responsible for the day-to-day management of the NASPCP which includes coordination of NGO education activities implemented under the Cooperative Agreement with the Program for Appropriate Technology in Health (PATH). The Field Epidemiology Training Program (FETP) of the DOH implements the national HIV Sentinel Surveillance (HSS) and the Behavioral Surveillance System (BSS) supported by USAID.

LGUs, headed by the city mayors, including the city administrators and city health officers and active hygiene clinic staff, coordinate HIV/AIDS/STD surveillance and prevention activities.

Three other agencies collaborate. PATH, a U.S. NGO, manages education activities through a program of subgrants to NGOs. The World Health Organization/Western Pacific Regional Office WHO/WPRO provides administrative and technical assistance to the DOH for the implementation of the National HIV Sentinel Surveillance System (HSS) and the Behavioral Sentinel Surveillance System (BSS). And Family Health International (FHI)/IMPACT Project provides assistance to DOH's AIDS/STD Unit to develop a rational national STD control plan.

More than 20 local NGOs perform IEC functions aimed at changing the behavior of people who are at high risk contracting HIV.

USAID's role – USAID has established an SpO team that is responsible for achieving the SpO under the direction of the Chief of the Office of Population, Health and Nutrition (OPHN). All the offices involved in managing the SpO are represented on the team. They work together informally and meet at least monthly to review progress and iron out problems that may emerge. The SpO is managed by an SpO Team Leader, who is one of OPHN's highly skilled FSNs. Representatives of USAID, the collaborating agencies and GOP officers with program implementation responsibilities comprise the team. An advisory committee consisting of widely recognized leaders in government, academia and the donor community assist the team.

Challenges Addressed Through the Special Objective

- The high prevalence rates of STDs found by surveillance in a number of high-risk groups (HRGs) has raised the concern for STDs as a co-factor in the spread of HIV/AIDS. Further inputs will be required to strengthen the capacity of the DOH to treat STDs and other HIV/AIDS related diseases.
- The devolution of health programs to LGUs was expected to change the priority given to different DOH program activities, with HIV/AIDS a likely candidate for down-scaling in terms of resources and attention.
- Sustaining HIV/AIDS surveillance system, increasing the effectiveness of organizations implementing IEC prevention activities, and identifying revenue sources to finance prevention programs at the local level will be required to prevent further spread of HIV/AIDS.
- Ensuring the safety of the blood supply is another major concern in preventing the spread of the HIV virus. The DOH proposed changes will involve a massive revamping of the system over the next four years. Until these changes are fully

enacted, the blood supply as a co-factor in the spread of HIV/AIDS disease remains an important concern.

The Intermediate Result

The Intermediate Result is to have increased the Knowledge, Attitudes and Practices to prevent STD/HIV/AIDS infection among high risk groups. Five USAID-supported activities have been assigned to attain the Intermediate Result:

- Activity-Level Result #1 - HIV Sentinel Surveillance (HSS), Behavioral Sentinel Surveillance (BSS), and NGO program monitoring systems are coordinated and utilized by the DOH. LGUs and NGOs to monitor HIV prevalence and risk behavior among HRGs with national and local program interventions guided by results.
- Activity-Level Result #2 - Network of NGOs, Government Organizations (GOs) and Private commercial sector groups delivering IEC services to STD/HIV/AIDS HRGs.
- Activity-Level Result #3 - National Safe Voluntary Blood Bank System designed by December 1996
- Activity-Level Result #4 - Local government units (LGUs) and NGOs manage and sustain effective STD/HIV/AIDS prevention and control programs in their cities.
- Activity-Level Result #5 - Policy and environmental/structural constraints to promoting STD/HIV prevention are being analyzed, results

- *National HIV/AIDS Sentinel Surveillance Systems*

A National HIV Sentinel Surveillance (HSS) System is being established in order to have an early warning system in place to monitor the spread of HIV infection and to guide the design and strengthening of intervention programs. With USAID assistance, the system conducts annual surveys at eight sites where there are high concentrations of persons at high risk of HIV infection. The sentinel risk groups include: registered female sex workers, freelance sex workers, men who have sex with men and injecting drug users. The system involves laboratory testing of blood samples, with the collaboration of BRL and RITM.

**SPECIAL OBJECTIVE
RAPID INCREASE OF HIV/AIDS
PREVENTED**

**INTERMEDIATE RESULT
Knowledge, Attitudes and Practices for STD/HIV/AIDS Prevention
by High-Risk Groups (HRG)* Increased**

INDICATOR
HIV Seroprevalence Rates among
Registered Female Commercial
Sex Workers in HSS Sites Remain
<3% in 2000.

*HRGs composed of:
Registered Female Commercial Sex Workers - RFCSWs
Free-lance Female Commercial Sex Workers - FFCSWs
Men who have sex with Men - MSM
Injecting Drug Users - IDU
(RFCSW and FFCSWs data are from all HSS** sites,
MSM data cover Cebu and Quezon cities only,
IDU data are for Cebu only.)

INDICATORS

A. Knowledge

Percent of HRGs who are able to identify at least three correct ways to protect themselves from STD/HIV infection.
RFCSWs: 59% in 1997 to >79% in 2000
FFCSWs: 55% in 1997 to >75% in 2000
MSMs: 68% in 1997 to >88% in 2000
IDUs: 53% in 1997 to >73% in 2000

B. Attitudes

Percent of HRGs who perceive themselves at risk of STD/HIV infection due to their behavior.
RFCSWs: 30% in 1997 to >50% in 2000
FFCSWs: 25% in 1997 to >45% in 2000
MSMs: 20% in 1997 to >40% in 2000
IDUs: 27% in 1997 to >47% in 2000

*Note:
1997 baseline and targets in A, B and C2
are established by the 1997 BSS. *** C1 and C3
are from the HSS***

C. Practices

1. Percent of HRGs who report consistent condom use with partner at risk in the past week
RFCSWs: 32% in 1993 to >50% in 2000
FFCSWs: 14% in 1993 to >40% in 2000
MSMs: 2.5% in 1993 to >30% in 2000
IDUs: 2.0% in 1993 to >30% in 2000
2. Percent of HRGs who report condom use during the last sexual intercourse at risk.
RFCSWs: 70% in 1997 to >90% in 2000
FFCSWs: 55% in 1997 to >75% in 2000
MSMs: 41% in 1997 to >61% in 2000
IDUs: 34% in 1997 to >54% in 2000
3. Percent of IDUs who report sharing injection equipment
IDUs: 67% in 1994 to <40% in 2000

USAID- SUPPORTED ACTIVITIES

1. HIV Sentinel Surveillance (HSS), Behavioral Surveillance Survey (BSS), and NGO program monitoring systems are coordinated and utilized by the DOH, LGUs and NGOs to monitor HIV prevalence and risk behavior among HRGs with national and local program interventions guided by results
Benchmarks:
A. HIV Sentinel Surveillance System (HSS) functioning in HSS sites. 0 HSS sites in 1993 to 8 HSS sites by 2000.
B. Behavioral Surveillance System (BSS) functioning in HSS sites. 0 HSS sites in 1993 to 8 HSS sites by 2000
C. DOH/FETP and AIDS Unit and PATH meeting quarterly to coordinate activities. 2 meetings in 1997 to 12 meetings by 2000
D. NGOs routinely reviewing and using behavioral data for project development. 5 NGO projects in 1997 to 20 NGO projects by 2000
2. Network of NGOs, GOs and Private Commercial Sector groups delivering IEC services to STD/HIV/AIDS HRGs
Benchmarks:
A. HIV/AIDS outreach workers trained and active in STD/HIV/AIDS work. 30 in 1993 to 120 by 2000
B. Peer educators supported and active in STD/HIV/AIDS education. 50 in 1993 to 1000 by 2000
C. Private and public health care providers in HSS sites trained in improved STD management. 0 providers in 1993 to 1200 providers by 2000
D. Entertainment establishments in 2 HSS sites promoting 100% condom use policy. 0 in 1997 to 50% of establishments in 2 sites by 2000
3. National Safe Voluntary Blood Bank System designed
Benchmark: - Strategic Plan for the National Safe Voluntary Blood Bank System designed by December 1996
4. LGUs and NGOs jointly manage and sustain effective STD/HIV/AIDS prevention and control program in their cities/municipalities
Benchmarks:
A. Joint LGU/NGO comprehensive STD/HIV/AIDS Prevention Action Plans developed and implemented. 0 plans in 1995 to 8 plans by 2000
B. Local STD/AIDS Multi-sectoral Committee established and actively supporting STD/HIV policy reforms. 0 sites in 1996 to 4 sites by 2000
C. LGUs and partner NGOs finance STD/HIV activities through new revenue sources. 0 LGUs in 1997 to 4 LGUs by 2000
5. Policy and environmental/structural constraints to promoting STD/HIV prevention being analyzed, results disseminated and advocacy efforts conducted
Benchmark: - Studies on policies/constraints completed, results disseminated and advocacy efforts conducted. 0 in 1997 to 5 advocacy efforts by 2000

A behavioral sentinel surveillance (BSS) system is also being established to monitor the prevalence of risk-taking behaviors. This system exists at 8 sites where the HIV sentinel surveillance are also being conducted.

A USAID grant to WHO supports the development of the HSS and BSS system. WHO works with DOH's FETP which manages the system, collecting and analyzing all data from the local surveillance units, regional laboratories and central laboratory and producing semi-annual technical reports (HSS conducted at the beginning of the year and BSS conducted towards the later part of the year).

- IEC

The educational component of the Special Objective aims to reduce high risk behaviors, thus reducing the transmission of HIV/AIDS infection. USAID supported the development of a communications strategy that guides the AIDS/STD program's IEC efforts. Now, its focus is on IEC targeted toward the high risk groups in the geographic areas that are also the focus of the surveillance system, creating synergy between two key components of ASEP. Local NGOs are the vehicle chosen to reach these groups because they are able to gain access to segments of the community that may be difficult for government to reach. Twenty NGOs in most major cities in the country provide community-based IEC, under a program of subgrants managed by an American NGO, PATH.

IEC activities under the Special Objective will be measured in several ways in the year 2000:

- The number of outreach workers and peer educators trained and active in STD/HIV/AIDS work;
- The proportion of entertainment establishments that promote condoms in target areas will have reached 50 percent in two HSS sites; and
- The number of private and public health care providers in the target areas that have been trained in improved STD management will have increased.

- *Design of a National Blood Banking System*

A USAID-financed field survey in 1993-94 revealed that the blood banking system had significant problems with respect to safety and adequacy, with potentially infective blood circulating in the system and uneven screening practices around the country. Accordingly, USAID proceeded to support the design of a national safe voluntary blood banking system to provide the framework and direction for an integrated national response to the problem of an unsafe blood supply.

The New Tropical Medicine Foundation undertook the task of developing a plan, under the cooperative agreement with PATH. A number of activities were conducted to build consensus and identify the best solutions to remedy the problems of safety and inadequacy of blood supply and a plan was accepted and officially endorsed by DOH in 1996. The plan lays out strategies and the components of a voluntary program to be implemented over the next five years.

- *LGU and NGO Program Management*

Because of devolution, it is critical to build the capabilities of the LGUs to develop and manage effective HIV/AIDS/STD control programs. This is being done by strengthening HIV/AIDS surveillance and prevention teams in targeted cities. Training is being provided on surveillance activities, HIV/AIDS fora are being held, program management and planning capabilities are being strengthened and the advocacy skills of local executives and local NGOs upgraded. Particular attention are being given to identifying new revenue sources for the LGUs and NGOs to finance their future activities.

- *Policy and Advocacy Activities*

High risk behavior for many individuals has been found to be facilitated by structural and environmental factors that limit the individuals ability to adopt risk-reduction practices, such as condom usage with commercial sex partners. Efforts to overcome such policy and environmental constraints to behavioral change are being supported. Advocacy activities to generate multisectoral support for HIV/AIDS prevention will be undertaken to encourage adoption of risk-reduction behavior among high risk groups.

Financing of the Program

USAID will provide \$15 million between 1993 and 2000 under the bilateral program. The Philippine government will provide an additional \$5 million. Over and above these resources, USAID/Washington Global Bureau resources (ranging from \$150,000 in 1995 to \$300,000 in 1996 to \$500,000 in 1997, etc.) will be provided for specific technical assistance and training activities.

Program Evaluation

A mid-term evaluation of ASEP was conducted in early 1995 and found project implementation to be good, with potential to become a model program for HIV prevention in low-prevalence countries.

The Special Objective assessment was undertaken in January/February 1997. Based on the recommendation of that assessment, 1) Surveillance activities were refined to

focus on 6-8 cities among 3 risk groups and surveillance rounds reduced to annually; 2) education activities were refined to include policy and environment/structural interventions to assure that the complementary individual risk reduction interventions are effective, and; 3) current Results Framework was revised to reflect needed changes in indicators and targets of the objective, Intermediate Results and Activity levels to improve validity of performance measures.

A final evaluation will be conducted at the end of the program.

E. USAID Organizational Arrangements

The Philippines is a high priority country for USAID. It has one of largest USAID Missions in the world, with a staff of about 20 U.S. direct hires and 117 foreign service nationals. Its overall portfolio amounts to \$780 million, of which OPHN accounts for \$141 million.

Globally, USAID focuses on five program areas, as articulated in "Strategies for Sustainable Development" (1994). These are:

- Protecting the environment;
- Building democracy;
- Stabilizing world population growth and protecting human health;
- Encouraging broad-based economic growth; and
- Providing humanitarian assistance and aiding post-crisis transitions.

Recently, a sixth strategy was added on human capacity development through education and training.

The Philippine Mission plans its program together with NEDA and other GOP agencies, with these priorities and those of the GOP in mind, and it is accountable to USAID in Washington for its activities. Its overall strategic framework has been approved by Washington and, under the new re-engineered system, funds are contingent on achieving results. Thus, the Mission submits an annual report on the results it has achieved under its strategic objectives and receives funds based on its performance.

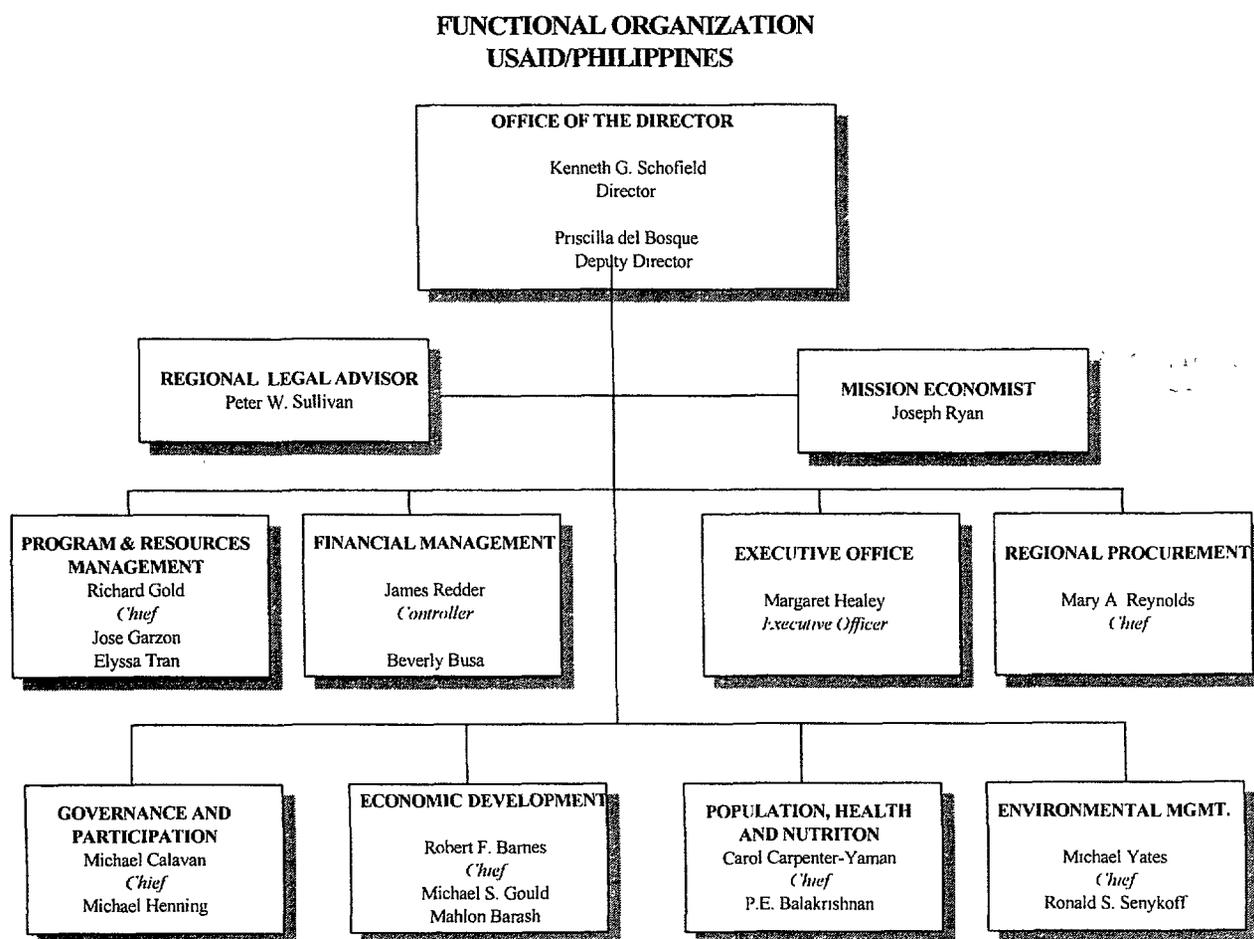
USAID funds are programmed two different ways. Washington supports certain centrally-managed activities from which USAID missions around the world may obtain services through by providing Mission "field support resources." For example, Population Communication Services at Johns Hopkins University in Baltimore provides population IEC support to USAID programs around the world; the Philippines has a resident advisor, a staff of IEC experts and a budget for IEC activities provided through the centrally-managed cooperative agreement with JHU. The Mission also receives

funds directly from Washington for bilateral activities, i.e., activities it supports directly. Under SO 3, USAID/Philippines finances several grants, cooperative agreements and contracts as well as the tranche of funds for the GOP from bilateral funds.

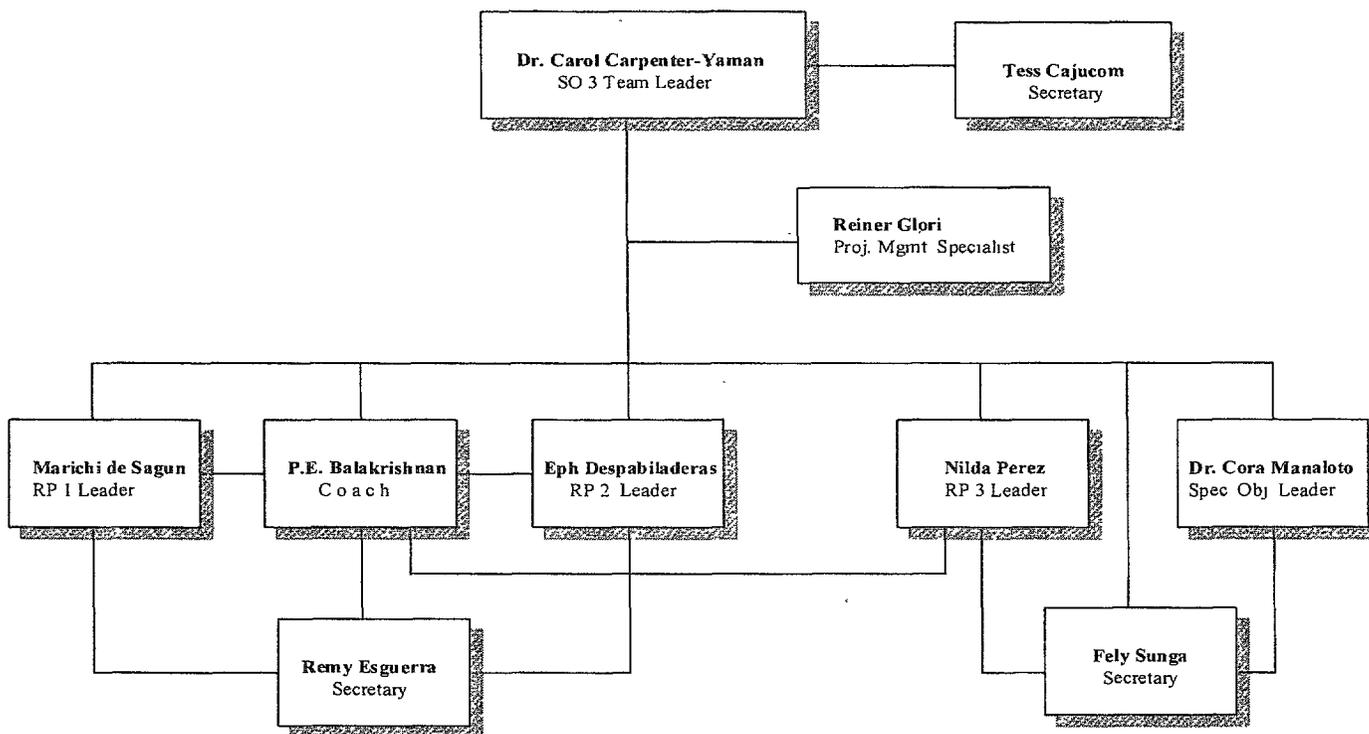
The USAID Director in the Philippines, with assistance from the Deputy Director and the Program and Resources Management Office, is responsible for overseeing the activities of the Mission's four technical offices:

- Office of Economic Development (OED)
- Office of Population, Health and Nutrition (OPHN)
- Office of Environment Management (OEM)
- Office of Governance and Participation (OGP)

The Mission also has other offices responsible for financial management, procurement, administration and legal matters.



OPHN ORGANIZATIONAL CHART



While the different offices are concerned with specialized topics, much of the agency's work is done in strategic objective teams that cut across offices and that are responsible for achieving the results expected by the Mission and USAID/Washington. Thus, the team concerned with SO 3 and the HIV/AIDS Special Objective includes, in addition to representatives from OPHN, representatives from the Office of Program and Resources Management, Office of Governance and Participation, Office of Financial Management, the Office of Regional Procurement, the Executive Office and the Regional Legal Advisor's office.

OPHN is staffed by two Americans and eight foreign service nationals. The Chief of OPHN, Dr. Carol Carpenter-Yaman, is also the overall team leader for SO 3 and the HIV/AIDS Special Objective. She is directly responsible for achieving the results expected from these two Mission objectives. As Results Package Coach, Mr. P.E. Balakrishnan, assists Dr. Carpenter-Yaman with the day-to-day management of OPHN and guides and mentors the three Results Package Team Leaders under SO 3.

Much of the responsibility for the management of OPHN's program lies with the Results Package (RP) Team Leaders, each of whom manages one Intermediate Result:

- Ms. Marichi de Sagun, RP1 Team Leader
- Mr. Ephraim Despabiladeras, RP 2 Team Leader
- Ms. Nilda Perez, RP 3 Team Leader
- Dr. Corazon Manaloto, Special Objective Team Leader

The team leaders are foreign service nationals with extensive experience in public health programs. The Results Package Team Leaders are hands-on managers, closely involved in planning, overseeing and monitoring activities for their component of the program and the fulfillment of each collaborating agency's obligations to USAID. They also head Results Package Teams comprised of representatives of USAID, the collaborating agencies and GOP offices with front-line responsibilities in program implementation. Each team also has an advisory committee whose members are widely recognized leaders in government, academia or the donor community. The membership of these teams is presented in Annex 10.

OPHN also has a Project Management Specialist, Mr. Reiner Glori, who handles financial, administrative and procurement matters, and three support staff, Ms. Tess Cajucom, Ms. Fely Sunga and Ms. Remy Esguerra.

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ANNEX 1

Population of the Philippines (in thousands) and Population Growth Rate, by Region and Province, 1995

Region/ Province	Population (000s)	Population Growth Rate	Region/ Province	Population (000s)	Population Growth Rate
National Capital Region	9,454.0	3.3	Cordillera Admin. Region	1,254.8	1.7
Manila	1,654.8	0.6	Abra	196.0	1.1
Mandaluyong	286.9	2.7	Benguet	540.7	2.0
Marikina	357.2	2.7	Ifugao	149.6	0.3
Pasig	471.1	3.2	Kalinga	154.1	2.2
Quezon City	1,989.4	3.3	Apayo	83.7	2.1
San Juan	124.2	-0.4	Mountain Prov.	130.7	2.2
Kalooocan	1,023.2	5.6			
Malabon	437.5	4.1			
Navotas	229.0	3.8			
Valenzuela	347.2	4.8			
Las Pinas	413.1	6.4			
Makati	484.2	1.2			
Muntinlupa	399.8	7.0			
Paranaque	391.3	4.6			
Pasay	408.6	2.0			
Pateros	55.3	1.4			
Tagig	381.3	6.9			
Ilocos (I)	3,803.9	1.3	Cagayan Val. (II)	2,536.0	1.5
Ilocos Norte	482.6	0.8	Batanes	14.2	-1.1
Ilocos Sur	545.4	0.9	Cagayan	895.0	1.4
La Union	597.4	1.6	Isabela	1,160.7	1.3
Pangasinan	2,178.4	1.4	Nueva Vizcaya	335.0	2.0
			Quinino	131.1	2.6
C. Luzon (III)	6,932.6	2.1	S. Tagalog (IV)	9,940.7	3.5
Bataan	491.5	2.7	Aurora	159.6	2.5
Bulacan	1,784.4	3.2	Batangas	1,658.6	2.2
Nueva Ecija	1,505.8	2.6	Cavite	1,610.3	6.5
Pampanga	1,635.8	1.2	Laguna	1,631.1	3.3
Tarlac	945.8	1.8	Marinduque	199.9	1.4
Zambales	569.3	0.2	Occ. Mindoro	337.2	3.4
			Orient. Mindoro	608.6	1.9
			Palawan	640.5	3.7
			Quezon	1,537.7	2.1
			Rizal	1,312.5	5.7
			Romblon	244.6	1.4

Bicol (V)	4,325.3	1.9	W. Visayas (VI)	5,776.9	1.3
Albay	1,005.3	2.0	Akian	410.5	1.4
CamarinesNorte	439.1	2.2	Antique	431.7	1.1
Camarines Sur	1,432.6	1.7	Capiz	624.5	1.3
Catanduanne	202.5	1.5	Guimaras	126.5	1.3
Masbate	653.8	1.6	Iloilo	1,749.6	1.1
Sorsogon	591.9	2.3	Negros Occ.	2,434.2	1.4
C. Visayas (VII)	5,014.6	1.6	E. Visayas (VIII)	3,366.9	1.8
Bohol	994.4	0.9	Biliran	132.2	2.1
Cebu	2,921.1	1.9	E. Samar	362.3	1.8
Negros Occ.	1,025.2	1.9	Leyte	1,511.2	1.9
Siquijor	73.8	0.0	N. Samar	454.2	3.2
			Samar	589.4	1.9
			S. Leyte	317.6	-0.3
W. Mindanao (IX)	2,794.7	2.4	N. Mindanao (X)	2,483.3	2.3
Basilan	295.6	4.1	Bukidnon	940.4	2.0
Zambo. del Norte	770.7	2.5	Camiguin	68.0	1.1
Zambo. del Sur	1,728.4	2.1	Misamis Occ.	459.0	1.5
			Misamis Orient.	1,015.9	3.1
S. Mindanao (XI)	4,604.2	2.6	C. Mindanao (XII)	2,359.8	2.8
Davao	1,191.4	2.3		713.8	2.9
Davao del Sur	1,683.9	2.4	Lanao del N.	862.7	2.3
Davao Orient.	413.5	0.9	Cotobato	522.2	3.4
S. Cotobato	948.3	3.5	Sultan Kudarat	146.8	2.7
Sarangani	367.0	5.0	Cotobato City	114.4	4.2
			Marawi City		
ARMM	2,020.9	1.8	CARAGA	1,942.7	1.8
Lanao del Sur	571.8	2.2	Agusan del N.	514.5	1.9
Maguindanao	662.2	0.9	Agusan del S.	514.7	3.8
Sulu	536.2	2.5	Surigao del N.	442.2	0.7
Tawi-Tawi	250.7	1.8	Surigao del S.	471.3	0.8

Source: NSO, 1995 Census of Population, Highlights

ANNEX 2

Estimated Infant Mortality Rate (IMR), Under-Five Mortality Rate (UFMR) and Maternal Mortality Ratio (MMR), by Region, 1990 and 1995

	IMR		UFMR		MMR	
	1990	1995	1990	1995	1990	1995
NCR	45.8	32.2	62.2	38.5	170.1	119.1
CAR	63.0	54.9	90.5	76.9	221.6	192.8
Ilocos	55.6	45.7	78.1	61.4	196.3	161.0
Cagayan Val.	61.6	53.7	88.1	74.6	219.3	190.8
C. Luzon	44.7	40.4	60.9	52.6	189.7	170.7
S. Tagalog	53.2	44.9	73.8	60.0	165.1	138.7
Bicol	63.7	58.3	91.3	82.3	180.0	165.6
W. Visayas	60.8	55.2	86.2	77.4	202.4	184.2
C. Visayas	55.2	47.3	77.1	64.0	183.9	158.1
E. Visayas	76.3	64.3	113.5	92.6	225.9	189.8
W. Mindanao	63.6	58.6	91.4	82.8	217.7	200.3
N. Mindanao	57.4	53.7	80.6	74.6	239.3	224.9
S. Mindanao	55.7	51.8	78.0	71.6	172.5	160.4
C. Mindanao	56.5	53.5	79.1	74.0	197.1	187.2
ARMM	74.1	63.4	109.7	91.1	376.8	320.3
Philippines	56.7	48.9	79.6	66.8	209.0	179.7

Source: NSCB, Technical Working Group on Maternal and Child Mortality, *Recommended Infant Mortality Rates, Child Mortality Rates, Under-Five Mortality Rates and Maternal Mortality Ratios, National, Regional, Provincial and City Levels, 1990 - 1995*, November 1995

ANNEX 3

Total Fertility Rate by Residence and Region, 1991

	TFR
Residence	
Urban	3.5
Rural	4.8
Region	
Metro Manila	2.8
CAR	5.0
Ilocos	4.2
Cagayan Valley	4.2
Central Luzon	3.9
Southern Tagalog	3.9
Bicol	5.9
Western Visayas	4.2
Central Visayas	4.4
Eastern Visayas	4.9
Western Mindanao	4.5
Northern Mindanao	4.8
Southern Mindanao	4.2
Central Mindanao	4.8
Total	4.1

Source: NSO and Macro International, NDS 1993, Table 3.2

ANNEX 4. Percent Distribution of currently married women by contraceptive method currently used, according to selected background characteristics, Philippines: 1997

Background Characteristics	Any Method	MODERN METHOD											TRADITIONAL METHOD				No Method	Total	
		Any Modern Method	Pill	IUD	Injection	Diaphragm Foam/Jelly Jelly/Cream	Condom	Female Sterilization	Male Sterilization	Mucus/ Billings/ Ovulation Temp	LAM	Any Traditional	Calendar/ Rhythm	With- drawal	Other				
Residence																			
Urban	50.0	33.8	13.4	3.0	1.7	-	2.2	12.3	0.2	0.1	-	0.8	16.3	9.5	6.4	0.3	50.0	100	
Rural	44.1	28.2	11.6	3.0	2.3	0.2	1.1	8.8	0.2	-	-	0.8	15.9	9.9	5.4	0.7	55.9	100	
Region																			
Metro Manila	51.1	35.2	15.6	1.8	0.7	-	2.6	13.4	0.2	0.1	-	0.7	15.9	8.2	7.8	-	48.9	100	
CAR	46.3	31.1	8.1	1.6	5.5	0.3	2.9	12.2	-	-	-	0.4	15.3	7.3	7.0	1.0	53.7	100	
Ilocos	43.3	29.2	9.9	0.9	3.6	-	2.4	12.1	-	-	-	0.4	14.1	7.5	6.4	0.2	56.7	100	
Cagayan Valley	50.3	40.8	20.2	3.7	4.7	0.9	0.4	10.5	0.2	-	-	0.3	9.5	4.7	4.5	0.3	49.7	100	
C-Luzon	52.0	36.4	12.7	0.9	1.3	0.1	1.8	18.4	-	-	-	1.1	15.6	5.0	10.3	0.3	48.0	100	
S-Tagalog	49.5	33.5	13.5	2.4	2.1	-	1.7	11.8	0.3	0.1	-	1.6	16.1	8.4	7.4	0.2	50.5	100	
Bicol	37.1	19.6	8.2	0.8	0.7	-	1.3	7.8	0.3	0.1	-	0.5	17.5	10.2	6.7	0.7	62.9	100	
W-Visayas	44.4	26.9	10.1	2.4	1.9	-	1.8	9.2	0.2	0.2	-	1.2	17.5	13.3	3.9	0.3	55.6	100	
C-Visayas	51.3	31.6	11.6	5.1	2.8	0.1	2.6	8.1	0.4	-	-	0.9	19.8	15.1	4.5	0.2	48.7	100	
E-Visayas	33.8	20.2	7.2	1.9	1.5	0.1	0.4	7.8	0.4	0.1	-	0.9	13.7	6.9	5.9	0.8	66.2	100	
W-	36.3	23.2	11.7	4.3	0.6	-	0.2	5.8	0.3	-	-	0.4	13.1	9.9	2	1.1	63.7	100	
Mindanao																			
N-Mindanao	59.8	40.7	15.4	11.0	3.7	-	1.2	8.1	0.7	0.2	-	0.3	19.1	16.7	2.0	0.4	40.2	100	
S-Mindanao	59.9	37.2	16.4	6.4	2.7	0.1	1.5	8.9	0.4	0.3	-	0.6	22.7	17.6	3.5	1.7	40.1	100	
C-Mindanao	43.9	26.0	10.0	6.0	2.6	0.5	0.9	5.3	0.4	-	-	0.3	17.8	13.4	3.8	0.6	56.1	100	
ARMM	13.0	6.4	3.9	0.2	1.2	-	0.3	0.8	-	-	-	0.1	6.6	2.0	2.6	2.0	87.0	100	
CARAGA	51.5	36.4	15.4	7.3	3.1	1.2	1.5	7.4	0.3	0.1	-	0.3	15.1	12.0	2.5	0.6	48.5	100	
TOTAL	47.0	30.9	12.5	3.0	2.0	0.1	1.7	10.6	0.2	0.1	-	0.8	16.1	9.7	5.9	0.5	53.0	100	

Source: NSO, 1997 Family Planning Survey

ANNEX 5

Percent of Currently Married Women with an Unmet Need for Family Planning Services,
by Region, 1993

	For Spacing	For Limiting	Total
Region			
Metro Manila	12.1	12.2	24.3
CAR	15.2	12.1	27.2
Ilocos	14.2	14.4	28.5
Cagayan Valley	12.7	11.6	24.3
C. Luzon	12.4	11.1	23.4
S. Tagalog	9.4	15.9	25.3
Bicol	12.5	19.6	32.1
W. Visayas	13.4	13.7	27.1
C. Visayas	10.4	11.4	21.8
E. Visayas	13.2	23.4	36.5
W. Mindanao	18.3	13.2	31.5
N. Mindanao	12.6	11.2	23.8
S. Mindanao	12.2	12.1	24.3
C. Mindanao	13.1	14.2	27.2
Total	12.4	13.8	26.2

Source: NSO and Macro International, NDS 1993, Table 6.4

ANNEX 6: Percent of Children 12 - 23 Months who Received Specific Vaccines, by Residence and Region, 1993

	BCG	DPT 1	DPT 2	DPT 3	Polio-1	Polio-2	Polio-3	Measles	All	None
Residence										
Urban	93.0	93.0	90.0	81.4	92.9	89.0	81.2	83.7	73.2	4.9
Rural	89.4	89.4	85.9	78.5	89.0	83.4	75.2	79.2	69.9	8.6
Region										
Metro Manila	93.1	93.1	89.6	77.1	94.4	87.5	77.1	72.9	61.1	4.2
CAR	92.8	97.1	97.1	89.9	95.7	95.7	89.9	91.3	85.5	2.9
Ilocos	93.8	94.7	90.3	79.6	93.8	83.2	68.1	81.4	59.3	4.4
Cagayan Valley	88.7	93.8	87.6	75.3	93.8	87.6	74.2	73.2	61.9	6.2
C. Luzon	94.4	93.7	93.0	81.0	92.3	89.4	76.1	85.9	71.8	4.9
S. Tagalog	94.1	93.5	90.5	83.4	92.3	87.6	83.4	84.6	77.5	5.3
Bicol	88.0	86.7	81.0	74.1	89.9	80.4	72.8	82.9	70.3	7.6
W. Visayas	89.8	90.6	87.5	82.8	89.8	88.3	82.0	80.5	74.2	7.8
C. Visayas	92.4	90.4	88.5	83.4	92.4	88.5	82.8	80.9	76.4	5.1
E. Visayas	92.6	92.6	89.4	83.0	91.5	89.4	81.9	85.1	75.5	6.4
W. Mindanao	82.9	82.9	81.4	75.2	82.2	78.3	72.9	76.0	69.8	17.1
N. Mindanao	95.6	96.4	89.8	79.6	92.7	87.6	78.8	91.2	75.9	2.9
S. Mindanao	91.7	91.0	88.9	84.7	91.7	90.3	83.3	86.8	79.9	5.6
C. Mindanao	80.2	80.2	76.3	71.8	77.1	74.0	71.0	71.8	67.2	18.3
All Children	91.2	91.1	87.9	79.9	90.9	86.2	78.2	81.4	71.5	6.8

Note: These data refer to children vaccinated at any time before the survey, not necessarily by 12 months of age as required by the FIC definition. See Table 8.7 of 1993 NDS report.

Source: NSO and Macro International, NDS 1993, Table 8.8

ANNEX 7

SO 3 COLLABORATING AGENCIES

As of January 1998

Public Sector Component:

Access to Voluntary and Safe Contraception (AVSC) Tel. 832-3168

Dr. Maria Otelia Costales

Diplomat Condominium, Unit 803

Roxas Boulevard cor. Russell Avenue

Pasay City, Metro Manila

Works with hospitals to make high quality VSS services more accessible to the population.

Helen Keller, Inc. (HKI)

Tel. 551-7920 extn. 7555, 7748, 7544

Rolf Klemm

Fax: 833-1917

Rm. S358-372, 3rd Flr., Secretariat Bldg.

Phil. International Convention Center (PICC)

CCP Complex, Roxas Boulevard

1307 Pasay City, Metro Manila

Works in selected LGUs on strategies for Vitamin A supplementation.

Management Sciences for Health (MSH)

Tel. 743-8301 to 23, Local 2259

Dr. Jose Rodriguez

Department of Health

Building 12, 3rd Floor

San Lazaro Compound

Rizal Avenue

Santa Cruz, Manila

Provides technical assistance to the LGUs to enhance the managerial capability of local government managers in assuming their new roles in the devolved health care system (bilateral).

World Vision

Tel. 927-0676

Dr. Milton Amayun/Ms. Evita Perez

Fax: 921-0195

95 Maginhawa St., UP Village,

Diliman, Quezon City

Works with LGUs (province/municipalities of Sorsogon) and local NGOs in promoting child survival and maternal health through technical assistance in improving leadership capabilities of LGUs in health care system and management.

National Services Component:

Academy for Educational Development/Linkages Project

Tel. (202) 884-8845

Barbara Jones

Fax: (202) 884-8701

1255 3rd Street, N.W., Suite 400

Washington, D.C. 20037

Provides technical assistance to the Dept. of Health to enhance service delivery of the LAM as One of the contraceptive methods of the Philippine Family Planning Program.

De La Salle University, Social Development Research Center TeleFax: 595-177
Dr. Exaltation Lamberte Tel. 524-4611, Local 540, 542
Taft Avenue
Malate, Manila
Conducts a training and research practicum project for program managers on basic research methodology using the quality of care approach.

East-West Center Program on Population Tel. (1) 808-944-7464
Philip Estermann Fax: (1) 808-944-7490
1777 East-West Road
Honolulu, HI 98848
Provides technical assistance and subgrants to research institutions in the conduct of family planning studies, analysis of secondary data and research dissemination activities.

Family Health International/Women's Studies Project Tel. (1) 919-544-7040
Nancy Williamson Fax: (1) 919-544-7261
P.O. Box 13950
Research Triangle Park, NC 27709
Provides technical and funding support for the conduct of research studies on the impact of family planning programs on women's lives.

Georgetown University, Institute for Reproductive Health Tel. (1) 202-687-1392
Myrna Seidman (for NFP) Fax: (1) 202-687-6846
Georgetown University Medical Center
Georgetown Center, 6th Floor
2115 Wisconsin Avenue, N.W.
Washington, D.C. 20007
Provides technical assistance to the government and NGOs to make natural family planning and breastfeeding more acceptable, available and effective family planning methods.

Johns Hopkins Program for International Education in Reproductive Health (JHPIEGO) TeleFax: 926-3893
Dean Remedios Fernandez
PASDA Mansion, Suite 402
77 Panay Avenue
Quezon City, Metro Manila
Works with the schools of nursing and midwifery nationwide to enhance pre-service training in family planning and reproductive health.

Johns Hopkins University/Population Communication Services (JHU/PCS)
J. Miguel de la Rosa Tel. 743-8301 to 23, Local 3503
Department of Health Fax: 711-6085
Building 25, 2nd Floor
San Lazaro Compound
Rizal Avenue
Santa Cruz, Manila
Provides technical assistance in implementing the IEC component of the program.

John Snow, Inc./Family Planning Logistics Management Project (JSI/FPLM)
David Alt Tel. 743-8301 to 23, Local 3502
Department of Health Fax: 711-6085
Building 25, 2nd Floor
San Lazaro Compound
Rizal Avenue
Santa Cruz, Manila
Assists DOH in implementing the contraceptive distribution and logistics management information systems.

John Snow, Inc./Opportunities for Micronutrient Interventions (JSI/OMNI)
Dr. Melgabal Capistrano Tel. 551-7920 extn. 7174
3rd Flr., Secretariat Bldg. Fax
Phil. International Convention Center (PICC)
CCP Complex, Roxas Boulevard
1307 Pasay City, Metro Manila
Works with DOH and the commercial sector on micronutrient supplementation and fortification.

Macro International, Inc./Demographic and Health Surveys (DHS) Tel. (1) 301-572-0899
Martin Vaessen Fax: (1) 301-572-0999
11785 Beltsville Drive, Suite 300
Calverton, MD 20705-3119
Works with NSO on the conduct of the Demographic and Health Survey and the dissemination of survey results.

Management Sciences for Health (MSH) Tel. 743-8301 to 23, Local 2259
Dr. Jose Rodriguez
Department of Health
Building 12, 3rd Floor
San Lazaro Compound
Rizal Avenue
Santa Cruz, Manila
Provides technical assistance to the LGUs to enhance the managerial capability of local government managers in assuming their new roles in the devolved health care system (bilateral).

The Population Council Tel. 722-6886
Dr. Marilou Palabrica-Costello Fax: 721-2786
Monteverde Mansions, Unit 2A3
85 Xavier Street
Greenhills
San Juan, Metro Manila
Works with DOH and LGU managers, NGOs and research institutions to upgrade their capabilities for operations research and use research findings to improve program performance.

The Futures Group (TFG)/The Policy Project Tel. 531-6956/6805
Mark Sherman Fax: 531-6907
Commission on Population
Welfareville Compound
Mandaluyong City, Metro Manila
Works with the government and the private sector to improve the population and family planning environment through policy reform and advocacy activities.

Private Sector Component:

Access to Voluntary and Safe Contraception (AVSC) Telefax 832-3168
Dr. Maria Otelia Costales
Diplomat Condominium, Unit 803
Roxas Boulevard cor. Russell Avenue
Pasay City, Metro Manila
Provides assistance for establishing voluntary sterilization services in the private sector.

Cooperation for American Relief Everywhere (CARE) Tel. 528-4004 to 4007
David Stanton/Apol Soriano Fax: 527-3853
2159 Madre Ignacia Street
Malate, Manila
Provides sub-grants to local NGOs to provide family planning referrals and services.

John Snow, Inc./Research and Training Institute (JSI/RTI) TeleFax: 924-7383
Easter Dasmarinas
CBT Building, Suite 303
60 West Avenue
SFDM
Quezon City, Metro Manila
Assists selected Philippine NGOs to develop more cost-effective and sustainable models, using performance-based payments to deliver family planning/MCH services through "franchised midwives".

Pearl S. Buck Foundation (PBSF) Inc. Tel. 522-0195/525-7292
Kevin F. Lind/Nancy F. Obias Fax: 526-0270
5th Floor, Prudential Bank Building
1377 A. Mabini cor Sta. Monica Street
Ermita, Manila
Implements intervention to meet the critical health needs of infants, children under five and mothers in selected areas of Leyte.

Philippine Center for Population and Development (PCPD) Tel. 843-6981/7061
Ma. Socorro C. Reyes Fax: 817-5997
Population Center
Pasong Tamo Extension
Makati City, Metro Manila
Implements a family planning/MCH program for the industrial sector.

The Futures Group/Social Marketing for Change (TFG/SOMARC) Tel. 843-4161
Jestyn Portugill Tel. 893-7161
Unit 208 Cityland 10 Tower 2 Fax: 893-7182
H.B. dela Costa Street
Ayala Avenue, Makati City, Metro Manila
Provides advertising and promotional support for certain pharmaceutical companies that are willing to reduce their profit margins on contraceptives.

ANNEX 8
Local Government Units (LGUs) Included in
Strategic Objective and Special Objective Activities
as of February 5, 1998

Local Government Unit		IFPMHP						AVSC VSS	Private Sector & NGOs	ASEP	PVO Co-Fi
		LPP									
Region	Province/City	1994	1995	1996	1997	1998					
CAR	Abra							S			
	Apayao										
	Benguet		x	x	x	x	x	S,J			
	Baguio City	x	x	x	x	x	x	S,J			
	Ifugao					*					
	Kalinga										
	Mountain Province					x	x		S		
I	Ilocos Norte							S			
	Ilocos Sur			x	x	x	x	S,J			
	La Union			x	x	x	x	S,J			
	Pangasinan	x	x	x	x	x	x	S,J			
II	Batanes										
	Cagayan		x	x	x	x	x	S			
	Isabela	x	x	x	x	x	x	S			
	Nueva Vizcaya				x	x		S			
	San Jose City							S			
	Quirino										
III	Bataan			x	x	x	x	S			
	Bulacan	x	x	x	x	x	x	P, S,J			
	Nueva Ecija		x	x	x		x	S			
	Cabanatuan City						x	S			
	Pampanga	x	x	x	x	x	x	S			
	Angeles City					*		S	s,b,e,c		
	Tarlac		x	x	x	x	x	S			
	Zambales				x	x		S			
Olongapo					*		S				

Acronym:

IFPMHP - Integrated Family Planning Maternal Health Program
 ASEP - AIDS Surveillance and Education Project
 AVSC - Association for Voluntary and Safe Contraception
 PVO Co-Fi - USAID/Washington PVO Co-Financing Grants
 NGO - Non-Government Organization
 VSS - Voluntary Sterilization Services
 LPP - Local Gov't. Unit Performance Program

Legend:

x - One of the participating LGUs in the LPP and AVSC.
 J - Participating NGO/s under JSI/RTI's project in the area.
 C - Participating NGO/s under CARE/Philippines' project in the area.
 S - SOMARC contraceptive social marketing activities on-going in the area.
 S - SOMARC contraceptive social marketing focus area.
 P - Participating industrial clinic/s under PCPD's project in the area.
 M - Margaret Sanger International sub-grantees
 K - Helen Keller International activities
 p - Pearl S. Buck Foundation
 W - World Vision
 A/P- AVSC/Private Sector
 s - HIV sentinel surveillance site.
 b - Behavioral sentinel surveillance site.
 e - IEC/mass media campaign site.
 c - STD syndromic pilot clinic site.
 * - Tentative Only

Local Region	Government Unit Province/City	IFPMHP					AVSC VSS	Private Sector & NGOs	ASEP	PVO Co-Fi
		1994	1995	1996	1997	1998				
IV	Aurora									
	Batangas	x	x	x				S, P, J		
	Batangas City						x	S		
	Lipa City							S		
	Cavite			x	x	x	x	J, S, P, A/P		
	Laguna	x	x					P, S		
	Marinduque					*				
	Occidental Mindoro				x	x		S		
	Oriental Mindoro				x	x		S		
	Palawan			x	x	x	x	S		
	Puerto Princesa							S		
	Quezon				x	x		S		
	Lucena City					*		S		
	Rizal				x	x	x	J, S, P		
	Antipolo							J		
	Cainta							J, A/P		
	Taytay							J		
Binangonan							J			
Romblon					*		S			
V	Albay		x	x	x	x	x	S		K
	Legaspi City							S		
	Camarines Norte				x	x		S		
	Camarines Sur	x	x					S, C		
	Naga City						x	S		
	Catanduanes					*		S		
	Masbate			x	x	x	x	S		K
	Sorsogon				x	x		S		W
VI	Akian				x	x		S		
	Antique				x	x		S		
	Capiz			x	x	x	x	S		
	Roxas City							S		
	Guimaras					*				
	Iloilo	x	x	x	x	x	x	S		
	Iloilo City	x	x	x	x	x	x	S, J	s, b, c, e	
	Negros Occidental	x	x	x	x	x	x	J, S, A/P		
Bacolod City	x	x	x	x	x	x	J, S, C, A/P			
VII	Bohol			x	x	x	x	S, C		
	Tagbilaran City						x	S		
	Cebu	x	x	x	x	x	x	J, S		
	Cebu City	x	x	x	x	x	x	J, S, A/P	s, b, c, e	
	Mandaue City							J, S, P		
	Lapu-Lapu City							J, S		
	Danao City							S, P, J		
	Toledo City							J, S		
	Negros Oriental			x	x	x	x	S, C		
	Dumaguete City							S		
	Siquijor									
VIII	Biliran									K
	Leyte / Northern Leyte	x	x	x	x	x	x	S, J, A/P		p, K
	Tacloban City						x	S, J, A/P		K
	Southern Leyte							S, J		K
	East Samar				x	x		S		K
	North Samar				x	x		S		K
West Samar				x	x		S, C, J		K	

Local Region	Government Unit Province/City	IFPMHP					AVSC VSS	Private Sector & NGOs	ASEP	PVO Co-Fi
		1994	1995	1996	1997	1998				
IX	Basilan					*				
	Zamboanga del Norte				x	x		S		
	Zamboanga del Sur	x	x	x	x	x	x	S		
	Zamboanga City	x	x	x	x	x	x	S	s,b,e,c	
	Pagadian City							S		
X	Bukidnon		x	x	x	x	x	J,S,C		
	Camiguin					*				
	Misamis Occidental			x	x	x	x			
	Misamis Oriental			x	x	x	x	J,P,S		
	Cagayan de Oro City		x	x	x	x	x	J, P, S		
XI	Davao del Norte	x	x	x	x	x	x	J, P, S		
	Davao City	x	x	x	x	x	x	J, P, S,A/P	s,b,e,c	M
	Davao Oriental			x	x	x	x	P, S		
	Davao del Sur		x	x	x	x	x	J, S		
	Saranggani					*		J, P		
	South Cotabato	x	x	x	x	x	x	J, C, P, S,A/P		
	Gen. Santos City					*	x	J, P, S,A/P	s,b,e,c	
XII	North Cotabato		x	x	x	x	x	S		K
	Cotabato City						x	S		
	Lanao del Norte				x	x	x			
	Iligan City					*	x	S		
	Sultan Kudarat				x	x	x	J, S,A/P		
	Lanao del Sur							S		
	Marawi City							S		
ARMM	Maguindanao		x	x	x	x	x	S		
	Sulu									
	Tawi-Tawi					*				
CARAGA	Agusan del Norte					*		C, S		
	Agusan del Sur				x	x		S		
	Butuan City					*		S,J		
	Surigao Norte			x	x	x	x	S		
	Surigao City							S		
	Surigao Sur			x	x	x	x	S		
NCR	Caloocan					*		J, S		
	Las Pinas					*		J, P, S		
	Makati						x	J, P, S		
	Malabon			x	x	x	x	J, S		
	Mandaluyong				x	x	x	S		
	Manila						x	J, P, S		
	Marikina				x	x	x	P, S		
	Muntinlupa			x	x	x	x	P, S		
	Navotas							S		
	Paranaque					*		J, P, S		
	Pasay			x	x	x	x	S	s, b, e, c	
	Pasig			x	x	x	x	P, S		
	Pateros							S		
	Quezon City			x	x	x	x	P, S, J	s, b, e, c	M
	San Juan							S		
	Taguig							P, S		
Valenzuela				x	x	x	S, J			

ANNEX 9

HIV/AIDS SPECIAL OBJECTIVE COLLABORATING AGENCIES

Family Health International/IMPACT

Tony Bennett

Arwan Bldg., 7th floor

Pracharat 1 Road, Bangsue

Bangkok 10800, Thailand

Helps DOH strengthen its STD program.

Tel. (662) 587-4750

Fax: (662) 587-4758

Program for Appropriate Technology in Health (PATH)

Dr. Carmina Aquino

TJCC Building

Senator Gil Puyat Avenue

Makati City, Metro Manila

Implements the education component of the special objective and provides technical assistance to DOH on IEC.

Tel. 899-1580, 895-3201

Fax 899-5161

World Health Organization (WHO)

Annette Ghee

Western Pacific Regional Office

Taft Avenue cor. United Nations Avenue

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Manages a grant and provides technical assistance for the national HIV sentinel surveillance system.

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ANNEX 10

Intermediate Results (Results Package) #1: INCREASED PUBLIC SECTOR PROVISION OF FP/MCH SERVICES

02/05/98

RP 1 - Public Sector		C O R E U S A I D A S S I G N M E N T S							Res. Advisor
TEAM LEADER: Marichi G. de Sagun	Resources to Support Intermediate Result Activities	PEB	EED	RLP	MDS	CRM	RRG		
MANAGEMENT TEAM MEMBERS: USAID MEMBERS: Ephraim Despabiladeras, OPHN Nilda Perez, OPHN Reiner Glori, OPHN Sarah Diama, PRM Thea Pura, ORP Ramon Saguinsin/Sonia Ferrer, OFM Peter Sullivan, OLA Nap deSagun, OGP CONTRACTOR AND COLLABORATING AGENCY MEMBERS: Dr. Jose Rodriguez, IFPMHP/MSH Fred White, IFPMHP/MSH TBD, IFPMHP/MSH Romeo Mascardo, IFPMHP/MSH Dr. Maritel Costales, AVSC Rolf Klemm, HKI Dr. Milton Amayun, WVRD Ms. Evita Perez, WV GOP MEMBERS: Dr. Rebecca Infantado, DOH Dr. Ellery Dayrit, MCHS/DOH Dr. Loreto Roquero, FPS/DOH Dr. Jocelyn Ilagan, FPS/DOH Dr. J.P. Perez, LGAMS Ms. Adelisa Ramos, Nutrition Service, DOH		IFPMHP: LPP IFPMHP: MSH Contract (also in RP 2) IFPMHP: AVSC AID/W PVO Matching Grant: Vitamin A: HKI AID/W CSP Grant: CHAMPS: WVRD	B X B B	S S S S	S S S S	X B X X X	S S S S	1, 2, 3, 4 1, 2, 3 5 6 7	
ADVISORY GROUP MEMBERS: Dr. Carmencita Reodica, DOH DILG Representative President, League of Governors President, League of City Mayors Mr. Satish Mehra, UNFPA	X - Activity Manager B - Backstop Officer S - Support Officer Resident Advisors: 1 - Dr. Jose Rodriguez, MSH-COP 2 - Fred White, MSH 3 - TBD, MSH	4 - Romeo Mascardo, MSH 5 - Dr. Maritel Costales, AVSC 6 - Rolf Klemm, HKI	7 - Evita Perez, WV						

Intermediate Results (Results Package) #2: NATIONAL SYSTEMS STRENGTHENED TO PROMOTE AND SUPPORT THE FP/MCH PROGRAM

02/05/98

RP 2 - National Services		CORE USAID ASSIGNMENTS						Res. Advisor
Resources to Support Intermediate Result Activities		PEB	EED	RLP	MDS	CRM	RRG	
TEAM LEADER: Ephraim Despabiladeras								
TEAM COACH: P.E. Balakrishnan								
MANAGEMENT TEAM MEMBERS:								
USAID MEMBERS:								
	IFPMHP: IEC - JHU/PCS	X	B					1
Marichi de Sagun, OPH	IFPMHP: Contraceptive Logistics							
Nilda Perez, OPHN	- FPLM	S	B				X	2
Dr. Cora Manaloto, OPHN	IFPMHP: Contraceptives							
Reiner Glori, OPHN	- CCP	S	B				X	
Sarah Dama, PRM	IFPMHP: Training							
Thea Pura, ORP	- MSH/DA/EDF	B	X				S	3
Ramon Saguinsin/Sonia Ferrer, OFM	- JHPIEGO	B	X				S	4
Peter Sullivan, OLA	- DLSU	B	X				S	6
	- Participant Training	B	X				S	
CONTRACTOR AND COLLABORATING AGENCY MEMBERS:	IFPMHP: NFP (Georgetown University)	B	X				S	
	IFPMHP: LAM (Linkages/AED)	B	X					
	IFPMHP: Policy/Advocacy - TFG	B	X				S	7
	IFPMHP: Research and Evaluation							
Jose Miguel de la Rosa, JHU/PCS	- PopCouncil/Operations Research	B	X	S				8
David Alt, FPLM/JSI	- FHI/Women/s Studies	B	X	S				
Dean Remy Fernandez, JHPIEGO	- EWC/Secondary Analysis	B	X	S			S	
Dr. Marilou Costello, PopCouncil	- MACRO/DHS	B	X	S			S	
Dr. Melgabal Capistrano, OMNI								
Dr. Tess Castillo, UNFPA/National Services	IFPMHP: Monitoring							
Mark Sherman, TFG/Policy Project	- USBuCen	B	X					
Dr. Florante Magboo, MSH	- MSH - MIS	B	X	S	S			9
Dr. Cynthia Garcia, MSH/DA	- Quality Assurance	B	X	S	S			5
Dr. Trinidad Osteria, DLSU	- Urban Strategy	B	X	S				10
GOP MEMBERS:	OMNI Project	S	X			B		11
Dr. Rebecca Infantado, DOH								
Dr. Joseph Arecheta, DOH/FPS								
Dr. Loreto Roquero, DOH/FPS								
ADVISORY GROUP MEMBERS:	X - Activity Manager							
	B - Backstop Officer							
	S - Support Officer							
Dr. Carmencita Reodica, DOH	Resident Advisors:							
Mr. Tomas Africa, NSO	1 - Jose Miguel de la Rosa, JHU/PCS							5 - Dr. Cecille Lagrosa, MSH
Mr. Tomas Osias, PopCom	2 - David Alt, JSI/FPLM							6 - Trinidad Osteria, DLSU
Mr. Satish Mehra, UNFPA	3 - Cynthia Garcia, MSH/DA							7 - Mark Sherman, TFG/Policy
	4 - Remy Fernandez, JHPIEGO							8 - Marilou Costello, PopCouncil
								9 - Florante Magboo, MSH
								10 - TBD, MSH
								11 - Melgabal Capistrano, OMNI

Intermediate Results (Results Package) #3: INCREASED PRIVATE SECTOR PROVISION OF FP/MCH SERVICES

01/06/98

RP 3 - Private Sector/NGO Assistance		CORE USAID ASSIGNMENTS							
TEAM LEADER: Reynalda L. Perez		Resources to Support Intermediate Result Activities	PEB	EED	RLP	MDS	CRM	RRG	Res. Advisor
TEAM COACH: P.E. Balakrishnan									
MANAGEMENT TEAM MEMBERS:									
USAID MEMBERS:									
	1 IFPMHP: NGO Strengthening								
Marichi de Sagun, OPHN	NFO Franchise Clinic Services: JSI/RTI	B		X				S	1
Eph Despabiladeras, OPHN									
Reiner Glori, OPHN	NGO Training Marketing: JSI/RTI	B		X				S	1
Sarah Diama, PRM									
Thea Pura, ORP	NGO VS referral JSI/AVSC	B		X		S		S	1, 5
Ramon Saguinsin/Sonia Ferrer, OFM									
Peter Sullivan, OLA	PVO FP Services: CARE	B		X				S	2
CONTRACTOR AND COLLABORATING AGENCY MEMBERS:									
	Industry-based FP: PCPD	B		X				S	3
Easter Dasmarinas, JSI/RTI									
Apol Soriano/David Stanton, CARE/Phil.	2. IFPMHP: Private Comercial Sector								
Marissa Reyes, PCPD	Social Marketing: SOMARC	X		B				S	4
Edna Cecilio/Jestyn Portugill, SOMARC/Phils.									
Dr. Maritel Costales, AVSC	3. Enhancing private sector participation								
Mark Sherman, TFG/Policy Project	Private Sector Policy Research	B	X	X					6
Kevin Lind, PSBF									
GOP MEMBERS:									
	4. PVO : Child Survival Grant: PSBF			X		B			7
Dr. Rebecca Infantado, DOH									
Dr. Orlando Pagulayan, DOH/NGO									
Private Sector Component Manager									
Dr. Loreto Roquero, Jr., DOH/FPS									
ADVISORY GROUP MEMBERS:									
	X - Activity Manager								
	B - Backstop Officer								
	S - Support Officer								
	Resident Advisors:								
Dr. Carmencita Reodica, DOH	1 - Easter Dasmarinas, JSI/RTI								
Mr. Satish Mehra, UNFPA	2 - Apol Soriano/David Stanton, CARE/Phil.								
Mr. Tomas Osias, PopCom	3 - Marissa Reyes/Emma Magsino, PCPD								
	4 - Edna Cecilio/Jestyn Portugill, TFG/SOMARC/Phil.								
	5 - Dr. Maritel Costales, AVSC								
	6 - Mark Sherman, TFG/Policy								
	7 - Kevin Lind, PSBF								

Special Objective: RAPID INCREASE OF HIV/AIDS PREVENTED

01/02/98

Intermediate Result: Knowledge, Attitudes and Practices by HRGs Increased		CORE USAID ASSIGNMENTS							Res. Advisor	
Activities to Support Intermediate Result		PEB	CC-Y	EED	RLP	MDS	CRM	RRG	Res. Advisor	
TEAM LEADER: Cora R. Manaloto, M.D. TEAM COACH: Carol Carpenter-Yaman MANAGEMENT TEAM MEMBERS: USAID MEMBERS: Marichi de Sagun, OPHN Ephraim Despabiladeras, OPHN P.E. Balakrishnan, OPHN Nilda Perez, OPHN Reiner Glori, OPHN Sarah Diama, PRM Thea Pura, ORP Ramon Sagunsin/Sonia Ferrer, OFM Nap deSagun, OGP Peter Sullivan, OLA CONTRACTOR AND COLLABORATING AGENCY MEMBERS: Gilles Pomerol, WHO/WPRO Leona D' Agnes, PATH (TBD*) AIDS RP #2 (Impact), FHI/ARO GOP MEMBERS: Dr. Rebecca Infantado, DOH Dr. Ma. Concepcion Rocas, DOH/FETP Dr. Ma. Elena Borromeo, DOH/AIDS Unit Dr. Remigio Olveda, RITM CHOs from ASEP sites, LGUs		SENTINEL SURVEILLANCE: - HIV (HSS): WHO/DOH-FETP - Behavioral (BSS): WHO/DOH-FETP EDUCATION; Interpersonal Communication - PATH/NGOs PR/Mass Media - PATH/Reach Out/NGOs Condom Promotion - PATH/DKT/NGOs STD Syndromic Management Trng. - PATH/LGUs/NGOs STD Workplace Program - PATH/ LGUs/NGOs LGU/NGOs Strengthening - PATH/ LGUs/NGOs Policy/Advocacy - PATH/NGOs AIDS RP #2 (Impact) - FHI/PATH								
		B				S	X		1	
		B				S	X		1	
		B					X	S	2	
		B		S			X		2	
		B			S		X		2, 3	
		B		S			X		2	
		B				S	X		2	
		B		S			X		2	
		B		S			X		4	
ADVISORY GROUP MEMBERS: Dr. Carmencita Reodica, DOH Geoff Manthey, UNAIDS Tokujiro Kamigatakuchi, JICA NVK Nair, WHO/Philippines Tony Bennett, FHI/ARO Hans Teunissen, Netherlands Embassy	PEB - P E. Balakrishnan CC-Y - Carol Carpenter-Yaman EED - Ephraim E. Despabiladeras RLP - Reynalda L. Perez MDS - Ma. Paz de Sagun CRM - Corazon R. Manaloto RRG - Reiner R. Glori	X - Activity Manager - within USAID; directly responsible for the activity B - Backstop Officer S - Support Officer Resident Advisors: 1. Annette Ghee/Ma. Consorcia LimQuizon, WHO/WPRO 2. Dr. Carmina Aquino, PATH 3. Andrew Piller, DKT 4. TBD								

* To be determined

ANNEX 11
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(* Recipient of USAID assistance)

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Malate, Manila

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***Community and Health Development, Inc. (COMDEV)**

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