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MULTI-YEAR POPULATION STRATEGY STATEMENT

1979

U. S. AID MISSION TO THE PHILIPPINES

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LIST OF ABBREVIATIONS

ADB	Asian Development Bank
AFS	Area Fertility Survey
ASI	Asian Social Institute
ASFR	Age-Specific Fertility Rate
BAEX	Bureau of Agricultural Extension
BHS	Barangay Health Stations
BLISS	Bagong Lipunan Integrated Sites and Services
BNS	Barangay Nutrition Scholars
BSP	Barangay Service Point
BSPO	Barangay Service Point Officer
CBR	Crude Birth Rate
CCMP	Commercial Contraceptive Marketing Projects
CDR	Crude Death Rate
COS	Community Outreach Survey
CPO	City Population Office
CPR	Contraceptive Prevalence Rate
DPO	District Population Office
FP	Family Planning
FPPIA	Family Planning International Assistance
FPOP	Family Planning Organization of the Philippines
FTOW	Full Time Outreach Workers
GOP	Government of the Philippines
IBRD	International Bank for Reconstruction and Development (World Bank)
IDA	International Development Association
IEC	Information, Education and Communication
IMCH	Institute for Maternal and Child Health
INC	Iglesia Ni Cristo
IPAVS	International Project Association for Voluntary Sterilization
IPPF	International Planned Parenthood Federation
IUD	Intra-Uterine Device

JHPIEGO	Johns Hopkins Program for International Education in Gynecology and Obstetrics
KAP	Knowledge, Attitude and Practice
LOI	Letter of Instruction
MCRA	Married Couple of Reproductive Age
MEC	Ministry of Education and Culture
MEP	Months of Effective Protection
MHS	Ministry of Human Settlements
MIS	Management Information System
MLGCD	Ministry of Local Governments and Community Development
MOH	Ministry of Health
MOL	Ministry of Labor
MSSD	Ministry of Social Services and Development
NCSO	National Census and Statistics Office
NDS	National Demographic Survey
NEDA	National Economic and Development Authority
NMPC	National Media Production Center
NPFPOP	National Population and Family Planning Outreach Project
PASE	Population Awareness and Sex Education Program
PCF	Population Center Foundation
P.D.	Presidential Decree
PEP	Population Education Program
PGR	Population Growth Rate
PIACT	Program for the Introduction and Adaptation of Contraceptive Technology
POPCOM	Commission on Population
PPO	Provincial Population Office
PREPF	Population, Resources and Environment for the Philippine Future
RHU	Rural Health Units
RPFS	Republic of the Philippine Fertility Study
RPO	Regional Population Office

SCRPPP	Special Committee to Review the Philippine Population Program
TFR	Total Fertility Rate
TIDA	Total Integrated Development Approach
UNFPA	United Nations Fund for Population Activities
UPPI	University of the Philippines Population Institute
USAID	United States Agency for International Development
VSC	Voluntary Surgical Contraception
WFS	World Fertility Survey

I. INTRODUCTION

The Philippines, with a population of 46.4 million, is the seventeenth most populated country in the world. With a land area of about 300,000 km², it is also one of the most densely populated-154 persons per square kilometer. The population per square kilometer of farm land is 542 persons.

Rapid population growth continues to be a serious problem in the Philippines, hampering improvements in education, housing, health, income, nutritional status and employment levels. While the population growth rate has declined from around 3% per year in the late 1960s to about 2.3-2.4% today, the momentum for future growth continues, with high fertility (TFR = 5.0 in 1977), a young population (median age of 16.4 years in 1975) and declining mortality. The population of the Philippines is expected to reach 70-75 million by the year 2000.

This document, prepared by the staff of the U.S. AID Mission to the Philippines, will propose a strategy for the United States in assisting the Government of the Philippines (GOP) in addressing its population problem. Although projecting problems and objectives through the year 2000, it will focus primary attention on the five year period 1981-1985, describing the current national policy and program, assessing its strengths and weaknesses, reporting on the plans of the GOP for the near future, and finally, proposing an appropriate role for AID in relation to the efforts of the GOP and other donors.

For the reader of this document who wishes to look at any given area of the Philippine Population Program in more depth, a set of Back-Up Papers have been prepared to accompany this document. Copies are available in AID/Washington at the Philippine Desk, Asia/TR/HPN and DS/POP. They are also available at the Mission. The ordering and content of the Back-Up Papers more or less follows the outline provided in AIDTO Circular A-143, omitting only the "Action Strategy" section which, of course, is found herein as Section V, "Proposed U.S. Strategy."

We cannot bring this Introduction to a close without expressing our special thanks to the two consultants who provided us invaluable assistance in developing the MYPS. They were Dr. J. Jarrett Clinton of the Population Council and Dr. Steven Sinding of the Asia Bureau, AID/Washington.

II. THE DEMOGRAPHIC GOAL AND AID'S ASSESSMENT OF IT.

A. Feasibility

The current goal of the Government of the Philippines, as formulated in 1977 and expressed in the Five Year Development Plan of 1978-1982, is to achieve replacement-level fertility by the year 2000. This goal may be too conservative judging from the recent results reported by the Republic of the Philippines Fertility Surveys (RPFS)^{1/} and the 1978 Community Outreach Survey (COS).

Based on these two surveys, the University of the Philippines Population Institute (UPPI) has proposed a new set of goals and targets that more accurately reflect current levels and past trends of fertility and contraceptive practice. These data suggest rapid fertility decline and steadily increasing contraceptive prevalence during the decade of the seventies, with the trends continuing on into the future. The Five Year Population Plan, now under preparation by POPCOM and its Partner Agencies, will use the UPPI recommended projections as set forth below in Table 1.

TABLE 1
Projected Trends in Contraceptive Prevalence Rates (CPRs)
and Demographic Variables⁽¹⁾

Year	Contraceptive Prevalence % ⁽²⁾	# of MCRA's ⁽³⁾ x000	Users x000	Crude Birth Rate/1000 Persons	Crude Death Rate/1000 Persons	Annual Population Growth Rate
1979	40.9	5659	2315	32.7	9.0	2.37
1980	43.0	5806	2497	31.7	8.9	2.28
1981	45.1	5972	2694	30.9	8.8	2.21
1982	46.9	6138	2877	30.3	8.7	2.16
1983	49.1	6305	3097	29.5	8.6	2.09
1984	51.1	6471	3306	28.8	8.5	2.03
1985	53.1	6637	3524	28.1	8.4	1.97
1990	63.0	7533	4746	24.1	7.9	1.62

(1) John Laing, UPPI, 11/79.

(2) Prevalence here refers to that of all methods regardless of source.

^{1/} The RPFS is part of the World Fertility Survey.

Continuation of Table 1

- (3) MCRA's - Married Couples of Reproductive Age. In measuring CPR, it has been customary in many population programs to establish it in relation to MCRA's. This may fail to include a substantial number of non-married users of contraception. In the Philippines, under-reporting could be significant in that, according to the 1975 Census, 72% of women aged 15-24 were not yet married, while another survey source, the Area Fertility Survey, found that 25% of currently married women reported premarital cohabitation. The effect of this probable under-reporting on the overall prevalence rate is unknown and should be researched.

Table 1 projects that replacement fertility can be achieved before the year 2000 at some time during the 1990s. Over the next six years, if current trends continue, the crude birth rate (CBR) will be reduced by roughly one point (0.75) per year to about 28 births per 1000 population in 1985, accompanied by an annual population growth rate (PGR) of 2.0%. The contraceptive prevalence rate (CPR) is projected to increase from 41% in 1979 to 53% in 1985 at a rate of two percentage points per year.

The UPPI projections seem reasonable; and the Mission feels confident that these goals are feasible given past demographic trends and the generally favorable socio-economic environment for fertility reduction.

B. Current Demographic Situation in Context of Recent History and Socio-Economic Setting, Determinants of Fertility.

The CBR has declined substantially in the past decade from 41-42 per 1000 in 1968 to 36-37 per 1000 in 1975 and to 32-33 per 1000 today. This represents a decline of almost one point (0.82) per year or roughly a 22% decline in the CBR since 1968 (see Table 2). This follows a lengthy period during the 1950s and early 1960s when the CBR had been declining gradually from a maximum level of 45-50 per 1000.

*In fact, the UPPI estimate of the current CBR may be conservative given the RPF's estimate of a CBR of 31.9 in 1977.

TABLE 2

Estimate of Past and Present Contraceptive Prevalence
and Demographic Rates (1)

<u>Year</u>	<u>CPR</u>	<u>CBR/ 1000</u>	<u>CDR/ 1000</u>	<u>PGR</u>
1968	16	41.4	11.8	2.96
1969	18	40.7	11.5	2.92
1970	20	40.0	11.2	2.88
1971	22	39.2	10.9	2.83
1972	24	38.4	10.6	2.78
1973	26	37.6	10.3	2.73
1974	28	36.9	10.0	2.69
1975	31	36.3	9.8	2.65
1976	34	35.2	9.6	2.56
1977	36	34.2	9.4	2.48
1978	38.5	33.5	9.2	2.43
1979	40.9	32.7	9.0	2.37

(1) Laing, 11/79. Based on 1968 and 1978 survey data. Estimates for other years were derived by interpolation and extrapolation of a smooth curve.

Other demographic measures provide additional evidence of substantial fertility declines. Between 1965 and 1977, the Total Fertility Rate appears to have declined 21% at an increasing rate from 6.3 in 1965 to 5.9 in 1970 to 5.0 in 1977. The Marital Total Fertility Rate, which remained relatively constant between 1965 (9.7) and 1970 (9.6), declined about 7% to 9.1 in 1977. Almost all the declines in marital fertility were due to reductions in fertility for married women 25 years and older. The indications are that fertility declines for women below 25 years of age are almost all associated with increasing age at marriage.

The overall CPR, including all methods from all sources, has increased dramatically between 1968 and 1978 to a level of 38.5% at a rate exceeding 2% per year. The exact course of the trend of the CPR is unclear as the evidence is mixed; however, the CPR data in Table 2 are based on an assumption of a relatively smooth rate of increase. Data in Table 3 provide estimates of recent and past contraceptive use by method at three different points in time.

TABLE 3

ESTIMATES OF CONTRACEPTIVE USE OF PROGRAM METHODS^{1/}

Method	May 1968 ^{2/}			May 1972 ^{2/}			June 1978 ^{3/}		
	Users x 000	Percent Method Mix	Percent of MCRA	Users x 000	Percent Method Mix	Percent of MCRA	Users x 000	Percent Method Mix	Percent of MCRA
Pills	54	2	1.3	326	30	7	276	13	5.0
IUD	37	6	0.9	93	9	2	138	6.5	2.5
Sterilization	5	1	less than 1.0	24	2	less than 1.0	308	14.5	5.6
Condom	20	3	less than 1.0	46	4	1	215	10	3.9
Rhythm	228	34	5.5	326	30	7	507	24	9.2
Program Methods	344	51	8.3	815	74	17.5	1444	68	26.2
Other Methods	331	49	8.0	280	26	6.0	678	32	12.3
Total CPR	675	100	16.3	1095	100	23.5	2123	100	38.5
MCRA x 000		4131			4659			5513	

^{1/} Data refers to National Population Program - including inputs from all sources.

^{2/} University of the Philippines Population Institute (UPPI), Research Note #136.

^{3/} J. Laing, UPPI, 8/2/79.

Note: Some totals do not add due to rounding.

MCRA - Married Couples of
Reproductive Age
(Ages 15-44 years)

CPR - Contraceptive Preva-
lence Rate

Since the early 1970s, most of the dramatic increase in contraceptive use has been due to greater practice of the "less effective" methods, like the condom and the traditional methods. Between 1972 and 1978, the number of users of pills, IUD, and sterilizations increased by 63% adding 279,000 more users; whereas, the number of users of condoms and the traditional methods increased about 114%, increasing the 1972 total by almost 750,000." Most of the increase in the number of users of "more effective" methods (pills, IUD, sterilization) has been due to a continuing increase in the number of sterilization users which has, to some extent, offset a decline in the use of pills and IUDs.

In 1978, users of the "more effective" methods made up only 13.1% of MCRA, and accounted for only 34% of all contraceptive users. The other 66% were using condoms or traditional methods or some combination of these methods. Apparently, the use of the "less effective" methods is, however, contributing to the substantial declines in fertility, suggesting that couples are controlling their fertility without substantial recourse to the "more effective" methods. A reasonable hypothesis is that the rate of decline in fertility could be accelerated by program efforts which improve the use effectiveness of less effective methods, while motivating people already committed to contraception to switch from less to more effective methods.

Socio-economic determinants of fertility are difficult to assess. Nevertheless, it is clear that the rising age of marriage has been and continues to be, associated with fertility declines in the Philippines. The current singulate mean age of marriage for females is quite high (23.8 years)^{2/}; however, there is potential for further increases, especially since there still is a large difference (1.5 years) between urban and rural averages. Also, the fertility declines have been associated with rising levels of education, especially for women (86% female literacy rate)^{3/}, increasing urbanization (32% urban) and improving socio-economic status. The relative effects of female labor force participation^{4/} and decreasing infant and child mortality on fertility are less well documented in the Philippines, but these may also be factors influencing fertility trends. It is also possible to hypothesize that, in the face of economic stringency, the increased costs of raising of children is affecting fertility negatively.

^{2/} 1977 Area Fertility Survey

^{3/} National Census Statistical Office

^{4/} Females account for more than one-third of the total labor force.

On the other hand, the socio-cultural environment still contains powerful incentives for large families. There are several perceived and actual benefits, both pecuniary and non-pecuniary, in having children. For the Filipino, non-monetary benefits of children include: maintenance of family continuity, parental fulfillment and social approval, emotional security, family warmth and closeness, and the fulfillment of traditional Catholic values. Often, children are still desired for economic reasons as there are commonly held perceptions about their present and future economic contributions and the social security children can provide.

C. Household Access and Response to FP Services

There have been significant improvements since 1976 in the availability of contraceptives and access to reliable family planning information. The number of contraceptive service centers have increased from around 3000 clinic and hospital based centers in 1976 to over 40,000 today. This figure includes around 33,000 village-based barangay service points (BSPs), established by the 2700 "Outreach workers". The BSP volunteers provide pills and condoms to their neighbors and referral services for those interested in IUD and sterilization. In addition, there are approximately 4700 barangay health station MOH midwives, providing FP/MCH services to village residents throughout the country.^{5/} The midwives provide an important extension of the services supplied by the 3,500 MOH Rural Health Units and private clinics now functioning in small municipal centers.

Awareness of family planning today is almost universal in both rural and urban areas where 94% and 97% respectively of MCRA report knowledge of Family Planning.^{6/} However, while use of contraceptives is high, that of the "modern Methods" is low.

Recent measures of contraceptive use effectiveness are found in Table 4.

^{5/} To date, there are approximately 6000 barangay health center midwives; however, only 4700 are located in the villages and approximately only 35% of these are housed in health stations. Only a relatively small fraction of the total have received formal training in IUD insertion. Eventually all midwives are to be trained in pill distribution, with IUD training for those who wish to receive it.

^{6/} RPFS

TABLE 4
Contraceptive Use Effectiveness⁽¹⁾, 1978

<u>Method</u>	<u>CMU</u>	<u>PRC</u>	<u>MEP</u>	<u>Rank</u>
Pills	14.9	81	12.0	(3)
IUD	27.3	93	21.1	(1)
Condoms	6.1	57	3.5	(8)
Rhythm	14.6	61	8.9	(4)
Combinations ⁽²⁾	24.3	76	18.9	(2)
Withdrawal	12.6	60	7.6	(5)
Abstinence	4.9	81	4.3	(7)
Others	10.1	55	5.6	(6)

(1) Laing, UPPI, 1978 Community Outreach Survey, Preliminary Report #3, MEP were calculated by USAID in consultation with UPPI.

(2) Various combinations of condom, rhythm, and withdrawal.

CMU - Mean Number of couple-month of use. (Expected period of protection - 1st segment, 1st method continuation rates).

PRC - Percentage Reduction in Conception (Age Standardized). This is an estimate of fertility reduction when contraception is being used. $PRC = 1 - P_m / P_o$, where P_m = Probability of becoming pregnant while using a given method and P_o = Probability of becoming pregnant with no method.

MEP - Months of Effective Protection - Rough measure of number of months by which pregnancy is deferred as a result of a single segment of use. $MEP = CMU \times PRC$.

Due to definition, the measures of CMU, PRC, and MEP are only minimum estimates.

The different methods are ranked in order of the relative number of months of effective protection (MEP) provided. The MEP is a rough measure of the number of the months by which a pregnancy is deferred as a result of a single segment of use and can be used to compare the relative use - effectiveness of

the different methods. Not surprisingly, sterilization^{7/} and IUD provide the greatest number of MEP. However, the relatively high effectiveness of various combinations of withdrawal, condom and rhythm is particularly noteworthy. Each alone provides relatively low protection, but in combination, their effectiveness is estimated to be greater than that of the pill due to their longer continuation rates. These findings have important program implications, given that roughly two-thirds of all contraceptive users are using condoms, rhythm, or withdrawal and that two-thirds of these users state that they receive their "services" from friends, relatives, or neighbors.

The data on contraceptive use and awareness indicates that there has been significant growth during the past decade in community acceptance of the legitimacy of family planning. This is further documented by the level of discussion (usually positive) from non-program sources in the village about family planning. Eighty-five percent of village survey respondents said that they had heard about family planning from spouses, friends and neighbors, local officials, school teachers, and religious leaders.^{8/}

^{7/} Sterilization is not included in Table 4; however, it has the highest MEP, in excess of 120.

^{8/} COS Report #1, page 22.

III. THE CURRENT POPULATION POLICY AND PROGRAM OF THE GOP

A. The Policy

The national population policy dates to the late 1960s. It evolved from a series of private and public sector activities which led the GOP to create the Commission on Population (POPCOM) in 1969. Later, Republic Act 6365, in 1971, and Presidential Declaration No. 79, in 1972, officially established the national population policy and defined POPCOM's coordination and promotional authorities and responsibilities. The center-piece of this national policy was fertility reduction through voluntary measures, promoted by national family planning program with both public and private components. Only abortion was excluded as a contraceptive method.

Development plans of the GOP began incorporating population and family planning chapters as early as 1971 and have been setting demographic and family planning targets ever since. Other decrees and laws provided for tax and labor law changes, counselling for marriage applicants, etc., in support of lowered national fertility and population growth rates. The Five Year Development Plan, 1978-82, added the new policy element of encouraging cross-sectoral linkages in planning, recognizing that fertility is greatly influenced by developments in other sectors and that efforts to control population growth should "go beyond the sector's ordinary range of activities". Currently, the official objective of the GOP program, as set forth in the Philippine Long-Term Development Plan, is to achieve a Net Reproduction Rate of One by the Year 2000, at which time the PGR would be about 1.0% and the total population about 70 million. As noted in Section A, this objective may be too conservative.

B. Program Structure and Operations

Dissatisfaction with the limitations of a clinic based family planning program led POPCOM to initiate, in 1975, the Total Integrated Development Approach (TIDA) using multipurpose, community development workers in selected provinces.^{1/} However, the approach proved too diffuse for significant short term fertility changes and was gradually abandoned. Remnants of the "philosophy" still exist among some current workers.

With USAID's strong involvement, an alternative, the nation-wide Outreach Project, was developed in 1976 and implemented in 1977.

^{1/} At that time, the MOH had about 1,800 part-time family planning motivators engaged in community outreach but, reportedly, they were poorly selected and trained, underpaid and too frequently set to low-level health tasks around the clinics.

The fundamental concept of Outreach is to provide single-purpose, Full Time Outreach Workers (FTOWs) at the approximate ratio of one per 2000 MCRAs throughout the country. Supervised by a national network of regional, provincial/city and district population officers, each FTOW is to recruit, train and support approximately 20 Barangay Service Point Officers (BSPOs). Therefore, each BSPO should cover approximately 100 MCRAs although physical distances in more remote areas often preclude this degree of population coverage. With support from the FTOW, the BSPO resupplies oral contraceptives and condoms to continuing users and provides a source of information, motivation and referral for new acceptors to clinic facilities, particularly for those seeking IUD insertion or sterilization. Finally, with assistance from the FTOW, the BSPO maintains an ongoing record of eligible couples and current contraceptive users within the BSPO catchment area.

The Outreach Project now has about 3200 Outreach paid personnel, of whom 2700 are FTOWs. A total of about 33,000 BSPs have been established (about 11 per FTOW). These BSPs are providing coverage to about 42 percent of the 5.7 million MCRAs in the Philippines. The Outreach Project calls for the ultimate establishment of about 55,000 BSPs which will cover about 4 million MCRAs.

In addition to the development and support roles to the BSPOs, the FTOW is also expected to make home visits for follow-up and for motivating potential family planning users.

The FTOWs, though financed in varying degrees by the GOP, USAID and local governments, are considered local government employees. However, their status, as such, has not been fully regularized.

Meanwhile, over the past three years, with IBRD assistance, the primary health care system of the MOH is being improved significantly. The keystone is the Rural Health Unit (RHU) with a physician, nurse, midwives and a sanitarian. As satellites, Barangay Health Stations (BHS), staffed two days per week by a single midwife, extend basic MCH/FP services to the barangay. BHS midwives, now numbering about 6,000, will be capable of issuing oral contraceptives to new acceptors, inserting IUDs and managing minor side effects.^{2/} Furthermore, midwives when trained can provide a technical, supportive role to the FTOW and nearby BSPOs.

^{2/} At present, fewer than 3,500 of the midwives have been trained to dispense oral contraceptives and 350 to insert IUDs. Training is continuing under a recent IBRD loan. Each midwife is to serve a population of 5,000 people (about 600 MCRAs); by 1985, somewhat optimistic plans call for 10,000 trained midwives in service.

The RHU, with its stronger clinical base, should provide all of the above, plus vasectomy services and the management of any contraceptive side effects.

Supplementing the Ministry of Health facilities are scattered private clinics. 256 of these, operated by the Institute for Maternal and Child Health (IMCH), and 51, operated by the Family Planning Organization of the Philippines (FPOP), are the predominant, although not exclusive, private sector rural clinics. They include an "outreach" principle in their operations, with midwives making afternoon home visits.

Altogether, 3,594 clinics and hospitals provide family planning services at present, 2,140 of which are public and 1,454 private. Of these, 482 of the public facilities and 358 of the private institutions have the capacity to perform sterilizations. An institutional subsidy is paid by POPCOM or Medicare to most of these facilities per sterilization procedure performed. Additionally, there are 10 mobile sterilization teams working in the regions, supplied by the MOH, FPOP, MJH and PGHs. Most of the sterilizations involve the mini-lap procedure, although a laparoscopic program is active currently in about 14 hospitals throughout the country.

Responsibility for binding the network together rests with the outreach field staff consisting of Regional, Provincial and Municipal/City Population Officers, and their respective staffs. The staff coordinates with the Ministries of Health, Labor, Education, Local Government, the National Nutrition Center and the Bureau of Agricultural Extension of the Ministry of Agriculture, all of which participate in family planning with their own informational/educational programs.

The Ministry of Labor (MOL) now provides some degree of support in family planning to about two-thirds of 1,522 firms employing more than 200 people. About 900 health clinics in these firms get POPCOM-supplied contraceptives through the MOL, and also limited supplies of IEC materials. The MOL has also established 453 labor-management committees at as many work sites who help organize and promote family planning. Results are still modest with only about 4% of all contraceptive users reported out of the MOL Program. However, the program is young (established in 1975) and has important potential in developing male contraceptive practice.

The population education program in the public schools of Ministry of Education is active and widespread; although most private schools still have no program.

Commercial sales of oral contraceptives (lowest price about \$.60 per cycle) and a range of condoms take place outside of the established program in pharmacies.

In two provinces of northern Luzon, the Population Center Foundation (PCF), assisted by PIACT, has been carrying out a private sector condom sales program during the past 2½ years as an operational research activity. Preliminary research reports have been encouraging, especially data confirming that the program has been truly additive to contraceptive prevalence in the two provinces, complementing, rather than competing with, the National Family Planning Program. Plans are now being developed to add in one or two other contraceptive and/or nutritional products and to expand the area of operations to all of northern Luzon (8 provinces in Regions 1 and 2). Impetus to develop the program further has come from the continued technical assistance of PIACT, the decision to increase funding for the project through the new IBRD population loan, and a recently held international Contraceptive Retail Sales (CRS) Conference in Manila, funded by AID.

PCF was conceived as POPCOM's private sector arm for carrying out certain training, communication and research functions expeditiously. It has functioned well in some areas, but at present, relies primarily on public financing. It has failed to become self-supporting as donor support has diminished.

1. Strengths

a) Conceptually Sound Delivery System

We believe that the present national network provides a conceptually sound family planning information and services delivery system. With the addition of the "Outreach" element (FTOWs and BSPOs) to an expanding rural health care system, most family planning services can be provided close to the users' homes with an extant referral system for more technical procedures or complications.*

b) Extensive Program Support Systems

POPCOM is able to enlist program support from the Ministry of Local Government and Community Development plus mayors and governors and research groups like the University of the Philippines Population Institute and several private universities outside Manila. This broad array of official support provides sustained and comprehensive assistance to the service delivery program.

*Early indications of Outreach program impact have been encouraging. COS measurement occurred in 1978 after an average of 7 months of program operations. In Outreach areas, between March, 1977 and March 1978, contraceptive prevalence was up 6.8% and the pregnancy rate down 3.2%.

c) Nationwide Network in Place

The program is now nationwide, operating in all except one province and one city in Mindanao where security conditions preclude program activities. The establishment of some 33,000 Barangay Service Points (BSPs) in less than three years, with a proven record of keeping them well stocked with pills and condoms, has been no small accomplishment. The network is still growing and provides a community-based system which is a fundamental component in other dynamic Southeast Asian family planning programs (e.g., Thailand and Indonesia)

d) Highly Motivated Outreach Field Staff

In the 13 regional offices, numerous provincial offices and within the sub-provincial field network, the esprit de corps of the Outreach personnel has been outstanding. These workers are, for the most part, young, college educated and highly motivated.

2. Weaknesses

1978 witnessed two major program evaluations: the GOP's Special Committee to Review the Philippine Population Program (SCRPPP) and the POPCOM/NEDA/AID Evaluation of Outreach. Then, in early 1979, the preliminary reports of the 1978 COS were published. These three studies were important in focussing GOP and AID attention on the strengths and weaknesses of the Philippine Population Program, especially Outreach.

The back-up papers to this document, available in Asia/TR/HPN, DS/POP, the Philippine Desk and the Mission, include detailed accounts of the findings and recommendations of all three studies, as well as actions taken to date by the GOP and Mission in response thereto. Further, a summary of SCRPPP Report findings is found in Section IV below.

Though Outreach is a conceptually sound system with a highly motivated field staff, various constraints and weaknesses are evident in processes, collaboration and coordination; they are, however, deficiencies amenable to correction.

a) Lack of Direction within POPCOM

There have been longstanding problems of administration, management and leadership within POPCOM, particularly at the central level (Manila). Three POPCOM Executive

Directors have been assigned between 1971 and 1978. The fourth and current Executive Director is in an "acting" position, though the individual has had extensive experience in the program as the previous Deputy Executive Director. Some senior and mid-level positions within POPCOM Central are vacant or held by "acting" personnel. In part, this represents the extensive staff changes and discharges made under the leadership of the prior Executive Director, yet there has been a chronic deficit in various components of midlevel and senior staff for a number of years.

The staff vacancies and inadequacies have not been limited to a single element of the program. They have included finances, planning, medical affairs, training, IEC, logistics, research, data management, all of which at one time or another, have had long, significant vacancies or weak incumbents.^{3/}

This fundamental weakness leads to numerous problems, further handicapping the program.

b) A Weak IEC Program

The IEC program has been unable to sustain appropriate, plentiful materials at the field and clinic level for years.

Despite the merits of a new regional approach to the design of IEC materials, criticism has been voiced that local products have not always included evaluation by both medical and lay leaders to assure the correctness and appropriateness of the message. Insufficient quantities of IEC materials have been distributed to FTOWs and BSPs, as well as to the clinics and health stations, which must rely on POPCOM for these materials. Recent USAID efforts to fund graphic materials in large quantities for BSP use should help resolve this problem by late 1979, and a comprehensive IBRD-funded IEC program for POPCOM and the MOH will take over from 1980 through 1984.

c) Under-Trained Field Staff

Many of the field staff, particularly those in the Outreach system, have not had sufficient or adequate training on contraception in general and the more effective methods in particular. FTOWs today, for the most part, feel inadequate in initiating oral contraceptive use or discussing side effects. Many of them fail to emphasize the advantages

^{3/} Effective May 1979, POPCOM mid-level and senior staff received substantial pay increases from the GOP, about 40% at mid-level and 30% for the more senior positions. These may have a positive effect on the chronic management problem.

of the IUD and the oral contraceptive, thus favoring the condom and rhythm methods. Yet their knowledge of rhythm, and possible enhancement of its value in combinations, is also insufficient according to mid-1978 findings of the Community Outreach Survey. This shortcoming in training, especially with regards to BSPOs and FTOWs, is being corrected in 1979 with nation-wide programs financed by the GOP and USAID. About 8000 BSPOs will have been trained formally by the end of the year, and systematic in-service and replacement training for FTOWs is being planned now for all future years.

d) Logistics

The flow of funds for Outreach salary and transportation, as well as arrangements for contracting services such as logistics, is inadequate at the present time. Inquiries by USAID staff suggest that perhaps POPCOM's records is no worse than that of other government agencies in the social services field. Nonetheless, the slow reimbursement of transportation stipends and, sometimes, salaries adds to growing discontent among the field staff. A new system of GOP advances against AID project funds to be provided by the Ministry of Budget in 1980 will perhaps alleviate this shortcoming. However, it is not only a financial "liquidity" problem, but also a slow, cumbersome financial reporting system from the regions, that delays the liquidation of advances and the cycling of new funds into the system.

e. The Management Information System

One of the more serious weaknesses at the present time is the inadequate management information system (MIS), which has been the repeated recipient of full time expatriate and national consultants, review groups and significant funding by USAID and the GOP. While the system has some attractive features, the MIS activities have insufficient leadership and technical capabilities, particularly after the past Executive Director caused most of the MIS staff to depart.

The system continues to have some conceptual flaws, insufficiently clear instructions on the forms, no field manual yet for reference and guidance and inadequate supplies of forms at the field level. However, the main weakness has been the lack of uniform implementation by the field; also a slow, somewhat complicated feedback report system that does not lend itself easily to interpretation for field management decisions. A recent joint POPCOM/USAID task force outlined numerous recommendations for improvements and these are being acted upon

slowly at this time. Some of these were that: the MIS should be redesigned to conform with the objectives and strategies of the service delivery system; adequate MIS management within POPCOM requires certain specified recruitment, training and reorganizational measures; reports should be submitted bi-monthly instead of monthly; data verification and spot-checking procedures must be made operative at all operational levels; continued AID technical assistance is required.

The internal weaknesses in the MIS are correctable, but they will require more attention and resources from POPCOM than have been provided in the past.

f) Insufficient Program Coverage

At the field level, the services system still does not provide the degree of program coverage hoped for by this date. About 2,700 of the planned 3,100 FTOWs have been authorized to date with approximately 2,550 on the job. On the average, each of these has established 12 BSPs, theoretically more than half of the planned target of 20 per FTOW. However, less than half of the 5.7 million MCRA are covered by the current outreach system. This derives from the fact that the average BSP covers far fewer MCRA than the 100 MCRA standard due to geography or other considerations. Also, Metro Manila, with about one-eighth of the country's population, has not been programmed except in a few pilot area. Further, the rate of BSPs developed per month has slowed. This slowing was planned some months ago to help promote quality performance and to respond to a recommendation of the GOP Special Committee to Review the Philippine Population Program that Outreach be "retrenched" and/or "integrated".^{4/}

g) Competitiveness, Overlap and Poor Coordination

Though coverage is incomplete in many areas, competitiveness among agencies for new and continuing users exists where services are available. This manifests itself, in some cases, in misunderstanding between the FTOW and the clinic staff, from whom the former must gain information regarding continuing users; restrictions on the distribution of oral contraceptives to new or continuing users imposed by the RHU physician or higher health

^{4/} See Section IV-A, SCRPPP Recommendations.

system administrators; and, conflicts regarding logistics systems and reporting.^{5/}

Coordination guidelines, growing out of the POPCOM/NEDA/AID Evaluation in 1978 are in the final stages of formulation and approval by all Partner Agencies. All are hopeful that they will contribute to the alleviation of the chronic coordination problem. However, the matter is complex and will take time to solve. A description of the Guidelines is included in the back-up papers prepared for the MYPS. (Section XIII, Annex 1, Item 3)

As the total social services system in the Philippine expands, there is increasing awareness of the costliness and cumbersome potential of monitoring several different barangay-based workers. Only occasionally does this entail duplication of tasks, but the general areas of overlap may be increasing, not to mention the cost. For example, the Barangay Nutrition Scholar (BNS) program, assisted in part by USAID, provides nutrition education and services. BNSs also map villages and have a secondary task of identifying or encouraging family planning users. The number of BNS (about 5000) is greater than FTOWs, although much lower than the 33,000 BSPOs. Sometimes, a single person performs both BNS and BSPO functions. The BSPO, however, is an unpaid volunteer. The BNS receives transportation payments up to P60 per month because she/he may serve 2 to 3 barangays, going door to door, while the BSPO perform volunteer services only in her own neighborhood.

In some areas there are Barangay Health Workers, also funded by USAID, who receive approximately half the payment stipend provided FTOWs. These workers sometimes include family planning motivation or service within their broad set of activities. As noted above, the Ministry of Social Services and Development through its barangay workers, the Ministry of Agriculture through its Agricultural Extension workers, the Ministry of Agrarian Reform and others provide social services which also may include family planning information and services. All of these workers draw upon the total government resources to provide services at the barangay level. Finally, there is an emerging Ministry of Human Settlements (MHS), which so far provides no field barangay social services, preferring to concentrate initially on housing and environmental sanitation. But the MHS does have an eleven point service mandate which includes health. MHS activities in the social services field today are primarily at the municipal level through assistance to the Municipality Development

^{5/} According to some observers, FTOW-clinic staff relations started off somewhat poorly when Outreach personnel first replaced MOH family motivators in 1977, but improved gradually as both sides adjusted to the new situation. All observers agree that this area needs more attention.

Officer, who in the long run might coordinate all social services functions.

This overall picture of possibly redundant services at the community level has not yet been addressed by GOP leadership, and certainly not by POPCOM. However, NEDA and Ministries concerned with the total availability of funds are now discussing potential options for collaboration and integration, either administratively or by function.

C. Role of Foreign Donors

Currently, there are three, major external donors, - AID, the World Bank (IBRD) and the UNFPA. Of these, AID and UNFPA provide resident population staff. There are several population/family planning agencies, both private and public, working in the Philippines, that are contract-associated with AID. Of these, FPIA maintains a regional office in Manila with a staff of five professionals; Population Council provides two resident specialists; and PIACT provides two residents, one of them regional. The Ford Foundation has two persons in Manila who devote part-time to population interests. The WHO regional office, located in Manila, has supported family planning technical assistance and research. Other occasional bilateral donors, such as the Japanese, assign non-population persons from their respective Embassy staffs to monitor assistance, but also rely on visiting teams. The IBRD develops and monitors its programs through visiting population teams.

An initial \$25 million World Bank loan for Population programs was made to the Philippines in 1974. Most of these funds went to assist the Ministry of Health (MOH) in improving service delivery in rural areas. The rest has been designated to POPCOM for coordination, IEC, and training functions, and to meet needs of regional offices.

IDA and the GOP have approved a second major population/health loan of \$40 million (about \$17 million for POPCOM and \$23 million for MOH), with a contribution from the GOP of \$32 million equivalent. The IDA credit will cover all foreign exchange and a sizable portion of local currency costs. The project period runs from 1980 through 1984. Its major components are noted in Annex A.

The UNFPA signed a First Country Agreement with the Philippines in 1973. It was funded at \$8.3 million over a period of 5 years. Among other things, it provided assistance to POPCOM in planning

and IEC, to the MEC in population education, to the Bohol MCH/FP Project, and to the MOL for its industrial health/FP Services project.

The Second Country Agreement, at \$20 million, runs from 1980 to 1984. Its elements are noted in Annex B.

Donor contributions are subjected to careful scrutiny and coordination, not only by the GOP, but also by the 3 major donors. Annex C provides a comprehensive, but not exhaustive, list of program elements, categorized by (1) Community-based Family Planning Activities; (2) Clinic-based Family Planning Activities; and (3) Non-Family Planning Population Activities which illustrate the extent and interdependence of program activities, as well as the donor coordination that has been consciously planned. The reader wishing more detail is referred to the UNFPA's "Population Programmes and Projects", Vol. 2, pps. 293-304, for a complete list of donor activities in the Philippines as of May 1979 (also found in Section V of back-up papers to the MYPS).

A review of the data in the Annexes indicates that AID bilateral assistance is now largely centered on the community-based, Outreach family planning program; however, Outreach also receives substantial help from the IBRD. The IBRD provides the majority of its assistance through the MOH to public, clinic-based health/family planning programs, with AID helping directly in sterilization subsidy through POPCOM. Meanwhile, the UNFPA focuses much of its attention on the non-family planning sector. In fact, all three major donors assist activities in all three program areas. AID's partner agencies are also involved in a variety of smaller-scale activities in all three program areas, but with emphasis on support of service delivery and physician training requirements in selected public and private sterilization programs. These partner agencies provide flexibility to the overall program in such key areas as operational research, pilot demonstrations, opportunity programming with high performance institutions or doctors and commodity support. The projects they assist continue, or are terminated, following periodic (usually annual) reviews by the GOP, USAID and AID/Washington. They thus tend to be timely and well coordinated into major program areas.

Day to day coordination of the major donors' programs is largely informal, with the resident representatives getting together for lunch and arranging special contacts when other important donors are in town. Coordination is also facilitated by donor meetings in Washington, D.C.

The donor "package" for the Philippine Population Program cost approximately \$60 million for the period 1969 through 1977 according to GOP sources.

IV. THE FUTURE OF THE PROGRAM

A. GOP Plans

In 1978, President Marcos appointed a Special Committee to Review the Philippine Population Program (SCRPPP) and to "recommend program and policy thrusts for the next five years within a ten-year perspective." Subsequently, the President accepted the Committee's Final Report, directed conformance with its recommendations and the preparation of necessary legislative work, as required, for its "total" implementation (LOI 765).

The SCRPPP Report deals comprehensively with all major aspects of the Philippine Population Program. Major policy findings/ recommendations included the following:

- Integration of the population dimension into development plans, policies and programs;
- Formulation of family planning policies and programs within the context of family welfare objectives;
- Linking of population level targets with projected resource availabilities;
- Spelling out of income redistribution targets in GOP development plans;
- Encouragement of the private sector participation in population programs;
- Advocated number of three children per family in this decade, thereafter, two;
- Twenty-five years of age as a guideline for marriage;
- Encouragement of community incentives to promote lower population growth rates;
- Review of the disincentive effect of current maternity leave benefits on couple participation in family planning programs.

Program thrust findings/recommendations included the following:

- Strengthening IEC programs by targetting messages to particular audiences and by developing a national plan;

- Integration of population education into grade school text books;
- Involving private schools in population education;
- More program emphasis on the problem of pre-marital conception and on pre-marital counselling;
- Development of a national training plan;
- Promoting use-effectiveness and cost-effectiveness in contraceptive method choice;
- Providing information on all contraceptive methods, including rhythm, but with emphasis on its use in combination with other methods;
- Following adequate training of pill prescription, permitting population field workers to dispense pills where no clinics or qualified personnel are available;
- Abandonment of the TIDA (Total Integrated Development Approach) concept in implementing Outreach. "The primary responsibility of population field workers in Outreach should be family planning;"
- Developing improved indicators of program performance;
- POPCOM to maintain a primary responsibility for coordination, with implementing functions, such as Outreach, to be "only supportive of implementing agencies participating in the program;"
- Outreach is to either "integrate" or "retrench" (Implication: cost considerations involved in the "proliferation" of social service field workers in several fields must be dealt with realistically);
- In developing the Five Year Plan, POPCOM should correct the "noticeable" compartmentalization of the family planning program;
- Role of the Population Center Foundation (PCF) is to be further delineated in relation to that of POPCOM and there should be a gradual phase-out of the major GOP contribution to the funding of PCF;
- Commercial acquisition and distribution of program methods of contraception should be considered in coping with the expenditure levels associated with the national program;

- A research plan is to be developed, responsive to the findings and recommendations of the SCRPPP Report.

POPCOM, its Board of Directors and representatives of eight Partner Agencies, ^{1/} have been working on the Five Year Population Plan as called for by the SCRPPP Report and President Marcos. It will cover the period 1981-1985. It will be based on the SCRPPP Report findings and recommendations. It should be Board approved by the end of this year (1979).

The POPCOM Board is composed of a number of important people. It is chaired by Dr. Gerardo Sicat, a member of President Marcos' super cabinet and Minister of the GOP's central planning authority, NEDA. Among its members are found the Ministers of Health, Education and Labor, the Director of UPPI and the Dean of the Medical School of that same university system.

This Board met on October 31, 1979 with representatives of USAID and the UNFPA as invited guests. The Board took up two initial documents associated with the preparation of the Five Year Plan: "The Philippine Population Program Joint Program Planning Report," and "In Search of Options - PROJECT OUTREACH, 1981-1985." These documents set forth a proposed statement of the future mission of POPCOM, reaffirmed the basic philosophies with which the program is already associated, presented policy statements, general program objectives and policy concerns. Finally, the second document diagrammed three optional models for the future of Outreach.

Even though the Five Year Plan will not be finalized for another two months, the Mission now has an excellent reading on the GOP plans for the future of the program.

It is evident that Outreach will be continued, but perhaps not taken, for the present, beyond current, paid staff levels. At the same time, the volunteer contingent of Outreach will continue to be expanded. GOP leaders are heartened by recent evidence of fertility decline and initial successes of Outreach as reported in the COS. Assurance of continued AID assistance after 1980, implied by the recent PID and MYPS exercises, have helped to allay the fear that GOP budget requirements would jump substantially in 1981.

1/ MOH, MEC, MOL, MOA, UPPI, UPIMC, PCF, IMCH and FPOP.

The future Outreach models now under study by the Board do not vary from the present conceptual model except with respect to the relative authorities and contributions of POPCOM and the local governments. Key members of the Board appear to favor an Outreach patterned after the GOP ministries in which all field employees would be paid, supervised and obtain policy and technical guidance directly from POPCOM, even though nominally on the staffs of governors and mayors. This pattern, if adopted, would constitute a change from the present day Outreach in which - from Provincial Population Officers on down to FTOWs - workers are appointed by the local chief executive and must take only technical supervision from POPCOM. This approach would tend to discourage a present trend in which local chief executives sometimes ask population field workers to perform both political and other developmental tasks in addition to their regular duties.

In favoring increased POPCOM control, Board members at the same time reassert that, ideally, POPCOM should perform only policy and coordination functions and that the "selective implementation" of Outreach is justified only by the priority required to achieve population objectives. POPCOM implementation of Outreach is viewed as temporary. Some key statements by Board members: "Outreach may not be needed in its present form beyond five years." "During the next five years, we must be building into the program what is to happen afterwards."

These statements shed light on the Board's thinking with reference to the integration and cost issues. While working on the Five Year Plan during the past month, POPCOM and partner agency representatives have considered, and rejected, plans which would have set out to rapidly integrate, or drastically change, the organizational picture of Outreach. In short, it seems as though the GOP proposes to use the next five years to experiment with integration alternatives and to take other measures which would make Outreach more cost effective in the interim.

There seem to be three areas of consensus among Board Members: that an Outreach solely dedicated to family planning should be viewed as a short term rather than an indefinite governmental function; that in promoting any pattern of integration, dilution of the family planning work and priority should be avoided for at least the next five years; finally, that the first step in arriving at a reasoned and workable long term plan for Outreach is to field test alternative organizational concepts. There is also a view that, eventually, the family planning outreach function should be a part of the primary health care system of the MOH, related closely to the functions of the emerging midwife program.

Although to this point, the Five Year Plan may seem preoccupied with Outreach issues, it will also cover other important elements of program emphasis for the next five years, guided by the SCRPPP Report. With UNFPA assistance, NEDA is establishing the Population/Development Planning and Research Unit in NEDA to help assure the integration of the population dimension into the development programs of the Government. Clinic family planning services in the MOH will be strengthened, especially by the fielding, equipping and training of midwives and the further development of the primary health care system (all IBRP-assisted). Finally, the GOP will be working with the private sector, encouraging their increased involvement in production, promotion and distribution of contraceptives, in IEC and in private agency family planning programs.

B. U.S. Assessment of These Plans

The GOP has devoted considerable attention to planning the future of the population program, starting last year with the SCRPPP.

The Mission is in basic agreement with GOP plans, as discussed above, and specifically with its intention to continue Outreach. Outreach completes a national network of clinic and community-based family planning services which is functioning and which is conceptually sound for this country, given its cultural, economic and geographical characteristics and its urgent need to reduce the population growth rate.

However, it was expected that, by the end of 1980, the combined local government/GOP financial commitment would be sufficient to cover the basic, operational costs of Outreach. Local government contribution was to cover virtually all recurrent costs.

As early as last year it became apparent that these objectives would not be reached. At the same time, top Filipino leadership had toned down its speeches promoting family planning. Consequently, AID officials began to question whether there was GOP commitment commensurate with the scope of the problem. There was an American effort to obtain Presidential and First Lady exhortations on family planning which had little success.

A more upbeat, official stance on population is probably not politically feasible in the near future, given the tensions existing in Church-State relations. More importantly, it does not appear as necessary as was earlier assumed considering that the demographic situation and climate for family planning have evolved so favorably. In fact, apart from "low key" top level pronouncements, Government support cannot be faulted

seriously in terms of recent budget support of POPCOM and Outreach, the negotiation of the large population IBRD loan, NEDA's active leadership in population planning and the impressive variety of program support activities backed by the GOP in both the public and private sectors.

Taking a closer look at central GOP budgeting for population programs, AID has rated its performance quite good in relation to that of many other countries.^{2/} In this connection, the 1979 POPCOM budget remained intact at ₱65 million-₱21.8 million of that for Outreach - after its final Presidential review, even though the total GOP budget was to suffer a ₱2 billion cut at that time. For 1980, the POPCOM budget has been upped from ₱65 million to ₱110 million of which Outreach is to receive ₱45.5 million, more than doubling the 1979 Outreach figure. Meanwhile, the GOP has also authorized \$32 million counterpart equivalent to the new \$40 million population loan from the IBRD.

The Outreach financing problem lies more in the contribution of local governments than in national budget allocations. It was assumed, when Population Planning II was being designed in 1976, that local jurisdictions could take over all basic operational costs by the end of the project in 1980. In fact, by the end of 1978, only about 10% of costs had been assumed and, in 1979, local governments are falling short of a 15% contribution. The Population Planning II assumption was invalid and probably inappropriate in that the central government has a continuing stake in the population program and its substantial contribution to operating expenses could provide the only unifying leverage to program activity.

Nevertheless, it should be understood why local governments have not done better. The question is worth asking because of the many Governors and Mayors who have been supportive of Outreach. The basic problem is that, like almost everywhere, local governments have serious financial and budget problems and in the Philippines, these are exacerbated recently by a rapid inflation of costs. Second, the Governors and Mayors must deal with entrenched, valued and highly visible development activities, such as roads, bridges, irrigation systems, agriculture, health and nutrition which actively compete with the population newcomer for funds, as do other new projects, such as BLISS, sponsored by the First Lady. Third, the Governors and Mayors perceive that the GOP and foreign donors, with their greater resources, give high priority to population programs and will probably continue support.

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The failure of local government to contribute more to Outreach has put pressure on the national budget, relieved somewhat in 1979 by P8.2 million in PL 480 funds,^{3/} and it also slowed down the process of AID reducing its percentage of contribution to recurring costs each year.^{4/} The GOP has responded to the problem in three ways: A series of meetings have been held by POPCOM, the Ministries of Finance, Budget and Local Government, NEDA and the Commission on the Audit to devise a new formula for local government participation. A scheme is being put into the form of a legislative proposal in which local governments would pay a fixed percentage (perhaps slowly increasing) of their total income for population activities. The second response of the GOP has been to begin exploration of the integration possibilities for social services. The third involves seeking assurances of continued AID support for Outreach beyond 1980.

This assessment must also take into account the fact that the current Outreach system is not functioning in an optimal fashion. Its weaknesses have been analyzed in Section III-B-2. Chief among them are the chronic management and leadership problems at POPCOM central and the slow progress being made in resolving POPCOM-MOH differences. Outreach is a young program with its earliest volunteers fielded only about 2½ years. It has moved fast in the quantitative sense to establish a huge infrastructure, and although doing well in providing contraceptive availability in all Outreach areas, its qualitative accomplishments in training, IEC, motivation of clients, etc. have been less than satisfactory. The GOP and POPCOM Board are well aware of these shortcomings. They are being addressed directly in the Five Year Plan, in the implementation of the Coordination Guidelines and in Board action on the reorganization of POPCOM and Outreach.

As a final point in this assessment, the Mission believes that it is of great importance that the GOP pay attention to maximizing cost effectiveness of FTOW deployment and BSPO establishment in the near future. The indications are that a ceiling may have been placed already on the hiring of any additional FTOWs due to budget considerations. At first glance, this seems to place in doubt whether Outreach could ever approach the original objective of assuring total MCRA coverage. At this point, about 2700 FTOWs supervise about 33,000 BSPOs. There are 5.7 million MCRA's in the country and, of course, that number increases each year. At present, only about 42% of MCRA's are covered in Outreach program areas, that is to say, 2.4 million couples. In achieving this coverage, each BSPO is working with an average of 74 MCRA's instead of the expected 100.

^{3/} PL 480 funds may not be available in 1980 and beyond.

^{4/} In 1980, AID's contribution to recurrent costs (salaries and travel allowances) will be slightly less than 50%.

If this level of coverage per BSPO continues, then by 1985, with an assumed 55,000 BSPs and 6.6 million MCRA, Outreach would realize only about 62% coverage, or excluding Metro Manila 72%.^{5/} If the number of FTOWs is stabilized at 2800 - the planned figure for 1980 - then in 1985 the average number of BSPOs per FTOW would be 20.

Currently, FTOWs seem hard pressed to keep up with an average of 11 rural BSPOs, informing and motivating them, supplying them with contraceptives and assisting them with monthly reporting requirements. Obviously, some measures to make operations more cost effective must be taken. As in Metro Manila, there are probably urban areas where BSPO volunteers are not needed. There are also relatively isolated rural areas with populations so dispersed, or security conditions so bad, that the benefits of establishing the program would not be worth the cost (or risk). These considerations are already being taken into some account, but an in-depth study and plan are needed. Perhaps in some urban areas already developed by Outreach, nearby clinics or midwives can take over the resupply function for established BSPs. Perhaps less attention could be placed on FTOW maintenance of contraceptive supply for, and reporting by, clinics, with the MOH assuming responsibility in these areas.

In various ways, POPCOM will face the challenge of adjusting the program to local realities and budget availabilities. However, it should be kept in mind that the objective of total MCRA coverage is one for the combined public and private elements of the national family planning program, with Outreach designed only to complete the network. 62% coverage through Outreach could be sufficient, depending on where and how Outreach works. The issues of cost effective staff deployment and overall MCRA targets, like that of the related matter of possible patterns of program integration, have not yet been subjected to rigorous study in the planning process.

^{5/} In Metro Manila, POPCOM is attempting to adapt its program to the metropolitan circumstance, carrying out special activities through social service agencies and hospitals and labor unions. Only a few BSPs have been established in slum areas with many recent in-migrants.

V. PROPOSED U. S. POPULATION STRATEGY

The preceding analysis projects a picture of rapid fertility decline in the Philippines, supported by relatively favorable socio-cultural circumstances, by the readiness of many Filipinos to accept family planning as a household imperative, and by the Government's demonstrated willingness over the past decade to lead the way in policy formulation, legislation and program implementation. Notwithstanding these favorable conditions, fertility remains too high if population growth is to be brought in line with the GOP objectives of sustained economic development.

A. Objectives

The USAID population strategy has three basic objectives:

1. To assure the availability and to foster effective use of fertility control measures among the entire Filipino population.

The gap between family planning knowledge (95%) and contraceptive prevalence (40-45%) is still great. Moreover practicing couples appear to be relying more on traditional and other less effective methods. If fertility is to be further reduced, the gap must be closed and more effective contraception must be practiced.

2. To bring about better organization and improved program/cost effectiveness in Outreach, while exploring ways to better integrate population, health and nutrition field programs.

POPCOM weaknesses have been cited above as well as the proliferation of local level workers in the delivery of services. Achievement of Objective No. 1 can be served by making progress toward this second objective.

3. To encourage incorporation of population considerations into all GOP/USAID development and project planning at national, regional and local levels.

Section 104d of the FAA underscores the interaction between population variables and other variables related to economic development.

B. Strategy Elements

The strategy proposed for achieving these objectives involves essentially continued support for Outreach while broadening assistance to other components of the Philippine Population Program. Outreach, despite its problems, is an effective vehicle. MOH clinics and others in the national FP network have yet to assume their full role in the program.

The elements of the strategy are summarized in Figure 1.

FIGURE 1

ELEMENTS OF U.S. STRATEGY
AS RELATED TO OBJECTIVES, CONSTRAINTS AND MEANS

Objective No. 1 - To assure the availability and to foster effective use of fertility control measures among the entire Filipino population.

KEY CONSTRAINTS TO
ACHIEVING OBJECTIVE

- Outreach now covering only 40% of MCRAs.
- Limits on ability of local government to fund costs of various Outreach programs.
- Seeming public preference for less effective contraceptive methods and concern re side effects of pill.
- Limited priority currently afforded FP in MOH Program.
- MOH clinics found in larger communities limiting access to potential clients living more than 3 kms. away.
- Trend toward declining input by key private agency programs.

USAID PROGRAM MEANS

- A. Continued support of Outreach for five more years.
 - Continue contributions to recurrent costs and sterilization subsidy on declining basis.
 - Assure unhampered, ample supply of appropriate contraceptives.
 - Diversify contraceptive methods promoted through program; support research as required.
 - Support increased use of vasectomy.
- B. Bolster MOH delivery of family planning services.
 - Broaden AID support to other clinical contraceptive methods while continuing contribution to sterilization subsidy.
 - As required, assist IBRD-funded primary health care and midwife training programs through AID intermediaries.
 - Inaugurate transportation for clients seeking clinical FP methods.
- C. Expand role of private sector in service delivery, research, training, IEC and production/promotion/distribution of low cost contraceptives.
 - Selective support of AID Intermediaries to enhance private agency FP programs.
 - Develop closer ties with PCF in project development, research, IEC and training.

Continuation of Objective No. 1

- Low contraceptive effectiveness of condom and potential side effects of pills.
- Free distribution of contraceptives in Outreach.
- Past, effective Church opposition to contraceptive sales in stores.

- Support, as appropriate, existing PCF contraceptive marketing project as it enters expansion stage beyond current pilot areas.
- Support market research on production, price, promotion and sales of contraceptives by private sector.
- Explore possibility of training for pharmacy employees in promoting contraceptive sales

Objective No. 2 - To bring about better organization and improved program/cost effectiveness in Outreach, while exploring ways to better integrate population, health and nutrition field programs.

- Spotty POPCOM record on management, MIS and coordination.
- Bureaucratic impediments in GOP procedures which hamper cash flow for salaries, sterilization subsidies, IEC, training and MIS.
- Uncertainties of volunteerism on which Outreach depends.
- Poorly conceived or executed integration plans can seriously compromise population targets.
- Management and coordination difficulties increase when programs cross agency lines.

- A. Help strengthen POPCOM organizational performance.
 - Support research and evaluation on problem areas in management, technical and operational aspects of program, including MIS.
 - Support more cost-effective use of FTOWs and BSPOs in population objectives.
 - Support increased programs of incentives and training to strengthen motivation/performance of BSPOs and FTOWs.
- B. Support specific studies and pilot activities designed to promote closer coordination/regionalization/integration.
 - Help assure adequate assessment of existing integrated delivery experiments; help undertake others as needed.
 - Adjust COS to regionalize data.

Objective No. 3 - To encourage incorporation of population considerations into GOP/ USAID development and project planning at national, regional and local levels.

- Some lack of understanding of interaction of population variables with other development activities.

- A. Continue implementation of Mission's 104d project review procedures.

Continuation of Objective No. 3

- B. Use of AID intermediaries to support program activities at regional levels and to provide seminars/training, as desirable, at any level.
- C. Support research on determinants of fertility.

C. Implementation Considerations

In negotiating Objective No. 1 with the GOP, USAID will call for two advance understandings: (1) That the present, declining scale of AID funding of recurrent costs is to be continued, with the GOP and local governments picking up increasing shares of total cost through 1985; and (2) that no further AID contribution to recurrent costs will be made after 1985.

The cost of the Philippine Population Program is substantial, even though essential to the country's future. The cost most apparent to the GOP - POPCOM's ₱110 million budget for 1980 - has been approved without difficulty. As noted earlier, about 40% of that sum represents the GOP central budget contributions to Outreach, amounting to about \$6 million equivalent. NEDA has also approved, in principle, the PID for AID's proposed Population Planning III which, from 1981-85, would require a combined GOP/local government contribution averaging about \$7.6 million per year. With appropriate arrangements made for future local government contribution, the GOP feels that it can manage an important share of the projected future costs of Outreach, given continued AID assistance.

To fail to continue AID support to recurrent costs would present the GOP with a financial and morale crisis of considerable proportions. From one year (1980) to the next (1981), it would face a drastic increase in budget requirements for over 3000 employees, absorbing the triple blow of AID withdrawal, lower local government contributions than planned, and greatly increased transportation/fuel costs. The continued, gradual withdrawal of AID from a program it started seems the preferable course of action, especially when the preliminary indicators of program impact have been favorable.

Fortunately, strong consensus exists on both the GOP and USAID sides that the need for an Outreach solely devoted to family planning goals is temporary and that, perhaps after five years, Outreach can turn at least part of its attention to other related development tasks, or its staff and services can be integrated into other agencies. It could be that the family planning outreach function will end up as part of the country's new primary health care system. This may be feasible when its midwives are trained and it has become a functional, nationwide program. Meanwhile, Outreach is there and definitely needed to assure immediate and continuing demographic impact.

The Mission feels that it is also important to assure that an unhampered and ample supply of contraceptives is available to the Philippine Population Program over the next five years. In preparing the Project Paper for the proposed, continued program, USAID will give careful study to how this can best be achieved in terms of financing method and proper lead-in to Philippine self-sufficiency. Also, the range of

contraceptive choice in the program must be expanded.

Outreach is viewed as an essential, but not separate, component of the Philippine Population Program, and therefore, USAID will work to enhance the Ministry of Health's delivery of family services. In doing so, additional inputs are being considered for the clinic-based programs, placing special emphasis on the promotion of the use of more effective contraceptive methods. To the extent that activities are not covered by the IBRD and UNFPA, USAID will plan along the lines set forth in Part B under this Objective (See Figure No. 1). A new element, already included in AID funding for 1980, will be transportation assistance for clients referred by Outreach to clinics for sterilization and IUD services.

USAID recognizes that little has been done in recent years to assure a continued strong involvement of the private sector in population affairs. PCF appears to have lost some ground in funds and influence. The key private agencies delivering family planning services, such as IMCH, have been cutting back on numbers of clinics due to funding problems. A contraceptive retail sales project, following an attack by the Catholic Women's League, has proceeded slowly and cautiously as a research activity limited to two provinces. Promotion of contraceptive sales in the private sector is limited. And to date, studies and action on possible contraceptive production in the Philippines have been inconclusive. As detailed in 1-C of Figure 1, USAID will be more helpful in stimulating private sector involvement. In the long run, the GOP can reduce its costs and increase the effectiveness of program by maximizing private sector involvement.

The constraints to the achievement of Objective No. 2, as earlier discussed, cannot be taken lightly. Many of them relate to the nature of bureaucracies and can only be ameliorated, not overcome. None of them are unmanageable. Most of them will be worked towards solution more quickly if foreign donors keep up a certain amount of pressure and support.

The most significant of those listed may be the uncertainties relating to volunteerism. Given the planned limits on staffing, can Outreach produce, train, support and motivate enough BSPO volunteers to spread effective fertility control services into most Filipino villages? There are at least two ways to answer this question. First, gaining experience and faced with staffing realities, Outreach must adjust by providing "scarcer" resources in a more cost-effective manner. USAID intends to encourage this development vigorously. Second, the matter of volunteer and staff incentives and training will be given special priority in proposed future AID assistance to Outreach. In 1980, the final year of Population Planning II, AID money is being programmed for a range of incentives and training for volunteers and short term study grants to selected FTOWs as a start on this new effort.

A special future requirement, made urgent by fuel shortages, will be the development of a realistic transport plan. There may be a shift to horses, bicycles and scooters to meet a good share of the crucially important transportation requirements in Outreach, especially as the GOP is cutting back on purchase of new vehicles through the IBRD loan. These vehicles were counted on to replace the aging fleet of AID-supplied excess property jeeps. AID will assist, as required, in bicycle or scooter procurement and in spare parts for the old vehicles.

Objective No. 2 includes an area - proposed integration of health, nutrition and population services - in which both the Board of POPCOM and USAID feel a heavy sense of responsibility, -- POPCOM, due to the mandate received from the SCR?PP Report; USAID, due to its leading role over the years in promoting the use of field workers in health, nutrition and population. However, the Board feels that it would be folly to subject Outreach to substantial reorganization or turn it over to any other agency with a broader or different mandate than POPCOM's without first conducting careful studies of alternatives and consequences. USAID agrees with this Board position and proposes to give material support to the GOP over the next five years to help determine the future directions of Outreach and to assist GOP efforts to examine and test the possible integration of FTOW functions with those of other social service agents at the community level. There are already others concerned with the integration issue. The IBRD is financing 12 pilot projects testing alternative primary health care delivery. The Philippine Institute for Development Studies (PIDS) has an active project entitled "An Assessment of Integrated Mechanisms for Delivering Social Services to the Poor." USAID will coordinate with these other activities. As discussed in Section IV-B, USAID will also encourage the GOP to target Outreach to those segments of the population most difficult to reach through alternative delivery systems and to take other measures which will make Outreach operations more cost-effective.

Finally, with reference to Objective No. 3, USAID is in an excellent position to carry out an active program. The Mission project review procedures under Section 104d of the FAA have been established and are now being implemented. NEDA, with help from the UNFPA, is establishing a population unit which can bring population considerations into account in development planning not only at the national level, but also in the country's regional development councils. Primarily through AID intermediaries, USAID intends to encourage this emerging interest as described in the U.S. Strategy Table, under Objective No. 3.

D. Research and Evaluation Needs

The Philippine Population Program should continue to include a vigorous, comprehensive research program. A review of Figure 1 makes clear that

USAID intends to support research in connection with all three of its strategy objectives, both with bilateral funds and through AID intermediaries. Annex D, entitled "Population Monitoring, Evaluation and Research Framework," provides a comprehensive overview of the kinds of research and evaluation that can serve all aspects of the Philippine Population Program, noting the actual or potential financing sources available.

Some of the specific areas to which USAID will direct attention include: home insertion of the IUD; expulsion/perforation rates for IUD among female agricultural workers; effectiveness of sterilization service delivery; the decline in use of vasectomy; an anthropological study of the rhythm and other traditional methods as practiced in the Philippines; the potential of various "combination" methods of contraception; market research on contraceptive sales in the private sector. All of the foregoing relate to Objective No. 1 in Figure 1.

In the area of Objective No. 2, special interests include: continued COS with regionalized data and increased attention to MIS; in-depth, qualitative operational studies of management and implementation issues; studies and pilot projects on integration alternatives for the future of Outreach; demonstration projects in the use of community incentives to promote family planning.

Finally, in relation to Objective No. 3, we will support determinants of fertility studies and the adding of a socio-economic module to the Area Fertility Surveys.

A more detailed discussion of "Research Perspectives" is available in Section XIV of the Back-Up Papers.

3. Resource Requirements

Implementation of the U.S. population strategy will require roughly \$60 million in bilateral funds over the 1981-85 period. This represents a general order of magnitude. It includes contraceptive supply requirements for POPCOM and the partner agencies. This total can be matched to the objectives and program means as follows:

Outreach Support (Objectives 1 & 2)	\$ 25 million
MOH Clinic Support (Objective 1)	20 "
Private Sector Support (Objective 1)	10 "
Planning, Research, Evaluation (Objectives 1, 2 & 3)	5
	<hr/>
	<u>\$ 60 million</u>

For its part, the GOP can be expected to provide at least \$150 million for all population activities over the same period.^{1/} Outreach alone will amount to some 26%, or \$40 million. This is a conservative estimate considering that GOP population expenditures in all sectors in 1979 approached \$20 million and given the current rate of inflation.

^{1/} Projected from Table B-5, page 163, "The President's Budget Message for 1980" Ministry of Budget, which shows estimated 1980 population expenditure level of P175 million (\$23.6 million), compared to P138 million in 1979.

IBRD/GOP LOAN (1980-1984)

Category	('000 P)			('000 US\$)			% of F.E.	% of Base Cost
	Local	Foreign	Total	Local	Foreign	Total		
Capital Cost								
1. Construction	82,900	35,500	118,400	11,200	4,800	16,000	30.0	27.0
2. Furniture	5,000	2,100	7,100	600	300	900	33.0	1.5
3. Equipment	-	12,300	12,300	-	1,700	1,700	100.0	2.9
4. Special equipment	4,500	22,900	27,400	600	3,100	3,700	84.0	6.3
5. Vehicles	3,200	4,700	7,900	400	700	1,100	64.0	1.9
6. Materials for finished products	4,400	3,000	7,400	600	400	1,000	40.0	1.7
7. Seed funds	18,200	-	18,200	2,500	-	2,500	-	4.2
8. Advisory services, studies & fellowships	9,300	11,300	20,600	1,300	1,500	2,800	54.0	4.7
9. Professional fees, construction	7,900	-	7,900	1,100	-	1,100	-	1.9
10. Contracts IEC prototypes & production	45,900	45,900	91,800	6,200	6,200	12,400	50.0	20.9
Subtotal Capital Cost	181,300	137,700	319,000	24,500	18,700	43,200	43.3	73.0
Incremental Operating Cost								
11. Project administration	5,200	-	5,200	700	-	700	-	1.2
12. Incremental salaries	18,500	-	18,500	2,500	-	2,500	-	4.2
13. Vehicle & equipment maintenance	8,900	2,100	11,000	1,200	300	1,500	20.0	2.5
14. Distribution (IEC materials)	1,000	-	1,000	100	-	100	-	0.2
15. Travel & per diem	67,200	-	67,200	9,100	-	9,100	-	15.4
16. Rentals	1,000	-	1,000	100	-	100	-	0.2
Subtotal, Incremental Operating Cost	101,800	2,100	103,900	13,700	300	14,000	2.1	23.6
17. Innovative activities	7,300	7,400	14,700	1,000	1,000	2,000	50.0	3.4
Subtotal Base Cost	290,400	147,200	437,600	39,200	20,000	59,200	33.8	100.0
Contingencies								
Physical Price	8,800	3,800	12,600	1,200	500	1,700	29.4	2.9
	54,800	27,400	82,200	7,400	3,700	11,100	33.3	18.8
Subtotal Contingencies	63,600	31,200	94,800	8,600	4,200	12,800	32.8	21.6
TOTAL PROJECT COST	354,000	178,400	532,400	47,800	24,200	72,000	33.6	121.6

ANNEX B

UNFPA/GOP SECOND COUNTRY PROGRAM (1979-83)

	<u>Amount (\$000)</u>	<u>Executing Agency</u>
Strengthening Census and Vital Registration System	3,000	NCSO
Population/Development Planning and Research	2,000	NEDA
Urban Poor MCH/FP Delivery (Excludes Manila)	2,000	MOH
Regional Population Education Centers	2,500	MEC
Regional Training Teams ^{1/} (Pilot First)	2,000	POPCOM
Bohol MCH/FP Services and Evaluation	2,500	MOH
Training and IEC activities to support	3,000	Non-government Organizations
Contraceptives (Low-dose pill)	1,000	MOH
Program Reserve	<u>2,000</u>	Various
TOTAL	<u><u>20,000</u></u>	

^{1/} Will be coordinated with IBRD

ANNEX C

COMPREHENSIVE LIST OF PROGRAM ELEMENTS
RECEIVING DONOR ASSISTANCE IN
THE PHILIPPINES POPULATION PROGRAM

(1) <u>Community-based FP Activities</u>	<u>Assistance Sources</u>
-- Outreach Workers Salaries and Allowances	- GOP with AID's major, but gradually declining support.
-- Project Management Support Central and Regional	- GOP with moderate help from IBRD and minor help from AID and PIACT.
-- Construction of 6 Outreach Regional Offices, warehouses, and vehicle repair facilities	- IBRD loan
-- Consulting and Training in Logistics, Warehousing, etc.	- Moderate help through IBRD and minor help through AID and PIACT.
-- Consulting, Training and Operations in Management Information System (MIS)	- Major help through AID, with supplementary inputs from IBRD.
-- Commodity Support	
- Contraceptives for community-based program	- Major help from AID, moderate through FPPIA minor through UNFPA.
- Vehicles and radios for Outreach	- Major help from IBRD, with excess property vehicles and spare parts through AID. Motor cycles from Japanese Government.
- IEC Equipment and Supplies for 13 Outreach regions	- IBRD provides major help; AID, minor.

- Condom and Pill Testing Equipment for Outreach and Commercial Contraceptive Marketing Program (CCMP).
- PIACT providing, as well as technical assistance, to a Regional Testing Center.
- Training
 - Program Managers and Special Technicians, abroad - POPCOM and its Partner Agencies
 - Major help from IBRD with minor supplemental help from AID and other donors.
 - Program Managers and Partner Agency Field Workers
 - IBRD for major help, AID/UNFPA may assist at regional levels.
 - Outreach Workers, In-Country Training
 - GOP with major AID assistance.
 - Outreach Volunteers (BSPOs) In-Country
 - GOP with major AID assistance.
 - Home Economists IEC activities in Family Planning
 - Workshops and materials through American Home Economics Association (AHEA)
 - Other Selected Non-Government organizations
 - UNFPA provides moderate help.
- Information/Education/Communication (IEC) Activities
 - Outreach and Partner Agencies
 - GOP with major assistance from IBRD in TA, Training, Equipment/Supplies and Printing.
 - Other Selected Non-Governmental Organizations
 - UNFPA assists, moderately.
- Incentive Programs
 - Outreach Workers & Volunteers
 - GOP, especially local governments, with planned AID and possible Asia Foundation assistance.

- Communities - Pilot Projects - GOP, local governments, with major assistance from AID.
- Other Operational Research Programs
 - Contraceptive retail sales program, an operational research project in two provinces, carried out by PCF. - GOP with IBRD assistance beginning in 1979 for research, and continuing in 1980-84 for expansion. TA from PIACT, also a worldwide conference in Manila in late 1979.
 - 11 Research Projects addressing current policy and program needs. - Funds programmed by IBRD.
 - "Innovative Activities" through POPCOM and PCF (to be determined). - Funds programmed by IBRD.
 - Operational Research at Regional Level in Outreach - GOP with moderate assistance from AID bilateral and central contract funds.
- Program Impact and Problem Identification Surveys - GOP funds Community Outreach Survey (COS) with TA from Population Council.
- Evaluation of community-based programs - See above for COS; also AID funds annual evaluations of Outreach.

(2) Clinic-based FP Activities

- Service Delivery Programs, both public and private, some with community-based elements. (Excluding sterilization activities) - Largely GOP, but AID plans future assistance to community-level clinic support through Outreach; IBRD strengthens midwife/paramedic programs with FP functions; UNFPA to assist MCH/FP urban poor program; IPPF assists clinical program of its affiliate, FPOP; Population Council and WHO provide

resident TA to Bohol MCH/FP project; Government of Japan assisting pilot integrated FP/nutrition/parasitic control project; FPIA helping selected private and local governments establish youth services.

- Service Delivery and Training Programs, Sterilization
 - Institutional Subsidies
 - GOP (POPCOM and Medicare) with major support from AID and minor support from FPIA, IPAVS.
 - Equipment and Supplies
 - Major, coordinated assistance from AID, FPIA, JHPIEGO and IPAVS.
 - Special Medical Services
 - GOP with minor help from AID; IPAVS preparing sterilization reversal project for possible implementation at PGH.
 - Itinerant Sterilization Teams
 - GOP with help from FPIA, IPPF, IPAVS.
 - Training of Medical Personnel in Sterilization techniques
 - GOP with help from JHPIEGO, FPIA, IPAVS.
- Commodity Support (other than sterilization programs)
 - Contraceptives for clinic-based programs
 - Major help from AID through POPCOM with assistance from FPIA, UNFPA, and IPPF (for its affiliate, FPOP).
 - IUD Insertion
 - Major help from AID and moderate help from FPIA.
 - IEC and Training Equipment and Supplies
 - Major support to public program from IBRD through POPCOM; IPPF helps its affiliate, FPOP.

- Construction of 75 Health Centers and 915 Barangay Health Stations
 - Logistics/warehousing in MOF and other partner agencies
 - Training and Other Assistance to Midwives, Paramedics
 - Operational Research and Evaluation
- Major assistance in 19 provinces from IBRD.
 - Special study, TA and MIS assistance through IBRD.
 - Major assistance from IBRD; Population Council and UNFPA assist Bohol MCH/FP project.
 - IBRD assisting on developing clinic-based "innovative activities" as well as evaluation of primary health care project and IEC program; UNFPA and Population Council/WHO assisting in evaluation of Bohol MCH/FP project. IFRP financing partial cost of 5 small operational research projects in 3 Filipino institutions on IUD, sterilization, oral contraceptives. PIACT funding sterilization demand/supply study, as well as contraceptive retail sales project.

(3) Non-FP Population Activities

- Population/Development Policy and Planning
 - Population Impact Assessment, National Level
 - Regional Level
 - USAID
- UNFPA has funds programmed to enter into this activity with NEDA. Ford Foundation may enter into this field, coordinating with UNFPA.
 - Assistance to NEDA from Population Council being explored.
 - Assistance to selected regional development council from Batelle Foundation proposed.
 - USAID-funded projects subjected to 104 analysis.

- Population Education
 - UNFPA Providing support to Population Education Centers in MEC; FPIA designing projects now with private and local government entities for youth information programs in coordination with MEC.

- Census/Vital Statistics Registration
 - U.S. Bureau of Census finances workshops; UNFPA plans pilot improved system with NCSO; NCHS offers assistance as requested. Other TA and training through UNC's POPLAB and East-West Population Institute.

- Fertility Surveys
 - World Fertility Survey (WFS) technicians assisting RFFS.

- Demographic Data Collection
 - GOP funds COS and Area Fertility Surveys with TA from Population Council; USAID makes minor inputs. Other TA from National Academy of Science and East-West Population Institute.

- Domestic Contraceptive Industry, Feasibility Studies
 - PIACT conducting study for NEDA. AID has potential to assist in studies and construction loan, as do IBRD, ADB, Japanese, Dutch, Belgium and British Governments.

- Training, Research and University Institutional Development
 - Ford Foundation

ANNEX D

POPULATION MONITORING, EVALUATION AND RESEARCH FRAMEWORK

<u>TYPE OF ANALYSIS</u>	<u>OBJECTIVE</u>	<u>ILLUSTRATIVE EXAMPLES</u>	<u>MEANS</u>	<u>FINANCING</u>
<u>PROGRAM MONITORING</u>	Provide rapid program activity feedback of immediate value to program managers on regular basis.	Monthly feedback of new and continuing contraceptive users by contraceptive type and sources of services.	POPCOM MIS including financial analysis and reports Rapid feedback reports	USAID GOP World Bank
<u>PROGRAM EVALUATION</u>	Provide periodic data on program effectiveness	Current contraceptive use prevalence and fertility levels Users perspective on FP services and fertility control methods. Program impact of Outreach activities.	Community Outreach Surveys Area Fertility Surveys National Demographic Surveys	USAID GOP World Bank UNC or Westinghouse
<u>PROGRAM DEVELOPMENT</u>	Provide continuing exploration of alternative program innovations for delivery of family planning services.	- Adolescent fertility - Program feasibility of new contraceptives, e.g. Copper T, implant, vaginal ring, foam - alternative delivery systems - community incentive schemes - integration - Commercial marketing - Home insertion of IUDs - Improved information on traditional methods - Expanded auxiliary use	Develop program with POPCOM/PCF subcontracting to Partner Agencies, government agencies and private sector or Contracting directly with agencies, public and private Use regional research institutes	USAID GOP ICARP FPLA PLACT Pathfinder World Bank WHO Population Council IFRP Columbia COC
<u>POLICY SIGNIFICANT RESEARCH</u>				
<u>COMMUNITY LEVEL</u>	Provide better understanding of determinants of fertility and fertility related behavior at family and community level.	Female labor force participation and fertility. Female education and fertility. Female labor response to multiple cropping.	Specific projects or set of interrelated projects. Contract through POPCOM, PCF or directly with agencies.	IDRC GOP UNFPA World Bank Battelle Foundation Population Council Ford Foundation SEAPRAP CAMS EWPI Australian Govt. ASEAN
<u>MACRO LEVEL</u>	Provide better understanding of interaction between development and fertility change determinants of fertility consequences of fertility	Fertility response to area development projects; rural electrification; Female rural urban migration in response to differential wages rates. Migration Effects of population growth on resources, environment and development.	Specific projects or set of interrelated projects. Contract with MEDA/PDPU or directly with agencies. AFS PREPT	UNFPA GOP IDRC Population Council Battelle Rockefeller Ford Foundation CAMS AID/W, PPC EWPI ASEAN USAID/ESIA/WID
<u>BASIC POPULATION RESEARCH</u>	Improve understanding of human fertility behavior	Value of children Culture-fertility interaction Reproductive biomedical research	Specific research projects	IDRC WHO IFRP