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THE FAMILY HEALTH CARE REPORT

A Review of the
Philippines' Population Program

Contract No. AID/afr-C-1138
Work Order No. 10

Family Health Care, Inc.
1211 Connecticut Ave., N.W.
Washington, D.C. 20036

Submitted:

Interim Discussion Paper: March 10, 1977
USAID/Philippines

Final Report: April 30, 1977

Second Edition: July 19, 1977

Agency for International Development
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I. SUMMARY

INTRODUCTION

The charge to the Family Health Care, Inc. (FHC) team focused on the Philippines Population Planning Program. The specific intent of the team's scope of work was to assess the program's results in achieving the purpose of reducing the population growth to a rate consistent with economic and social development goals. This assessment included a review of the reasons for success or failure of the program to attain its goals, and a review of the roles of the U.S. and other donors in the Philippines program. In relation to the future, the team was asked to recommend on desirable program elements, on needed changes in policy, and on changes in program directions.

The first members of the FHC team arrived in Manila on February 11, 1977. From that date through the following week, the team leader, Dr. Jarrett Clinton, attended negotiating sessions with representatives of USAID, the National Economic Development Authority (NEDA), and the Population Commission (POPCOM), to work out an arrangement whereby the assessment could be conducted as a joint review (excluding USAID). Although these sessions were satisfactorily concluded by all parties, it was possible subsequently for only one staff member from NEDA to join Dr. Clinton on one field trip. The remaining FHC team members were on post by February 20, and all had departed by March 20.

During the field trips, FHC staff members visited some 125 organizations and population service delivery points, meeting with well over 200 administrators, physicians, full-time population planning motivators, trainees, midwives, acceptors, and program managers. These visits were followed by a preliminary analysis of the data, and the team then presented on March 10 an interim discussion paper for separate briefings with representatives of USAID; NEDA; POPCOM; the Board of Commissioners, POPCOM; and the United States Ambassador to the Philippines. All of these briefings were concluded by March 14. Concurrent with these sessions, and immediately following them, numerous interviews and several field trips were conducted. The additional data gathered, and the analytical process in Washington, served to modify the character and tone of the interim discussion paper of March 10. These changes are reflected in the enclosed report.

Because of the constraints of time, and sometimes the difficulty of obtaining documents and information which were pertinent to its mission, the team is not convinced this report is a definitive study of the population planning program in the Philippines.

A list of the institutions which were visited for interviews with concerned administrators and policymakers can be found in Annex D. Documents in Annex A are provided for readers wishing

to acquaint themselves with some of the more salient issues of the population program: Program Financing; Coordination and Integration; the Total Integrated Development Approach (TIDA); and, Project Compassion (PROCOM); and the role of the Catholic Church. Many descriptive documents relating to the specifics of program organization, budgets, personnel, and background information were reviewed by the team and these are listed in the Bibliography (Annex C).

A Demographic and Economic Profile of the Philippines is provided on Page 12 of this section, and a list of acronyms designating the most often referred to agency and project descriptions used throughout the report is illustrated on page 13.

The Family Health Care Report is divided into three sections and four annexes:

- I. SUMMARY
- II. CONCLUSIONS AND FINDINGS
 - A. SYSTEM CAPACITY TO CONTROL POPULATION GROWTH
 - Population Policy Implementation
 - Program Planning Strategies
 - Program Organization
 - B. SYSTEM OPERATIONS AND SUPPORT
 - Program Resources
 - Program Services
 - Program Management
 - C. SYSTEM PERFORMANCE
 - Program Outcome Measures
- III. RECOMMENDATIONS

- ANNEXES
- A. ISSUES OF CURRENT CONCERN
 - 1. Program Financing
 - 2. Coordination and Integration of Programs
 - 3. TIDA: POPCOM's Role in "Integrated Rural Development"
 - 4. PROCOM: PCF's Role in "Integrated Rural Development"
 - 5. The Role of the Catholic Church
 - B. THE STATE OF KNOWLEDGE ABOUT POPULATION AND FAMILY PLANNING MATTERS IN THE PHILIPPINES
 - C. BIBLIOGRAPHY
 - D. INSTITUTIONS VISITED BY FAMILY HEALTH CARE

The team members assigned to this Study by Family Health Care were:

Jarrett Clinton, M.D., M.P.H., Team Leader, Director of Evaluation, FHC
Alan Fairbank, M.P.A., Research Associate, FHC
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Jeremiah Norris, Director, International Division, FHC

FHC was able to obtain consultative services from Peter C. Smith, Ph.D., Research Associate, The East-West Center, Honolulu, who assisted the team in the areas of population research and demography; and Roger P. Bernard, M.D., M.S.P.M., Director of Field Epidemiology, International Fertility Research Program, Research Triangle Park, North Carolina, who visited the Island of Bohol to interview participants in the MCH/Family Planning Project. The team is appreciative of Drs. Smith's and Bernard's contributions to the report in these areas, and is especially pleased that Dr. Bernard could spend a brief time with us while he was passing through the Philippines on

a return visit from Sudan. FHC, however, accepts full corporate responsibility for the substance of this report.

A PRECIS OF CONCLUSIONS, FINDINGS AND RECOMMENDATIONS

Every major policy initiative is a tension-generating force. This is particularly true when powerful national intervention techniques are taken in an area which cuts across traditional institutional lines of authority in the political, religious, social and economic spheres.

Population policy at any point in time is concerned with urgent needs and threatening possibilities, with the necessary and feasible, with some of the parts rather than the whole. The implementation of that policy through planning and programming is a method of moving beyond the immediate and of systematically enlarging the basis for a more reliable comprehension of the whole. In this context, programming processes address, or ought to address, the critical implications of the donor's transactions with the beneficiaries' environment. During the past six years, approximately \$81.3 million has been spent by all donors, including the Government of the Philippines, on the population problem. While there is much to be gained by improving the vigor and relevance of these investments, there is also a critical need for knowledge of the relationship of the parts to the whole. The strategic question is the net effect of the many specialized

and large scale forms of programmatic intervention on the reduction of the population growth rate in a manner consistent with societal norms and the value structure of the beneficiaries. As specialized organizations in this field, namely USAID/ Philippines and POPCOM, acquire power and knowledge to increase the effectiveness of their interventions, the need to provide talent and resources to at least learn how to pose the strategic issues becomes paramount. Only then will it be possible to fully appreciate how knowledge and power ought to be linked to deal with urgent issues.

If population programs in the Philippine context are to become an accepted mode of developmental activity, it is important to acquire an understanding of who gains and who loses as a result of the process. How do those who are to be helped fare? Is the program an intrusion on cultural values? Religious beliefs? What are the integrative, coordinative, and other effects with respect to the performers of population programming--POPCOM, donors, research organizations, private groups--profit and non-profit. What are the implications for the local government jurisdictions which are the site of the programs and are required by statute to fund other social service sectors, i.e., education?*

* Though financed in the main from central sources, local funding for education constitutes the greater percentage of local government social service expenditures.

And what are the potential costs and benefits for the political leadership sponsoring or supporting a program when one of the components, sterilization, runs counter to the teachings of those who lead the religious majority? Lastly, it is essential for policymakers to achieve a common understanding of where population programming fits into a coherent development process which leads to improved social policy and programs. At present, there appear to be no reassuring answers to these questions, as the clear implementation of population policy has been increasingly blurred over the past two years in the Philippines.

Population policy is a most difficult act to orchestrate harmoniously within the body politic. The act consists of comprehending shared and divergent purposes among competing interest groups in a way that permits the mobilization of support for a practical program of action. Population policy is concerned with a range of problems that tend to be intrinsically relative in nature and about whose resolution there is often considerable uncertainty. The political, religious, social and economic complexity of a large scale intervention, such as the Outreach Project, places a signal responsibility onto the national government of the host country and donor agencies for the reduction of this uncertainty.

Rather than a reduction in uncertainty, however, the initiation of the Outreach Project has increased it to a level where confusion abounds, among program managers and donors alike. Of immediate attention is the complex issue of local government absorption of program costs. This subject has sobering implications for the prospects of the Philippine's Government ability to support and carry out the Project. These implications deserve the prompt attention of planners at both USAID and POPCOM; further delay in fully exploring the issues and in inviting the provinces/cities' participation in their resolution, could jeopardize the entire program.

The team was unable to find any analysis which supported the capability of local governments to assume the projected costs, or of the consequences of their attempting to do so in respect to competing claims for public funds, e.g., other social services. A brief analysis by the team of the financial situation of local governments, and of their options for raising additional operating funds for population programs, shows that their collective ability to assume a share of population program costs will largely depend on the availability of central government assistance, and on their own willingness to forego spending on other development priorities in favor of spending on population. As a mechanism for diverting some of the

fiscal demands that Outreach will make on the central government budget, the attempt to get local governments to assume program costs will be severely hampered by the local governments' lack of resources, and lack of power to raise revenue.

Another issue requiring immediate attention is the Catholic Bishops' of the Philippines pastoral concern for their followers on sterilization and other forms of fertility control which they believe are being introduced to the people through the deployment of involuntary schemes, some of which include incentives. An examination of this concern expressed by church leaders reveals that their opposition is based on what they perceive are the coercive aspects of this program, i.e., that sterilization is linked, in the Philippines context, to economic incentives, or what one Bishop calls "a new form of colonialism." And, that the poor are being motivated over-aggressively by clinicians, to accept the insertion of IUDs, but then are unable to obtain remedial medical services when complications develop. The church leadership states that if such schemes were removed from all methods of contraception, but especially those related to sterilization, their opposition would undoubtedly dampen considerably.

The United States is a powerful donor worldwide in population service delivery, and its population assistance program in the Philippines is one of its largest. Through its Agency

for International Development, it continues to make resources available and to demonstrate active interest in funding the Outreach Project. In scale and complexity, this Project represents the largest undertaking by both the Government and USAID in implementing population programming in the Philippines. FHC believes that the Outreach Project offers significant potential for providing fertility control services to rural and low-income urban Filipinos. Yet, the team failed to note the appropriate blending of bilateral resources with an indigenous determination to internalize the Project's goals and objectives as national priorities. Those goals and objectives are a logical extension of a national population policy which is exemplary in its comprehensiveness and its clear articulation of the population aspects of national planning. But the present lack of an operational consensus on fundamental implementation issues of the Outreach Project now appears to heighten uncertainty about the effectiveness and impact of implementing that national policy.

The FHC team stands by its basic findings and recommendations as presented herein. The report which follows will be difficult for USAID and the Government of the Philippines to accept. It has been most difficult to prepare and its authors take somber refuge in the knowledge

that the terms of a contract between two parties have been fulfilled. We do ask the readers' maintenance of objectivity, even in the face of some harsh realities which could just as easily have remained untouched. The search for truth is always accompanied by tension and disagreement, and we are not exempt from that experience. The authors make no pretense to have found all the truth, or that all they found was the truth. In our representation of it, we did strive for equity and fairness to all concerned parties.

The questions raised here will not be resolved tomorrow; therefore, we must learn to live patiently with this tension, allowing its generative, positive forces to weld purpose to action among those who seek the common good for the body politic.

DEMOGRAPHIC AND ECONOMIC PROFILE
OF THE PHILIPPINES
as of
December, 1976.

Population	44.2 million
Crude Birth Rate	37/1,000
Crude Death Rate	11/1,000
Annual Population Growth Rate	2.6 percent
Number of Years to Double Population	27 Years
Life Expectancy at Birth	59 Years*
Infant Mortality Rate (Recorded)	68/1,000 live births*
(Estimated)	80/1,000 live births*
Population Below 15 Years Old	46 percent
Dependency Ratio	0.94
Average Number of Children Born per Couple	6.3
Eligible Fertile Couples	5.3 million
Percent of Eligible Fertile Couples Contracepting	24 percent
Literacy Rate	88 percent*
Children in School	
(Elementary School Age: 7-12 Yrs.)	98 percent*
(Secondary School Age: 13-16 Yrs.)	40 percent*
Labor Force	15.1 million
Labor Force in Agriculture	52 percent
Population in Rural Areas	70 percent
Annual Per Capita GDP (in current U.S. \$)	\$385
Population per Physician (Nationwide)	2,940*
(Rural Areas)	5,000*
Population per Hospital Bed	800*
Peso Exchange Rate (March 1977)	\$1.00 = P7.30

* Figures for 1975.

Sources: World Bank and USAID estimates; demographic estimates based on updated information from POPCOM/UPPI sources and FHC consultants.

ACRONYMS

BSP	Barangay Supply Point
BRP	Barrio Resupply Point
DEC	Department of Education and Culture
DLGCD	Department of Local Government and Community Development
DOH	Department of Health
DOL	Department of Labor
DPO	District Population Officer
DSSD	Department of Social Services and Development
EDF	Economic Development Foundation, Inc. (Private company contracted to do POPCOM training)
FPIA	Family Planning International Assistance
FPOP	Family Planning Organization of the Philippines
FTOW	Full-time Outreach Worker
GOP	Government of the Philippines
GSIS	Government Services Insurance System
IEC	Information/Education/Communication
IMCH	Institute of Maternal and Child Health
INC	Iglesia ni Cristo (Church of Christ)
IPPF	International Planned Parenthood Federation
LOI	Letter of Implementation Letter of Instruction
MPO	Municipal Population Officer
NAS	National Acceptor Survey
NDS	National Demographic Survey
NEDA	National Economic and Development Authority
NFPO/DOH	National Family Planning Office of the Department of Health
NSCO	National Census and Statistic Office

PCF	Population Center Foundation
PD	Presidential Decree
PDAP	Provincial Development Assistance Program
PMS/DOH	Project Management Staff of the Department of Health
POPCOM	Commission on Population
PPO	Provincial Population Office
PROCOM	Project Compassion (a project of PCF)
RHUs	Rural Health Units
TIDA	Total Integrated Development Approach (a project of POPCOM)
UNFPA	United Nations Fund for Population Activities
UPPI	University of the Philippines Population Institute
WHO	World Health Organization

II. CONCLUSIONS AND FINDINGS

- A. System Capacity to Control
Population Growth
- B. System Operations and Support
- C. System Performance

A. SYSTEM CAPACITY TO CONTROL
POPULATION GROWTH

Population Policy; Program Planning/Strategies; and
Organization

INTRODUCTION

In the Philippines, the Population Commission (POPCOM) is charged with the coordination of a national population policy which is implemented by both central and local governmental units and private agencies. Initially, POPCOM conducted its programs primarily in urban areas (cities and small towns) through a clinic-based system. Between 1970 and 1973, acceptor rates continued to increase, then plateaued from 1974 until the present date. The first attempt to move from passive recruitment to active recruitment of acceptors came with the hiring of part-time motivators under the Department of Health. Because this attempt met with only limited success in terms of increasing acceptor rates, a new population program was initiated in June 1976, entitled Project Outreach (Phase I). Phase II (per Draft Project Paper, USAID/Manila, January 1977) is an extension of the Outreach Project through FY 1981.

Project Outreach is an effort to provide contraceptive techniques and sterilization services to a pre-

dominately rural population through the use of approximately 3,100* full-time motivators. Physician personnel are to be trained in sterilization procedures, and hospitals and clinics are to be equipped to support the clinical aspects of Outreach. The major outcomes of this program are projected upon the basis that:

- a. Local government units will implement a central funded program, with the requirement that the former cost-share, on an increasing basis throughout the life of the program, with the latter.
- b. Outreach will contribute substantially toward the national reduction of the current growth rate in the Philippines by an average of one-tenth of one percent annually for the life of the program.
- c. The primary target population of the program is in rural areas, and full-time staff can be effective in motivating this group toward acceptance of family planning concepts.

CONCLUSION

Since 1970, senior political and administrative leadership in the Philippines has used its full authority to develop and support a broad national population policy. This guidance has served to enrich sectoral and agency plans through a recognition and incorporation of the population dimension in effective public policy programming.

* Following the results of a future evaluation, additional motivators may be sited after March, 1978.

However, with the initiation of the National Family Planning Outreach Project, the FHC team found that the Government has not internalized sufficiently the goals and objectives of this particular program. And, as a result, there did not exist an operational consensus within the Government on the organizational processes and structures requisite for the achievement of Outreach purposes.

As the Outreach Project does engage the planning efforts of POPCOM and USAID, both must consider the implications inherent in the evolution of a population program originally emphasizing strictly voluntary acceptance of fertility control measures toward one now including mandatory clinical training (LOI 47) and aggressive economic incentives. FHC believes that these practices plus documented instances of over-zealous recruiting and of apathy toward requests for IUD removal can be perceived as the basis of incipient coercion and therefore deserve immediate attention.

The direction of this evolution places in jeopardy a national population program which was founded on one of the world's finest examples of a clearly enunciated statement in favor of a reduced population growth through voluntarily accepted and approved methods.

a. Population Policy Implementation

FINDINGS

- (1) The GOP, building on the activities of the private sector, e.g., IMCH and FPOF, and with the assistance of USAID, has been successful in the initiation of population programs within both the public and private sectors. Many government agencies, i.e., Department of Health, Department of Labor, Department of Education and Culture, etc., conduct and sponsor programs of the national government through POPCOM. To the extent one might attribute decreased population growth rates to this programmatic intervention, these results have been achieved since 1970:
- The average annual population growth rate dropped from 3.0 during 1960-1970 to approximately 2.8 in the 1970-1975 period.*
 - Contraceptive use prevalence rates increased from very low levels in the late 1960s to 24 percent in 1976.
 - Population and family planning practices are widely discussed, rather openly debated, and have gained an intersectoral acceptance among policymakers and government program managers.
- (2) Because of the plateauing of new acceptor rates, a decision was made to extend population family planning services into rural areas through the deployment of full-time motivators. The successes of the past are now in danger of being nullified, because a conceptually sound program design is being implemented before an operational consensus on implementation processes has been achieved. This lack of consensus on the implementation process reflects the fact that policymakers of the Government have not internalized the goals and objectives of the program. Though NEDA accepts juridical responsibility for Project Outreach vis-a-vis USAID, it does not appear to have vested its considerable authority in the decisional processes over Outreach policy formulation which affect program design and implementation.

* Using 1960, 1970, and 1975 census data.

- (a) The Phase I Project Agreement between NEDA/POPCOM/USAID for Outreach was signed on June 18, 1976. On September 28, a POPCOM Board member wrote to the Director-General of NEDA expressing his concern about Outreach being implemented nationwide before it was pilot tested and the role of POPCOM as the implementor of Phase I. He requested support from NEDA on (i) a phasing-in of Outreach over time and (ii) assurances that POPCOM would not implement; this would be the responsibility of local governments. Our review of the documents indicated that the NEDA Director-General generally agreed with these points.
- (b) A NEDA official acknowledged that the POPCOM Board was not fully aware of the Outreach Project details. This was attributed to pressures of time and schedules. When the Board did focus on the scope of the Outreach Project, they met several times and finally concluded that the Outreach Project should be pilot-tested before nationwide implementation. They learned subsequently however, that the subagreements (among NEDA, POPCOM, USAID) had already been signed.
- (c) Nevertheless, on October 7, 1976, the Executive Director of POPCOM informed USAID by letter that the Board of Commissioners, during its 36th Commission Meeting, decided to implement Outreach in stages, as follows:
- 17 Outreach provinces;
 - 17 TIDA provinces; and,
 - 10 Project Compassion provinces.

The letter went on to describe how Outreach workers will be fielded in all municipalities of Project Compassion, while no Outreach workers will be recruited, trained, or deployed in the 17 TIDA-PPO provinces. As primary reasons for their actions, the Executive Director noted that the Board considered insufficiency of future Program funds and the possibility that the Outreach Project may not be the only effective way of reaching the majority of the target women of the rural villages.

The letter closed by requesting USAID agreement to renegotiate the signed bilateral document.

- (e) After the Board's decision to restrict Outreach's implementation (a pilot basis versus nationwide), NEDA invited USAID to a meeting with POPCOM's Board representative to clarify the issues. The POPCOM representative attempted to convince USAID that the Board was not eager to implement Outreach on a nationwide basis. USAID remained unconvinced and suggested to the representative that failure to implement nationally the Outreach Project could jeopardize all USAID population assistance funding, POPCOM then conceded and accepted Outreach nationwide.
 - (f) A NEDA official acknowledged considerable concern about the need for multiple coordination of social service programs like Outreach, TIDA, and PROCOM in the field.
- (3) Over 84 percent of the Philippines is Roman Catholic, though many of these people are nominal practitioners of their faith. Neither the Project Agreement (Project Outreach Phase I) nor the Draft Project Paper (Phase II)* give recognition or understanding to the role of the Bishops as authoritative teachers of the Church's message to the majority of the population vis-a-vis sterilization.
- (a) Sterilization methods are being promoted and performed without informed discussion with Church leaders and without due regard for what the leadership perceive to be the spiritual welfare of their followers. These procedures are legal under Philippines civil law but are not in keeping with the Church's teachings or the pastoral concern of the hierarchy for their followers.
 - (b) Incentive schemes, particularly those statutorily directed and sponsored by the Department of Labor (funded by UNFPA with

* The Draft Project Paper does state that: "Opposition to FP, for religious or other reasons, is relatively light and moderate."

technical assistance provided by ILO in cooperation with POPCOM) are seen by the Church as in-kind reimbursements and thus economically coercive in the Philippines context. One criterion in a Manila bank for the promotion of females is that they avoid pregnancy for three years. Some companies give leave with pay for sterilizations; some companies give cash incentives with the leave; and, some companies give only a cash incentive. Physicians and hospitals are given cash incentives on a per case basis for performing sterilization procedures. Although USAID is not now directly involved in the implementation of these schemes, the Mission did provide the consultative services from the U.S. for the feasibility and design study of incentive schemes.

- (c) Coercion, as perceived by the Church hierarchy, is not limited to sterilization methods. Some women interviewed by FHC team members in Manila report "being motivated" four times in one day at a charity post-partum clinic. Other patients interviewed claim they had infections after an IUD insertion but were unable to get the government clinic staff to remove the device. A group of Catholic nuns operate a program in Manila for women experiencing difficulties with IUDs. A private physician, who donates his time, treats the infection and removes the IUDs, usually after the women have been motivated to another family planning method by the nuns.
- (d) These method failures (item c) only serve to increase the level of anxiety among the people about a government sponsored program.
- (e) A stated position of the USAID Mission staff on the sterilization components of Outreach is to keep a low profile. This plus the inadequate dialogue between the POPCOM and the Church is viewed by some Church leaders as an intrusion on the spiritual values of their people.

- (f) While Church leaders were found to have strong reactions to sterilization and to the incentive schemes, they could not be considered anti-natalist in their perspective of the population problem. Most wanted to disassociate the Church from the term "rhythm" and to use instead "natural methods." None were against standard modalities, i.e., pills, condoms, IUDs, etc., on moral grounds. They were all disturbed by the incentive schemes deployed to gain acceptors for these methods, and most were forthrightly against sterilization. One Bishop recognized the limits to which the Church could oppose sterilization effectively: "If people really knew the consequences, knew what it meant to sign the consent decree, then let them go ahead and accept sterilization."
- (g) A senior government official, involved in the design of in-plant family planning programs, was questioned by FHC on the acceptance of sterilization by the Filipinos vis-a-vis religious beliefs, and stated that they (DOL) are doing nothing about the religious controversy.
- (h) Though the Church appears to have been needlessly provoked into a moral stance by sterilization, and incentive schemes, the FHC team believes their institutional capacities could be usefully incorporated into the national family planning program.

b. Program Planning/Strategies

FINDINGS

- (1) The successful implementation of Project Outreach is dependent upon local governments (provincial and municipal) sharing the costs with POPCOM increasingly over time. There does not appear to have been a systematic or tentative evaluation of their capacity to participate in this endeavor.
 - (a) The sub-agreements signed between local government units and POPCOM during FHC's visit were

budgets rather than appropriations, as provincial budgets were already presented. In this sense, the sub-agreements represented "pledges" rather than actual budget commitments.

- (b) In 1975, an open-ended survey among governors, sponsored by NEDA and conducted by the National Tax Research Center, indicated that none had considered population family planning as a provincial development priority. On the second round of interviews, they (the governors) were asked to list other priorities and, again, population planning was not mentioned. (This is an unpublished study and FHC was unable to obtain it from the National Tax Research Center to verify these findings, which were stated by a Center official.)
- (c) In 1975, total expenditures by local governments for social services were \$30 million dollars. If the share of local government expenditures spent on social services were to remain constant at the 1975 proportion of 12 percent through 1981, 21 percent of the absolute increase in social services budget would have to be devoted to population programs in order for 50 percent of the total costs of all population and family planning activities to be absorbed by local governments.* This would be the minimum requirement to achieve the end-of-project-status indicator listed in the Draft Project Paper for Outreach, Phase II: "Absorption of a major share of field program costs into provincial and charter city budgets." (However, this may have changed since the team left Manila, as USAID had under advisement a plan which stated that only one-third of the provinces and cities would be expected to reach this funding level by 1980-81. The remainder would be scheduled out over a period of 10-15 years.) Social services include education with the following demands:

- In the 1970-1971 school year elementary enrollment was 66 percent greater than a decade

* Assuming that local government expenditures rise at about 19 percent annually, a reasonable conclusion from World Bank estimates. A lower rate of growth of expenditures, of course, would make population spending a higher proportion of increased social services spending.

earlier; secondary enrollment, 177 percent greater; and enrollment in higher education, 116 percent greater.

- Most of the recent increases in secondary enrollment have been in the public sector, which has grown about 8 percent a year against 4 percent for the private sector enrollment in secondary education. In 1973-1974, there were about 850,000 students in public secondary schools and 1,029,000 in private schools. This prospect has significant implications for the government's education budget.
- (d) In reviewing the capacities of local government units to cost-share with POPCOM on Outreach, a USAID official wrote in November 1976 that local governments cannot be expected to fully fund the national program. He continued by stating that it is reasonable to phase local government contributions to a yet to be determined share for an indefinite period.
- (e) Those provinces which presently have a TIDA program are expected to cost-share with POPCOM. However, a POPCOM senior official told FHC that TIDA provinces with the exception of Laguna and Nueva Ecija have not provided significant local support. TIDA provinces are expected to develop the same sub-agreement as the other provinces under Outreach.
- (f) An official with the Provincial Development Assistance Project (PDAP, which is in DLGCD) told the FHC team that POPCOM started Outreach without discussing the project with DLGCD/Manila, though POPCOM discussed it with local governments. In mid-February, 1977, however, POPCOM did request assistance from DLGCD/Manila. This official went on to say he had told POPCOM then that local governments cannot visualize the effects of social projects but they can see i.e., take a picture of capital projects and infrastructure. When asked by FHC about

the sub-agreements for cost-sharing between local governments and POPCOM, he indicated that the current subagreement financial obligations cannot be paid by local governments.

- (2) A major new population program, with an emphasis on sterilization, is being implemented in predominantly rural areas with the knowledge that there has been a national decline in method acceptance among Filipinos, through an increase in their knowledge about contraceptive methods.
 - (a) POPCOM acknowledges that "there is an average awareness of 80 percent among the people about various methods of contraception. Yet, acceptance is as low as 28 percent in urban areas and 13 percent in rural areas. Filipinos are shifting from the more effective methods to less effective ones. And, there is an increasing number of dropouts."* POPCOM's response to these data was to initiate a new direction for the program, the Total Integrated Development Approach (TIDA).
 - (b) At a time when method acceptance was high, the central government funded the national population program. Now, with acceptance declining, the provincial governments are being asked to cost-share on Project Outreach.
 - (c) In recognition of these facts, Outreach is being implemented in rural areas without adequate safeguards for current budget projections against a possible low client demand profile.
- (3) Since June 1976, POPCOM has had to establish the basic administrative and managerial structure to support Outreach in the field and to coordinate its activities with provincial and municipal governments. These key elements were still being discussed while the FHC team was in the field (February 8 - March 20):
 - (a) Civil Service status for the full-time motivators and supervisory field staff had not been approved.

* Commission on Population Annual Report, 1974-1975, p. 53.

Before the motivators can receive salaries paid through provincial treasuries, they must have obtained Civil Service status. USAID had raised this issue several times with POPCOM, beginning at least one year ago, but it was not pursued with vigor by the Commission. Most of the motivators had been trained as of March 31; those FHC spoke with had not yet been paid. After the FHC team returned to Washington, it was informed by cable that a temporary Civil Service status of one year duration had been granted.

(b) Both USAID and the POPCOM thought provinces and municipalities could tap into P.D. 144 funds* for their cost-sharing arrangements on Outreach. Before these funds can be used for this purpose, the DLGCD must declare population to be a development priority for local governmental units. On July 20, 1976, Presidential Letter of Instruction 435 empowered the DLGCD to develop the operational guidelines which would allow the authority to make such a declaration. The DLGCD and POPCOM were still working out these arrangements during the team's visit. The team was told by provincial authorities and DLGCD staff that these impediments remain:

- The provinces must now declare population to be a development priority.
- The P.D. 144 funds for any development purpose are limited to 20 percent, and within that allocation, provinces have statutory obligations, i.e., capital projects, natural disasters and calamities, etc. This leaves another undetermined percentage which may be used now for population programs but not for the salaries

* There are two pertinent sections to P.D. 144 which deals with the disbursement of funds from the central government to local governmental units: Section 6 and Section 7. As President Marcos has sole authority to authorize release of Section 7 funds, discussions in this report on the use of P.D. 144 for funding local projects pertain only to those possibilities which exist under Section 6 of that decree.

of new personnel, such as the full-time motivators. P.D. 144 allows 30 percent of the "20 percent development fund" to be utilized for salaries of existing staff.

- (c) POPCOM has been negotiating project sub-agreements with 132 provinces and municipalities for cost-sharing arrangements on Outreach. At least 51* of these agreements were signed during the team's stay, and most of the remainder are probably signed at this date. However, since provincial budgets were approved prior to the signing of most, if not all, of these sub-agreements, the governors must request a supplementary appropriation before contributions to the cost-sharing plan with Outreach and the POPCOM can be made this year.
- (d) There is ample confusion between the provinces, POPCOM Regional Offices, and the POPCOM central office as to the responsibility for program implementation. The POPCOM has assured the team that the provinces will implement the program; one Regional office said POPCOM will implement in provinces where no cost-sharing formula has been worked out. This officer says the instructions he has sent to governors for project sub-agreements are the same as those sent to other regions: "They are central POPCOM guidelines." In Marinduque Province, FHC was shown the sub-agreement from the POPCOM Regional Office which stated that if it did not contribute toward the costs of Outreach, then the POPCOM would implement the program and have administrative control of the motivators. The team believes POPCOM Central office is correct, that it has no intent to implement, and that it is moving to issue a uniform set of guidelines in this regard.

Generally speaking, the above items are administrative details and can be handled by cooperation between POPCOM, DLGCD, and the provinces. The new Executive Director of POPCOM is moving quickly to correct these matters; it is unfortunate that he had to inherit them in the first place.

* The total of counterpart contributions by provinces and cities is 18 percent of total Outreach budgets for the first year. These are budgets, not commitments, and FHC was unable to separate out the in-kind contributions from the proposed cash contributions.

(4) The Draft Project Paper for Phase II of Outreach cites empirical evidence which shows "that the effective impact of present clinics is limited to a radius of three or four kilometers beyond which service coverage rapidly tapers off." Thus, the part-time motivators (then under DOH) could be replaced by full-time Outreach workers to bridge this "critical geographical barrier to contraceptive acceptance by making pills and condoms available in every barangay."

(a) As empirical evidence, the concept would argue for a different ratio of full-time motivators to population in urban versus rural areas. At present, it is based solely on population, that is, one full-time motivator per 2,000 married couples of reproductive age (1:2,000). The population most in need of contraceptive supplies is to receive the same number of staff as those less in need. The reverse should hold true, and this may be a more appropriate siting of Outreach workers after March 31, 1978, when additional staff are scheduled to be deployed.

(b) The Metropolitan Manila Area is located in POPCOM's Region 4, and Mrs. Marcos is its Mayor. FHC was informed that the Commission will implement Outreach in Metropolitan Manila, with assistance from the regional office. No sub-agreement has been signed (as of March 15, 1977) with the Mayor.

- Some 373 full-time Outreach workers will be assigned to the area, in addition to 67 DPOs, 6 PPCs, and 4 PPOs.
- In full-time motivators alone, this is 12 percent of the national total. These resources are justified on the basis of population, but not on the empirical evidence cited in the Draft Project Paper. That is, as one moves away from towns, accessibility to clinics and contraceptive supplies declines. One would expect the residents of Metropolitan Manila to have a ready access to the city's hospitals, clinics, city health department facilities, and the in-plant family planning clinics sponsored by the Department of Labor. USAID/Manila is well informed on this subject and concerned about its implications.

- (5) The planning of this nationwide program has gone forward--while its goals and objectives had not been internalized by the Government--without sufficient attention devoted to developing the administrative and managerial requisites for effective implementation.
- (a) A USAID official related that there was now a greater need for faster implementation (Outreach Project) yet POPCOM had insufficient staff to accomplish this task.
 - (b) This point was further elaborated in a USAID memorandum which noted the recent loss of talent from POPCOM and the necessity of rapidly reversing this trend. The document noted the increasing difficulty of transferring several millions of dollars of assistance per year to POPCOM in the light of this disturbing development.
 - (c) A senior POPCOM leader stated a conviction that the Outreach Project would require the total resources of POPCOM. Therefore, it would weaken the previous multi-sectoral approach of the family planning efforts and could create enormous embarrassment if the project (Outreach) failed.
- (6) The extent to which other factors, i.e., education and urbanization, have contributed to the decline in population growth rates in the Philippines since 1960 is unknown, as is the degree to which the rate would have fallen independent of a national family planning program.

One authority, Frank Lorimer, projected (in 1966) a 1970 population of somewhere between 37.4 million and 37.7 million, and a 1960-1970 annual growth rate averaging about 3.2 percent. The 1970 census suggested only 36.7 million people in that year, and therefore an average annual growth rate of only 3.0 percent. There does seem to be evidence of a declining growth rate beginning sometime in the late 1960s (prior to the initiation of a national population program).

The national goal is to reduce the population growth rate by an average of one-tenth of one percent annually for the life of the Outreach program. Some

knowledgeable observers, not associated with the population program in the Philippines, believe it will be even lower, but that this decline will not be related to the effects of the national program.

Rather than state a numerical goal for the national program, which may be spurious when other factors are considered, i.e., female employment, increased age of marriage, etc., policymakers at POPCOM may want to increase the emphasis on other goals that their program can impact upon:

- (a) The knowledge and attitudes of the target population toward acceptance of population control measures.
- (b) Behavioral patterns which may lead to a reduction in family size.
- (c) The amelioration of Church attitudes on family planning so as to incorporate its positive approaches for the common good.

c. Program Organization

FINDINGS

- (1) The organizational structure of the Philippines population program has undergone a number of changes since 1970 which largely reflect the evolution of the program from one characterized by small-scale and piecemeal efforts by private voluntary organizations to one characterized by a large-scale, government-led implementation of a complex, comprehensive set of fertility control policies and programs.
 - (a) The transition from an uncoordinated series of efforts by a large number of agencies to a large and complex program has resulted in an organizational structure that has unclear chains of command, vaguely defined levels of authority, weak institutional linkages with other agencies, and over-centralized policy planning procedure.
 - (b) These characteristics of the structure of organizations working in family planning are a

contributing cause to the program management weaknesses (which are discussed in II.B.3). The structural weaknesses in the program are reflected both in the uncertainty of POPCOM's authority in population matters, and in the existence of other foreign donor programs operating separately and independently of POPCOM, such as the World Bank population loan.

- (2) An umbrella agency was created by the government in 1970 to take overall responsibility for family planning--the Commission on Population (POPCOM). The Commission on Population, as it has evolved, has functioned unevenly in the transition to a large-scale, comprehensive program, primarily because its structure and role have experienced relatively frequent and abrupt shifts.
 - (a) Since it was first created by Executive Order No. 171 on February 19, 1969, the Commission on Population has been reconstituted and restructured several times. These changes reflected some evolutionary passages in the Commission's "duties and functions" and changes in the membership of the Commission's Board.
 - (b) The first Commission was granted limited policy/program research and development functions; the Board consisted of 23 members from public and private sectors, and the University of the Philippines Population Institute acted as the Commission's Secretariat.
 - (c) Family planning was designated an official government policy and the Commission on Population given operational responsibilities by Executive Order No. 233, dated May 15, 1970.
 - (d) Republic Act 6365 established a national population policy and created a new 12-member Commission on Population in the Office of the President, on August 16, 1971.
 - (e) Presidential Decree No. 79 (dated December 8, 1972) reduced the size of the Board even further to a five-member Board, and enlarged the scope of POPCOM's powers to give it wider responsibilities and open the way for making surgical contraception available as a program method.

(f) Presidential Decree No. 166 (dated March 31, 1973) added two members to the POPCOM Board. They are appointed by the President from the private sector in order to give it "the opportunity to participate in the formulation and implementation of the Government's population program."

(g) The POPCOM Board of Commissioners is now made up of:

Secretary, Department of Social Services
and Development (Chairman)
Secretary, Department of Health
Secretary, Department of Education and
Culture
Director General, National Economic and
Development Authority
Dean, University of the Philippines
Population Institute

Three representatives from the private
sector; those presently serving are from:
Children's Medical Center
Population Center Foundation
University of the Philippines
Medical School

(3) The organizational relationship between the POPCOM executive director and the POPCOM Board appeared to have deteriorated badly in 1975-1976. The Executive Director during this period designed and initiated policies and programs which were a departure from the past and which ultimately did not appear to have had the favor of the majority of the Board. POPCOM had moved toward a major "implementation" role, claiming at one point that "full-time family planning workers will come directly under the Commission," and that, in provinces not contributing counterpart funds to Outreach, POPCOM would implement the program itself through its regional offices. The POPCOM Board informed the team that POPCOM does not now have an "implementation" role in the population program. The new Executive Director has described POPCOM's role as one of "broker/contractor" for the implementing agencies. In view of the fluidity of POPCOM's structural relationship to the agencies it is supposed to be "coordinating," additional clarification may be needed, particu-

larly with regard to POPCOM's lines of authority through its regional offices to the provinces, and with regard to the policy/program interface between POPCOM and the partner agencies.

- (4) The precise nature of organizational linkages between POPCOM and the partner agencies are difficult to determine and characterize; there is no operational organizational mechanism for allowing the participating agencies to actually participate in the formulation of programs and policies except through the POPCOM Board, which represents mainly the dominant public social service agencies.
 - (a) There are now approximately 40 participating agencies which, as part of the national family planning program, are coordinated in one or more of the four functional areas of POPCOM: research and evaluation, clinic services, training, and IEC. An important function served by POPCOM's coordination efforts has been the elimination of certain duplication of activities by two or more agencies, and the designation of agencies to specialize in certain areas of the program, or in certain geographic areas.
 - (b) However, specific instances of duplication of function at the field level usually have gone unnoticed or uncorrected by the POPCOM. Moreover, there have been situations in which POPCOM has initiated activities which are somewhat duplicative of activities already being performed by other agencies, i.e., some training initiatives. In the case of motivators, POPCOM's decision to implement TIDA and Outreach forced it to discontinue financing of all other motivators which had been employed by other agencies (DOH and DLGCD) for several years. Most personnel (some 3,000 part-time motivators) thus were lost outright, since very few were rehired under the new programs.
 - (c) The major partner agencies in the population program are public social service agencies: the Departments of Health; Education and Culture; and Social Services and Development. Private

agencies like the Institute for Maternal and Child Health (IMCH) and the Family Planning Organization of the Philippines (FPOP) still play significant, though declining, roles in the program.

- (d) Management of the delivery of clinical family planning services by the participating agencies generally appeared to be adequate, with a few notable examples of exceptionally effective and efficient operations. Effective management, however, has often been hampered by discontinuity of programming directions and abrupt changes in policy on the part of the POPCOM.
- (5) Management performance within the Department of Health was enhanced at the central level by the use of relatively complex project management systems interfacing with the regular bureaucracy. Some duplication of functions and blurring of authority have been caused by the existence of two project staffs involved in family planning: the National Family Planning Office (NFPO), responsible for integrating family planning services into all clinical facilities, and the Project Management Staff (PMS), responsible for implementing the Restructured Rural Health Care System (and for implementing the World Bank population project). The overlap has caused some friction within the DOH and some delays in implementation, and effectiveness of project management staff of these two offices at the field level is not universally sound. The currently underway transition to a regional, decentralized, unitary bureaucratic organization in the field is resulting in some friction between various actors in the family planning field, particularly in training, where the responsibilities of the NFPO's Nurse Training Officer are duplicative of those of the DOH's Office of Health Education and Personnel Training (OHEPT) detailed by the PMS to perform its family planning training functions.
- (6) Starting in 1974, POPCOM has implemented a policy to decentralize and regionalize its planning and operational organization, creating regional offices in each of the 11 regions. At the same time, POPCOM

underwent a major reorganization of its own operations into four functional areas--creating divisions responsible for research and evaluation, clinic services, training, and IEC. While these changes improved POPCOM's capacity to mount field-level operations, and established a network which made possible nationwide logistics distribution and nationwide access to more accurate management and program information, POPCOM's regional offices had no structural linkages to the regional offices of the partner agencies, each of which remained responsive and responsible to its Manila Office. POPCOM is not yet a member of the Regional Development Councils, which represent the National Economic and Development Agency's (NEDA's) initial step toward institutionalization of regional planning. The regional coordinating councils on which POPCOM sits are consulting bodies with no formal authorities. The nonformal nature of POPCOM coordinating "powers" extends below the regional into the provincial and municipal level.

- (7) NEDA is responsible for overseeing the programming of foreign donor assistance to the population program, but it has not consistently reinforced POPCOM's role as the central policymaking and planning body for population. NEDA, and higher authorities (under P.D.568), allowed the World Bank to disburse funds directly through NEDA to the DOH in support of implementation of its population loan by the DOH's Project Management Staff. In its own organizational and planning structure, population/nutrition/health are considered as one sector by NEDA.
- (8) The Population Center Foundation (PCF), which owns the building in which POPCOM Manila has its offices and one of POPCOM's warehouses, is in somewhat of an anomalous position with respect to the policymaking, programming, and financing aspects of the population program. According to its 1974-1975 Annual Report, PCF was founded "as a private, grant-making institution established to increase the participation of the private sector in (finding) timely and effective solutions to (the) population problem." But its relationship to POPCOM in general, and PCF's role in implementing, through one of its projects, the Outreach program in nine PROCOM provinces, seems to have made PCF competitive with POPCOM for funds and for program control and responsibility.

- (a) Since PCF's charter precludes its receiving public funds directly, funds appropriated for the PCF by the Government must be funneled through POPCOM, which is PCF's tenant. At the same time, the PCF Executive Director is one of the three private sector members of the Board of POPCOM, a public agency.
- (b) PCF is sponsoring a project conceived by Mrs. Imelda Marcos, Project Compassion (PROCOM). PROCOM is being implemented in at least "nine provinces, eleven chartered cities, and two additional municipalities," using local government funds and involving the field representatives of the central line agencies of the Government.
- (c) In those areas where PROCOM is being implemented, POPCOM has agreed to designate PROCOM its "implementing agency" for carrying out the Outreach project. As such, PROCOM will receive Outreach funds through the Commission to finance PROCOM-merged-with-Outreach in the "PROCOM provinces and cities."
- (d) POPCOM and PCF have adopted different programs-- Outreach and PROCOM, respectively--which have similar purposes and structures and must compete for funds and program authority. Because PCF/PROCOM can invoke the authority of the First Lady, PROCOM has considerable political influence at all levels. Because POPCOM, for the most part, is the recipient of foreign donor funds, principally from USAID, it is responsible for implementing bilateral and other donor agreements as to the use of funds. But because of the anomalous role of PCF, and its relationship to POPCOM, they are competitive rather than cooperative with each other.
- (e) A senior population program official believes the Outreach Project will so burden POPCOM in its execution that the Commission will be unable to do anything else over the life of the project. Therefore, PCF will be asked to undertake new and innovative population projects and research tasks which normally would have been POPCOM's assignment.

B. SYSTEM OPERATIONS AND SUPPORT

1. PROGRAM RESOURCES

a. Financial Support

- (1) Budget Support from the Government of the Philippines

CONCLUSION

Government budgetary support of the population program began on a small scale within the program budgets of the line agencies in FY 1969, but within five years had increased into annual budget obligations of almost \$9 million. Through FY 1976, the Philippines government has contributed about 40 percent of the total financial cost of the population program, and is currently funding 50 percent of program costs. Detailed breakdowns of budgeted and actual expenditures, however, are not available, and there is reason to question whether reported budgeted amounts accurately reflect actual expenditures.

FINDINGS

- (a) It was not until the creation of POPCOM in 1972 through Presidential Decree No. 79 that the government initiated large-scale budgetary support of the program. The initial appropriation of \$1.7 million for FY 1972 was increased dramatically during each of the next two years to reach a level of almost \$9 million in FY 1974. Annual government appropriations to the program through POPCOM (including those to the family planning components of other Philippine

public and private agencies) have stabilized at that level since then; future increases in financial support of the program are now expected to come from provincial and city budgets gradually absorbing the costs of the program within their jurisdictions.

- (b) Table 1 shows the rapid rise of the Philippines government's contribution from FY 1972 to FY 1974, and of the year-to-year increases in total contribution to the program from all sources. Of the total budgeted costs incurred for Fiscal Years 1969 through 1976, \$81.3 million, approximately 40 percent, has been contributed by the Philippines government-- a commendable effort in view of the fact that it was contributing an insignificant amount at the beginning of the decade.
- (c) However, a caveat: The data in Table 1 are actually budgeted obligations (which include an unknown amount in valuations of in-kind contributions) and should be treated as rough estimates, probably rather high estimates, of actual expenditures. Moreover, it should be kept in mind that accounting and reporting rules differ widely from one organization to another, and that the complexity of the program and the number of participating agencies inevitably had led to a complex and cumbersome financial accounting system. Detailed breakdowns of actual expenditures, by agency or by function, were not available from POPCOM; and, according to USAID staff, the detailed current financial reports required by the Project Agreements have been inadequate, late, or both, for at least one year. In questioning USAID officials about how they verified the accuracy of financial data reported by POPCOM, the team learned that USAID often questioned the validity of POPCOM's data, but with little success in establishing the accuracy of the data.
- More than a year ago, USAID elicited from POPCOM an admission that the Philippines' contribution to the UNFPA (a statutory appropriation of the peso-equivalent of \$350,000 annually), 75 percent of which is required by Section 13 of P.D. 79 to be spent in-country, is double-counted (to that extent) as a program expenditure. (Just this item alone meant that \$262,500--three percent of POPCOM's total reported FY 1974

TABLE 1
Philippine Population Program
Sources of Assistance(a)
Fiscal Years 1969-1976
In U.S. Dollars

<u>Fiscal Year</u> ^(b)	<u>GOP</u>	<u>USAID</u> ^(c)	<u>UNFPA</u>	<u>IPPF</u>	<u>Ford Foundation</u>	<u>Pathfinder Fund</u>	<u>Population Council</u>	<u>FPIA</u>	<u>Others</u> ^(d)	<u>Total</u>	<u>% Annual Increase</u>
1968-1969	--	2,367,300	--	--	113,015	8,888	5,714	--	1,270	2,496,187	--
1969-1970	--	1,488,888	148,888	--	--	26,666	54,603	--	5,079	1,724,124	(51%)
1970-1971	--	4,084,328	328,806	--	191,194	25,672	61,940	--	3,433	4,695,373	190%
1971-1972	1,226,866	5,773,134	638,507	--	--	137,910	119,701	--	6,119	7,902,237	68%
1972-1973	3,988,358	5,228,955	492,687	559,104	182,239	175,075	115,970	50,896	34,478	10,827,762	37%
1973-1974	8,711,194	5,146,269	1,807,761	444,328	140,597	293,881	97,015	255,223	45,970	16,942,238	56%
1974-1975	9,080,000	6,186,418	2,074,776	534,478	6,269	284,179	91,045	418,507	17,164	18,692,836	10%
1975-1976 ^(e)	<u>8,947,143</u>	<u>5,464,286</u>	<u>2,247,143</u>	<u>711,571</u>	<u>338,429</u>	<u>N/A</u>	<u>13,000</u>	<u>279,286</u>	--	<u>18,000,858</u>	(4%)
TOTALS	<u>31,953,561</u>	<u>35,739,578</u>	<u>7,738,568</u>	<u>2,249,481</u>	<u>971,743</u>	<u>952,271</u>	<u>558,988</u>	<u>1,003,912</u>	<u>113,513</u>	<u>81,281,615</u>	
Percentage of Total	39.3%	44.0%	9.5%	2.8%	1.2%	1.2%	0.7%	1.2%	0.1%	100%	

- Notes: a. Figures include local peso costs, dollar costs of participants, commodities, and counterpart contributions.
b. Fiscal Year starts on July 1 and ends on June 30.
c. USAID contributions include assistance directly provided by AID/Washington.
d. Asia Foundation and ESCAP contributions.
e. Budgeted amounts for FY 1975-1976. GOP amount includes only funds committed in project agreements with donors, not full amount appropriated (and, in the past, rarely spent). Total may be underestimated since figure for Pathfinder Fund and "Others" was not available. Data taken from POPCOM table dated February 15, 1976.
- SOURCE: Except for data for 1975-1976, these data were from a POPCOM folder entitled, "Part II, Philippines Population Program, Sources and Applications of Assistance, FY 1969-FY 1976," dated February 15, 1976. Comments in a USAID memorandum explaining the data included:
"1. Data apply to the entire Philippine Population Program, broadly defined."
"2. Data in Table 1 should be treated as approximations...Contributions are on an obligation base, with the exception of the GOP, which is on an expenditure base."
"3. The GOP column includes not only POPCOM but also other Philippine public and private agencies, a practice followed by GOP for at least four years."

contributions to the population program--was double-counted for that fiscal year.).

- When USAID 18 months ago suggested that POPCOM segregate valuations of in-kind contributions from cash contributions to the program, POPCOM responded that they would consider doing so in future reports; there were no "future" reports.
 - A USAID/Manila briefing paper in early 1977 stated that "POPCOM presently has an approved budget level of P49 million (\$6.7 million) contrasted to P30 million (\$4.1 million) actually released this year. It is important to remember that the GOP has never actually released the full amount (authorized) for POPCOM, and there have been consistent shortfalls between authorization or allocation levels and actual releases."
 - A September 1976 internal memorandum from the USAID Population Office explaining "GOP Contributions to the Philippines Population Program" noted that "a common condition (is that) funds earmarked for population in excess of ProAg commitment are subject to GOP freeze, so that high aspirations do not materialize."
- (d) It should be noted that the substantial, rapid increases in contributions from the Philippine government, to the extent that the data are accurate, have brought total government population expenditures roughly equal to health expenditures (per capita of targeted population). Government funds obligated to family planning rose from an insignificant amount in 1970 to the equivalent of over 12 percent of the total government expenditures on health in FY 1974. For FY 1976, the family planning budget was the equivalent of about 10 percent of the health budget. Since the target population of the population program fundamentally is the MWRA--roughly 13 percent of the population--annual government expenditures per person in the target population are about the same for health as for family planning--even though the government health system provides a much broader range of services (for the whole population) than the population program does (for the MWRA). When foreign donor

assistance is added to government expenditures, the family planning program spends much more per targeted person than the government health program.

(2) Foreign Donor Support

CONCLUSION

USAID provided most of the financial resources, and most of the foreign donor assistance, to the population program from FY 1967 through FY 1971. Since then, major increases in the levels of contributions from the Philippines government, and from other foreign donors, have greatly increased the level of resources supporting the program. The World Bank has recently disbursed initial installments of a \$25 million loan to help finance a "population project" which is to construct 205 new Rural Health Units and subsidize the pre-service and in-service training of midwives (including family planning).

FINDINGS

- (a) Table 1 also shows that substantial USAID financial support provided virtually all funds supporting the program up until FY 1972. Since then, Philippine government's contributions and assistance from other donor agencies have substantially increased the level of financial support to the program, the greatest increases coming between 1972 and 1974. USAID's contribution as a percentage of the total has decreased through FY 1976, and cumulatively amounts to about 44 percent of the total funding--or about \$32 million.
- (b) USAID financial data (in Table 2) show a somewhat different trendline than POPCOM data, peaking at \$8.4 million in FY 1973, and declining gradually

TABLE 2
USAID OBLIGATED EXPENDITURES
DISTRIBUTED BY CATEGORY OF EXPENDITURES
FY 1967 - FY 1976

FY YEAR	OBLIGATIONS (in \$000s)*	PERCENT DISTRIBUTION BY CATEGORY					
		U.S. TECHNICIANS	PARTICIPANTS	CONTRACEPTIVES	OTHER COMMODITIES	OTHER COST DIRECT DOLLAR-FUNDED	
						DOLLAR COST	PESO COST
67-71	\$ 10,475	15%	5%	0%	19%	1%	60%
72	5,609	9%	2%	17%	25%	5%	42%
73	8,411	5%	1%	58%	5%	7%	25%
74	6,375	2%	1%	45%	0%	2%	49%
75	5,054	4%	1%	31%	5%	1%	57%
76	4,800	3%	< 1%	33%	4%	< 1%	60%
TOTAL/ AVERAGE	\$ 40,714**	7%	2%	29%	10%	3%	49%

Notes:

* Totals include contraceptives obligated by AID/W in following amounts:

FY 1973	\$2,985,000
1974	2,659,000
1975	1,564,000
1976	1,600,000
TOTAL	\$8,808,000

** Of total obligated by USAID/Philippines (\$31,906,000) through FY 1976, 88% had been expended by June 30, 1976.

Source: "Financial Management Report," September 30, 1976, USAID Mission to the Philippines.

to \$4.8 million in FY 1976. The discrepancies between the POPCOM and USAID figures by fiscal year may be due to the lag in POPCOM's budgeting of USAID releases; at any rate, the totals for program expenditures of both tables show insignificant differences. Almost half of USAID's financial support has been toward local (peso) costs (direct, dollar-funded), while 42 percent has gone toward commodities and contraceptives; the remainder was spent as U.S. technical assistance and participant training.

- (c) UNFPA has contributed almost 10 percent of total budgeted cost of the program, and provided over \$2.2 million during FY 1976 (about 12 percent of that year's budget). The next largest contributor has been the International Planned Parenthood Foundation (IPPF), which has provided about 3 percent of total costs. The FY 1976 program was funded equally by the Philippines government (50 percent) and by donor agencies (50 percent), according to POPCOM.
- (d) World Bank assistance to the Philippines' population program has taken the form of a \$25 million project loan (at 7.5% interest payable within 25 years) to help finance the Department of Health's \$50 million project to restructure the rural health system, including a family planning component in the services available from midwives at Barangay Health Stations. The loan is programmed to finance construction of 205 new Rural Health Units and to support midwifery training (two-months pre-service training for newly recruited midwives and one-month in-service training for those already serving) which includes instruction in delivery of family planning services. The Project Management Staff, which has been operating for more than a year on the initial disbursements from the loan funds, has already begun preliminary planning with World Bank officials for a second loan.

(3) Local Government Budget Support

CONCLUSION

Although there are several provinces and chartered cities which have accorded both high priority and significant support to family planning activities within their jurisdictions, the overwhelming majority of provinces and cities have not, and probably will not, accord a very high priority to family planning activities (relative to their other priorities for development), and most cannot afford to finance such activities out of their own revenue. POPCOM's resort to the P.D. 144 "20 percent development fund," in agreement with DLGCD, to help the provinces finance population programs (with internal revenue shared by the center) will tend to substitute for truly local revenue and will impose opportunity costs on the local governments by diverting resources away from other local development priorities.

FINDINGS

- (a) Those provinces which have actively pursued family planning, and which have spent considerable sums on such efforts, are those that are among the most wealthy in the country and that have both the traditions of progressive development policies and the management/financial capacity to mount such efforts. There are several outstanding examples of provinces and cities that have taken the initiative in managing and financing their own family planning programs:

- Province of Nueva Ecija: When asked by the team whether local governments would really

be willing and able to finance--even 15 years from now--the total costs of the population program (as POPCOM and USAID are requiring), POPCOM officials at all levels cited Nueva Ecija as an example of the provinces' responses to the POPCOM/USAID requirement. The Province of Nueva Ecija has promised to fund 100 percent of the costs of its population program within three years; already, for FY 1976, provincial counterpart funds totalled 65 percent of the \$187,000 budget for its Provincial Population Office (the rest came from POPCOM). However, Nueva Ecija is a resource-rich province (comprising what could be called the "rice bowl of the Philippines"), and cannot be fairly compared with other provinces and their capacities. Moreover, the governor declared to the team that the province does not wish to receive central (POPCOM/USAID) assistance, since "it is easier to pay for it ourselves." Nueva Ecija was one of the first seven experimental "TIDA" provinces; its record for recruiting new acceptors during the first year under "TIDA" was the best of all seven, showing almost twice as many new acceptors during FY 1976 as during FY 1975.

- Province of Laguna: The governor of Laguna has been a leader and an innovator in family planning programming for more than ten years. In addition, like Nueva Ecija, Laguna is endowed with substantial real estate revenues with which to finance the local family planning program (its FY 1976 provincial budget was over \$3.1 million). Laguna was also one of the seven experimental "TIDA" provinces, contributing 65 percent of the total FY 1976 population office budget of \$125,000. The circumstances and conditions leading to Laguna's policies and programs toward family planning are, as in Nueva Ecija, rather exceptional.
- Chartered City of Cagayan de Oro: This city has one of the most innovative and comprehensive family planning programs of any city in the country, but the scope and depth of the program are in large part due to an unusually energetic mayor and to extensive financial support from the Ford Foundation in its Model City program.

(b) There is little likelihood in the great majority of provinces and cities that the family planning program will be supported by locally raised revenue except in relatively small amounts. There are several reasons for this conclusion:

- A substantial number of provinces and cities do not have sufficient revenue (or the prospects for raising it) to maintain a minimum of social services without central government financial assistance. Moreover, what little they did collect has been shrinking. Between 1967 and 1974, revenues and expenditures of local governments, as a percentage of total combined government revenues and expenditures, have actually declined: revenues dropped from 17 to 11 percent of combined government revenues, despite an effort to raise the taxing powers and resources of local governments; and expenditures declined from 20 to 15 percent of combined government expenditures.*
- Many provinces and cities view family planning as a national priority--a development priority set at the highest level of government, and thus one that should be financed by the center. The way the program has been run up until recently--i.e., by a centralized bureaucracy--has reinforced this view. In fact, the governments might question (although the team met none which did) the wisdom of spending their own resources on controlling fertility, when national development policies and programs might well cause interregional demographic and economic changes that could overwhelm whatever impact the local family planning program may have.
- There is evidence that the provinces and cities may anticipate that the Outreach program and other population programs of POPCOM will continue to be financed largely by central revenues, even though governors and mayors are being asked to sign agreements to gradually

* The World Bank, The Philippines: Priorities and Prospects for Development, A World Bank Country Economic Report, Washington, D. C. 1976, p. 90.

absorb the total costs of the program within five, ten, or fifteen years.

- Attempts to tap the P.D. 144 "20 percent development fund" to help pay for the population program could impose significant opportunity costs on local governments. The "20 percent development fund," which was prohibited from being spent for salary support or other operational expenses (at least until this proposed application to population program recurrent expenditures), has been allocated already by most local governments for local capital development projects, typically for rural roads. The proposed DLGCD/POPCOM agreement, designed to make available this "20 percent development fund" for use in provincial population programs, was to include a provision making such allocation mandatory, i.e., funds for other provincial priorities would not be released under P.D. 144 unless the province agreed to spend some of the P.D. 144 funds on population. Since the amount to be applied as "new funds" out of P.D. 144 for population are from the same total amount of funds, the local governments will be required to reduce expenditures (from P.D. 144) on other development priorities--an opportunity cost of spending on population. (See Annex A for a more detailed discussion.)

b. Training

CONCLUSIONS

POPCOM has "training specialists" at the Central and Regional Office levels, and has contracted with EDF and with hospitals and individuals to train various types of personnel. Three types of training needs were identified and two training resources examined during the team's inspection.

(1) Outreach

- (a) The training provided to Outreach workers proceeded smoothly, but its content was highly theoretical and is of questionable value for their intended role.

(b) Trainees and trainers appeared enthusiastic and committed, and those FTOWs visited by FHC in the field after training had retained this attitude. They may be able to overcome the substantive weaknesses of the training program on the basis of their energy and determination.

(c) Successful tapping of the energy of Outreach workers will require improved program management and follow-up training.

(2) Clinical Services

(a) Interest in sterilization training is high and the quality of training provided is a strong point in the Philippines' program.

(b) The small number of IUDs inserted suggests the need for reexamination of family planning training and/or follow-up supervision of those trained.

(c) The certification process for all family planning training programs should be examined and expedited.

(3) Local Officials

Although POPCOM has carried out orientation seminars for local officials to brief them about Outreach, these one-day training sessions do not appear to be sufficient to fully clarify the role and authority of the Outreach workers--PPOs, DPOs, and FTCWs. Provincial officials also have expressed to FHC the need and desire for more knowledge about family planning/population planning and its role in economic growth and development.

FINDINGS

(1) Outreach Workers

The Educational Development Foundation, Inc. was contracted to train Outreach workers for the seven TIDA provinces in 1975, using a curriculum designed to develop community outreach skills. That same curriculum was followed in training Outreach workers in the current expanded national program, with the addition of a contraceptive dispensing component. Exposure to the training process and product provoked a number of questions. The questions being raised concern:

- (a) The appropriateness of recent college graduates, without community outreach experience, as teachers of community outreach theory.
- (b) Reliance on the seven provinces TIDA training model, which--current performance in the provinces indicates--is fair in some regions, poor in others.
- (c) The lack of emphasis on family planning technology and dispensing skills, including the short amount of time allocated within the curriculum (family planning: 3 days) and the absence of practical experiences (no samples of pills, IUD's, or condoms provided during family planning lectures, and no opportunity to role-play family planning-related tasks prior to fielding).

On a more positive note, trainers and trainees evidenced high enthusiasm and commitment, and with proper harnessing, could energetically move the family planning program into the areas of greatest need, the remote barangays. Cooperation between the Central Office staff, regional office staffs, and EDF staff has made training proceed at least on the scheduled basis, with the notable exception of PROCOM/PROCOM merger regions. As discussed elsewhere, Outreach management and logistical support must improve in order to provide an expectation for realizing training potential and program success.

(2) Sterilization and Comprehensive Family Planning Training

Observation of both of these activities was limited to a small number of training sites and interviews with recent trainees and trainers. Interest in learning sterilization techniques is reportedly high. Training methodology is reported to be entirely satisfactory for both comprehensive family planning and sterilization techniques. Conversations revealed the following additional findings, which may indicate the need for reexamination of training design and/or follow-up supervision and management:

- (a) Laparoscopy is not as highly regarded as the mini-lap. Rumors of failure with the

laparoscope have frightened some physicians. Most physicians prefer the mini-lap because the procedure is simpler and the equipment does not have the maintenance problems associated with the laparoscope.

- (b) The number of IUD insertions by nurses is very small and IUDs are not often recommended. On the other hand, certain physicians have large numbers of women choosing IUDs.
- (c) Some midwives and physicians have good success in identifying post-partum sterilization acceptors. These individuals appear to stress the availability and desirability of sterilization during home deliveries.
- (d) Some physicians attended sterilization training workshops and had not yet received certification, although months had elapsed.

(3) Provincial and Local Officers

Exposure by the team to training for local officials was second hand and incidental to other observations. From this limited perspective, local officials' training seemed to be erratic in design and practice:

- (a) In at least one region, the POPCOM regional population officer had personally and formally explained the intent of the program and the roles of mayors and governors to a majority of those represented in his region. For at least one other region, the RPO had attended functions arranged by his staff and had participated in a vague and informal capacity.
- (b) Confusion expressed by various local officials suggests that the Outreach worker role is not a clearly understood phenomenon and requires some formal training effort.
- (c) Discussions with Governors indicated that training thus far has been concentrated on Outreach administrative details. Governors were anxious to improve their understanding of population growth, development concepts and issues, but very little of this sort of orientation has been offered by POPCOM.

c. Personnel

CONCLUSION

While the quantity and quality of program administrators at the regional level are generally adequate, and in some regions superior, at the central level the program is seriously understaffed. None of the participating agencies at the central level, however, have experienced the staffing deficiencies that POPCOM has recently suffered. Staffing key management slots and tightening program administration in POPCOM/Manila deserve the high priority they are being given by the new director, yet if the Outreach program is to have a chance of achieving its high goals, upgrading the quality of personnel and maintaining full staffs at the regional level deserve as much (if not more) attention. The current build-up of large numbers of field personnel and the increased complexity of the logistics system resulting from the Outreach program will place management demands on POPCOM which will be different, in kind and in magnitude, from those of the past. It is imperative that personnel selection, placement, and support procedures pay stricter attention to the specific demands of the job to be done in the field and to the objectives of the overall population program.

FINDINGS

- (1) The quantity and quality of program administrators within POPCOM/Manila has deteriorated greatly over the past two years. Nearly one-fourth of the 611 approved POPCOM/Manila personnel positions were unfilled in early March, 1977. In addition to the insufficiency of program administrators, critical technical personnel positions are unfilled. For example, the POPCOM/Manila Medical Services Division is unstaffed at the top; the "portfolio" is being carried currently by a non-medical person. In discussions with the POPCOM Board and Executive Director, the FHC team understood their keen sense of the urgency of this problem. Steps have been taken to address the deficiencies, but the rebuilding of staff quality and staff morale will require enormous efforts and considerable time, and should be paralleled by efforts, not just to maintain, but to substantially improve the management capacity of the regional level staffs.

- (2) With the exception of some regions, POPCOM's 11 regional offices have been competently managed so far, but the lack of experienced managers in some regions raises some doubts about the regions' abilities to meet their enlarged responsibilities under Outreach. At a time when POPCOM/Manila operations were disrupted by a change of leadership, it has been the regional offices that have performed most of the paperwork and legwork required to get the more than 3,000 FTOWs and supervisors trained and into the field on schedule. Under such difficult circumstances, several of the regional offices were managed particularly effectively. Effective performance by the dispersed group of Full-Time Outreach Workers in the future will depend on adequate management and logistics support from the regional office managers. The impact of an evident lack of experience among some regional staffs in the administration of such a large and complex program, which for the first time will involve provincial governors' offices, can be minimized, however, only if POPCOM/Manila focuses attention on more effective management support of its regional staffs. Furthermore, there is a need to encourage, assist, and support POPCOM regional staff collaboration with other social sector regional staff, e.g., Departments of Health, Education and Culture, Local Government and Community Development, and the Bureau of Agricultural Extension.

- (3) The deployment of more than 3,000 FTOWs and supervisors could dramatically overcome the program's past failure to penetrate the rural areas with family planning information and services. This group will need extensive and intensive field supervision, however, as they begin their jobs, posted singly in dispersed areas, and face a host of problems: rapport with the village leaders, identification of informal leaders and potential BSP persons, coordination with the nearest RHU and other family planning service delivery points, living arrangements, and at least minimal contact with the 2,000 households under their responsibility. Making full, effective use of the spirit of commitment and dedication that was instilled in most FTOWs during their three-week training will require a redoubled effort by the POPCOM regional staffs, and some substantial new measure of support from POPCOM/Manila. The immediate problem of getting the FTOWs their first paychecks, which had not been solved before the team left the Philippines, will seem as a small difficulty in comparison to the magnitude of other management and supervision problems which seem to lie ahead for POPCOM and the provincial governments in administering the Outreach program.
- (4) Personnel selection criteria have not been scrupulously followed by POPCOM in the process of selecting personnel to staff the Outreach program. Since effectiveness in motivating for family planning in rural areas depends heavily on the FTOW gaining the confidence of the rural people, the selection criteria--laying heavy emphasis on recruitment of satisfied users and of local residents of the area involved--were the subject of extended negotiations between USAID population staff and POPCOM. Provincial officials and USAID staff both told the team of instances where POPCOM/Manila appeared to make exceptions to the agreed-upon criteria; but the team was unable to determine the extent of such exceptional personnel selections.
- (5) Hundreds of experienced motivators are not working in the Outreach program because the selection criteria effectively excluded them. Approximately 2,600 part-time motivators were laid off, at POPCOM's direction, in order to make way for the more than 3,000 Full-Time Outreach Workers in the Outreach program. About 2,100 part-time motivators, assigned at two per RHU, had had four years' experience working

for the Department of Health motivating, new acceptors around RHUs; about 500 part-time motivators had had several years' experience working for the DLGCD at the barangay level, motivating for family planning. Selection criteria for recruitment of FTOWs specified that they have at least two years of college, and, since experience was not considered a substitute for college education, very few of the laid-off motivators were selected to be FTOWs.

- (6) Participation of paramedical personnel in the family planning program has been seriously constrained by two factors: (1) lack of understanding by field personnel of the authority of paramedical personnel to dispense family planning methods and advice without the direct supervision of a physician; and (2) lack of contraceptive supplies at the barangay health station level. These two conditions were not found to be universal during the team's field visits, but they were noted often enough to impress upon the team that this is a serious problem. Moreover, the training of midwives through the IBRD-assisted program was generally considered by regional and provincial health officials to give family planning training that is insufficient to instill the necessary confidence in midwives of their actual authority to dispense oral contraceptives directly, independent of the presence of a physician. Although the team was advised that the National Family Planning Office of the DOH had issued guidelines for pill dispensing by paramedical personnel, field visits revealed that DOH regional offices, provincial offices, RHUs, and midwives are still generally unclear regarding the degree to which appropriately trained midwives can provide direct OC and IUD services without a physician's supervision. During the team's discussions with midwives in the field, it learned that this lack of clarification has caused anxiety at the RHU and barangay health station levels; it has also meant that midwives continue to be excluded from POPCOM contraceptive supply distribution systems. A senior officer of the Department of Health acknowledged that there was a communication gap on this issue.

d. Supplies, Equipment, and Logistics

CONCLUSION

In-country supplies of contraceptives are presently more than adequate at all levels; a considerable amount are stocked in Manila. POPCOM's ability to ensure timely delivery of supplies, however, is limited to the distribution of contraceptives; its slow distribution of medical kits to physicians trained in surgical contraception and to hospital-based clinics has constrained the progress in the sterilization program. The Outreach logistics plan warrants review of the FTOWs' role in the distribution chain. The lack of sufficient, reliable transport in the field is a potential constraint on implementation of the Outreach program and thus warrants careful review.

FINDINGS

(1) Oral Contraceptives

At current usage rates of approximately 500,000 cycles OC per month, the available in-country supplies of oral contraceptives (Norinyl) are sufficient for approximately three years. Supplies in clinics are generally sufficient for one year's requirements. In some places there appears to be an excess of Norinyl 1+80, but this is the exception rather than the rule. Occasionally we noted a small quantity of Norlestrin in clinics. The personnel stated that this was being used only for continuing Norlestrin users. As in other countries, there are persistent requests from clinic personnel for Ovrul.

(2) Condoms

Field supply of condoms became considerably constrained in CY 1976, in part because of the earlier

demands of PCF's commercial condom distribution program, insufficient funds for in-country shipment of contraceptives, and the relatively low receipts of additional condoms during CY 1976. In late CY 1976, 63,000 gross were received from Pathfinder Fund and 50,000 gross from FPIA. In January 1977, 200,000 gross arrived from USAID procurement, and an additional 200,000 gross will arrive before the end of the year from USAID procurement. Recent receipts and current pipeline therefore total 513,000 gross. According to USAID documents, in March 1977 the POPCOM warehouses had 83,000 gross and the field warehouses and clinics had 108,000 gross. Inspection of warehouses' stock cards indicated that there were 260,000 gross in POPCOM's Manila warehouse. This discrepancy could not be accounted for during the team's stay in Manila. Considering the central warehouse records plus the USAID judgments of field supplies, in-country stocks are therefore approximately 370,000 gross (not including the quantity being held in the PCF warehouse area for the redesigned condom commercial program. At maximum, there are approximately 150,000 condom current users. Current in-country stocks are therefore approximately 370,000 gross (not including the quantity being held in the PCF warehouse area for the redesigned condom commercial program). Current in-country stock is approximately that for 2.5 year's requirement at current usage levels. The arrival of the additional 200,000 gross later this CY will provide more than one year's additional supply. On the other hand, these will be needed in part to fill the BSP pipeline. Receipts of condoms beyond the 200,000 gross noted above will come either from a grant from FPIA or will be charged against the proposed contraceptive loan which may become effective during FY 78. FHC's field visits confirmed that condom supplies within the clinics are generally adequate.

(3) IUDs

IUD supplies are exceedingly abundant, but the supply of IUD inserters has been low recently. The program has recently received additional inserters, thus this no longer should be a constraint.

(4) Medical Kits

IUD sets are available in Manila, but have not received adequate distribution. Currently trained field midwives need these kits now, and more midwives theoretically will be trained for IUD insertion in the near future. Over 300 locally-assembled vasectomy kits are available for distribution; 24 percent are in Manila. Further, over 1900 additional vasectomy kits are available for distribution; of these, 40 percent are in Manila. Over 1200 mini-lap kits are available for distribution, yet over 50 percent of these are still in Manila warehouses. The slowness of mini-lap kit distribution acts as a significant constraint to the sterilization program. The laparoscope supply is considerably in excess of current usage and is adequate for those trained in their use. Some laparoscopes that have been distributed to service agencies have not yet been used. Many physicians indicated that the mini-lap kit was much more suitable for their preferences and requirements.

(5) Transport

POPCOM currently has 350 vehicles, but about one-third of this fleet is inoperative on any given day. In large part this is due to the heavy reliance on excess property vehicles provided by USAID. While the vehicles are available to USAID for USAID procurement at considerably reduced costs, the maintenance and repair costs to the POPCOM are very high. The Department of Health's Rural Health Units have very little available transport. Many RHUs have no vehicle. Motorcycles, generally of 75cc size, have been provided in small quantities but the availability is small in comparison to need. In one province we noted that the motorcycles were still unassembled due to the lack of funds for this purpose. USAID and POPCOM officials state that the planned Outreach Workers are expected to use public transport for their field requirements.

Judging from the field transport requirement of other Southeast Asian intensive field worker programs, the team believes that the current availability of four-wheel vehicles, motorcycles, and bicycles is inadequate. The degree to which field mobility and field supervision are constrained by inadequate transport in the implementation of the Outreach worker program warrants careful and periodic scrutiny.

(6) Logistics

The orderly and regular movement of consumable supplies throughout the archipelago presents an enormous challenge. Without reviewing the entire history of the logistics problems, the team can confirm--on the basis of visits to regional offices and clinics--that for the immediate future the flow of consumable products, i.e., contraceptives, is adequate. From the limited review, the team concluded that this has been accomplished by the massive distribution of contraceptives to regional offices, which in turn distributed the contraceptives directly to clinics. As noted in the section regarding medical equipment, there continue to be unidentified constraints in moving medical kits from POPCOM/Central to trained personnel. This deserves immediate attention.

Looking to the future, the team noted in the proposed Standard Provisions of the POPCOM/NEDA/USAID National Population and Family Planning Outreach Project Agreement that consumable contraceptives will be delivered using the following distribution chain: from the POPCOM/Manila office to POPCOM Regional offices to Provincial/City Population Officers to District Population Officers to Full-Time Outreach Workers (FTOWs) and then to clinics. This plan, if implemented, will place a considerable logistics burden on the FTOWs and may create a new constraint on the orderly resupply of oral contraceptives and condoms to clinics. The team believes that this proposed distribution plan should be reviewed carefully before implementation, and if implemented, be reviewed on a periodic basis, e.g., every three months.

2. POPULATION PROGRAM SERVICES

a. Fertility Control Services

CONCLUSION

A major characteristic of the Philippines population program has been the concentration of family planning services in urban and semi-urban areas. Studies have documented the powerful inverse correlation between

distance from the clinic and the rates of new acceptors and current contraceptive users. Oral contraceptives and IUD utilization has appeared to decline while other services, i.e., condom and sterilization, have increased over time. To the extent that services are available in rural areas, the site of the services has been the poblacion, or the urban portion of the municipality (U.S. county equivalent). Program leadership is now clearly aware of this deficiency, and numerous Filipino and donor agency groups are developing noteworthy efforts to provide services to the rural populace.

FINDINGS

(1) Oral Contraceptives

- (a) OC services within established service points are significantly constrained by two factors: a negative attitude against the OC by most, yet not all, clinical staff, and insufficient use of available paramedical staff for OC distribution. From our limited observations, the latter problem is receiving considerable attention; the former is not.
- (b) OC utilization has experienced the problems of side effects, compounded by the earlier frequent changes in OC brands. Within many clinics, the team noted a near total "mind set" against the OC because of the side effects. In others, the team noted that over sixty percent of the new acceptors were choosing the OC and that the level of continuing users was significant. Appropriate counseling for anticipating the side effects, in our opinion, accounts for the striking difference between these two situations. The team found little OC literature for acceptors' use dealing with side effects.

- (c) The availability of OC service is further limited by the insufficient utilization of appropriately trained paramedicals now employed in the health and family planning sector. While the prescription requirement for oral contraceptives no longer exists in the Philippines, there is considerable uncertainty among field physicians and midwives regarding the explicit position of the Department of Health toward this matter. For example, in Rural Health Units in several provinces, the team learned that midwives had been trained to provide oral contraceptives from their own individual Barangay Health Stations, but had not been given OC supplies, because neither the RHU nor POPCOM had received orders to provide them. With nearly every midwife interviewed, the team learned that they had been instructed to do a pelvic examination before providing the first cycle of oral contraceptives to new acceptors. In FHC's judgment, this procedure acts as a further barrier to easy accessibility. Indeed, pelvic exams should be an integral part of primary gynecological care, yet requirements for primary health care should not act as impediments to those who are willing to use an effective oral contraceptive, yet are unwilling to undergo a pelvic exam.
- (d) The team noted among several physicians, from both the private and public sectors, a willingness that lay personnel be allowed to provide oral contraceptives to new acceptors after an appropriate training course. A senior official within the Department of Health also acknowledged that the concept should be tested as soon as possible. A spokesman for the Philippine Medical Society indicated a willingness to test the idea and endorsed its implementation if appropriate training and evaluation were introduced.

(2) IUD

- (a) This component of the family planning program has received increasingly less attention, and has represented with each passing year a smaller part of the total fertility control effort. Until recently, only physicians were allowed to insert IUDs. In the recent past, selected midwives

were given comprehensive family planning training which included IUD insertion theory and practice. The expanding training program for both old and new midwives (assisted by IBRD financing) has not yet incorporated sufficient theory and practice for IUD insertions. Even among those who had the USAID-financed comprehensive family planning training, the midwives are reticent to insert IUDs because of the lack of direct, unequivocal instructions and authorities from the Department of Health.

- (b) IUD supplies on a national basis are exceedingly abundant, enough for 15-20 years use at current utilization rates. The distribution of IUD insertion kits, however, has been slow and, in some instances, represents a constraint against IUD insertions in a field setting where a midwife does home visiting. The supply of IUD insertors has been low, but plentiful supplies have recently arrived in the country.

(3) Condom

- (a) The major setback in the availability of condoms resulted from the failure of the PCF-assisted condom commercial distribution scheme. This program failed primarily because it was launched with an aggressive media campaign which placed what had been heretofore considered a "private" object too quickly before the public eye. Catholic lay groups were thus able to mobilize an effective opposition against what they called this "coffee shop approach" to the purchase of condoms. Some now argue that the opposition might have been mitigated if the lay Catholic groups, or at least the clergy, had been more fully briefed as to the intent of the project.
- (b) Associated with the condom commercial distribution scheme was a directive that clinics were to minimize the free availability of condoms. Clinics were directed to provide condoms on an interim basis, i.e., for three months, during which the clinic personnel were to motivate the acceptor to utilize a more effective contraceptive or buy their continuing supplies from the commercial sector.

- (c) Massive transfer of available condom stocks to PCF control further constrained the availability of condom supplies for clinic distribution. By mid-1976, approximately 25,000 gross were retransferred from PCF to POPCOM and by late CY 1976, new shipments of condoms had arrived and were distributed to the field. Although not announced throughout the population program system at the time of the FHC review, the POPCOM Board had reversed an earlier decision, and has adopted a liberal condom distribution policy: new or continuing acceptors can now receive continuous resupply of condoms in their clinic or resupply point.
- (d) PCF plans to develop a modified condom commercial distribution program but will limit the "experiment" to two provinces, not yet chosen. In those provinces, free condoms supplied through clinics and barangay resupply points may be curtailed to maximize the probability of success of the commercial distribution scheme.
- (e) Condom distribution will be further enhanced through the creation of Barangay Supply Points (BSPs), by the FTOWs in their communities. In the past, Barrio Resupply Points (BRPs) were established in some provinces by the DOH and by POPCOM's TIDA program. Though the number of BRPs is rather limited at the present time and establishment of BSPs was just begun, those provinces with a considerable number of BRPs, e.g., Nueva Ecija and Misamis Oriental, have shown considerable progress using this easy, inexpensive method of bringing condom supplies to rural populations. Similarly, the resupply-point concept within the Model City Program of Cagayan de Oro provides documentary evidence that the concept is feasible.

(4) Sterilization

- (a) The acceptance of sterilization as a contraception measure has increased over the past two years, though criticism from the Church is gaining some momentum, particularly because the Hierarchy believes that if it gives ground on this issue, abortion is next. On the other hand, the training/certification of

physicians and the creation of sterilization centers have not grown as rapidly as original projections. Tables 3 and 4, prepared by USAID/Philippines staff provide the most accurate picture of institutional capacity and available trained manpower. In summary, over 400 voluntary sterilization service centers are now established, and more than 500 additional centers are planned for CY 1977-78. To date more than 600 physicians have been trained for sterilization, yet more than half of these were trained for vasectomy alone, which currently represents only one-third of the sterilizations done per annum.

- (b) In addition to the constraint presented by open Church opposition, the sterilization program is hampered by the slow distribution of medical equipment (mini-lap kits), the sometimes slow certification of trained physicians (in one instance, a physician reported waiting more than one year following training by an itinerant training team for receipt of the certificate necessary for him to operate with sanction) and the urban and semi-urban locations of the available sterilization facilities. Some areas, e.g., the eastern sector of the country ranging from Eastern Luzon, through Bicol on to the Eastern Visayas, continue to have very scarce sterilization services. Some provinces still have no available female sterilization services. Though ample equipment for current and new future requirements is in the country, according to USAID data over 800 vasectomy kits and 700 mini-lap kits were in POPCOM/Manila warehouse on March 9, 1977. Many of these are urgently needed in the field.
- (c) On the more positive side, the team sensed considerable enthusiasm among program personnel regarding the emerging sterilization program. Indeed, in some areas that enthusiasm for sterilization may transform to a constraint if problems with other fertility control methods are neglected because of the narrow emphasis on sterilization.

TABLE 3

DEVELOPMENT OF INSTITUTIONAL CAPACITY FOR
PROVIDING VOLUNTARY SURGICAL CONTRACEPTION (VSC)
(1975-1980)

TYPE HOSPITAL	NO.	NUMBER PROVIDING STERILIZATION SERVICES						TOTAL
		ESTABLISHED		PROJECTIONS				
		CY 75	CY 76	CY 77	CY 78	CY 79	CY 80	
Provincial	61	16	16	29	--	--	--	61
Emergency	236	7	24	52	97	--	--	180
City	15	1	2	12	--	--	--	15
Other Government	55	14	11	19	--	--	--	44
Total Government	367	38	53	112	97	--	--	300
Private (1)	136	34	23	79	--	--	--	136
Total Hospitals	503	72	76	191	97	--	--	436
Gov't. Clinics RHUs/Others	1521	59	48	100	100	--	--	307
Private Clinics		85	104	63	--	--	--	253
Total Clinics		144	152	163	100	--	--	559
Total VSC Ser- vice Outlets		216	228	354	197	--	--	995

(1) Of 280 private hospitals with 25+ bed capacity offering maternity and OB/GYN services, 136 are presently deemed eligible to provide sterilization services.

Source: USAID Population Division

TABLE 4

PHYSICIANS TRAINED FOR
VOLUNTARY SURGICAL CONTRACEPTION
BY END OF CALENDAR YEAR

END OF CALENDAR YEAR	PROCEDURE			TOTAL PHYSICIANS TRAINED
	MALE ONLY	FEMALE ONLY	BOTH MALE & FEMALE	
1975 (1)	201	171	18	390
1976	101	71	58	230
1977	274	127	157	558
1978	100	--	180	280
1979	--	--	--	--
1980	--	--	--	--

(1) Includes physicians trained in calendar year 1975 and prior years.

Source: USAID Population Division

- (d) The vasectomy program clearly lags behind the female sterilization program, and the team noted very few efforts to close this gap. Numerous cultural and societal excuses were offered for the lagging interest in vasectomy, and regrettably no group was specifically identified as willing to engage actively in the promotion of the vasectomy program.
- (e) Following the issuance of a Presidential Decree, which became effective on January 1, 1977, the Medical Care Commission permitted reimbursements to hospitals, clinics, and physicians for sterilization procedures of enrolled members (Social Security System and the Government Services Insurance System, about 20 million members in all). POPCOM will reimburse medical facilities for sterilizations on a case by case basis. Government officials openly agree that duplicative payments for these procedures can occur because administrative guidelines between POPCOM, the Medical Care Commission and the participating clinic/hospital facilities have not been instituted.

(5) Abortion

- (a) Though there is some confusion regarding the legal definition of abortion in the Philippine Penal Code, for all intents and purposes, abortion is illegal. Yet reports of abortion activities exist in nearly all parts of the country. A recent case study on induced abortion, undertaken by the International Institute of Rural Reconstruction among 676 MWRA within five villages, indicated that:
- 38 percent had knowledge of how and where to obtain an abortion.
 - 49 percent approved of abortions.
 - 57 percent responded that performing an induced abortion is not illegal.
 - 17 percent experienced at least one induced abortion.
- (b) Discussions with a variety of physicians and midwives disclosed that the price for an abortion in rural areas ranges from P200-P500 (U.S.\$27-68).

In some areas the prices are based on ₱100 (\$14) per month of pregnancy. Within Manila, an abortion in a private hospital, with overnight stay, proper anesthesia and the latest techniques (suction) costs about ₱1500 (\$205).

- (c) Though abortion is "rampant" (as described by one physician), there are few studies regarding the incidence of abortion and the complications of inadequately performed abortions. In one rural clinic a chart graphically portrayed that one-third of maternal mortality in that area was secondary to septic abortion.
- (d) Among the many clinicians with whom the team discussed this issue, none knew of a criminal charge or conviction against a physician for performing an abortion. The reason: "No one will testify."
- (e) Abortion is condemned by the Roman Catholic Church, and the Philippines' Bishops have stood on this issue as strongly and as conservatively as the American Bishops. Since the passage of the Helms Amendment to the Foreign Assistance Act, AID is not financing abortion abroad. The subject is somewhat moot here; it is only mentioned because the Hierarchy in the Philippines relates their position on sterilization to their fear that abortion is next. The opening of a constructive dialogue with the Bishops on the mutual exclusivity of these two modalities is needed.

b. Contraceptive Service Systems

CONCLUSION

Services in early 1972 were directed toward urban and semi-urban population groups. The proposed Outreach Project (Phase II) and its development of BSPs have been designed as the corrective action for this deficiency. Current clinical services in urban and semi-urban areas

are not well dispersed, and in some cases these services are duplicative of other efforts.

FINDINGS

(1) Clinics and Hospitals

- (a) Single-purpose family planning clinics and integrated health clinics have been and currently are the mainstay of the contraceptive service delivery system for the Philippine program. POPCOM MIS data for September 1976 indicate that 2,312 clinics were in operation nationwide. Because of the lag in reporting, there may be slightly more than that figure. Of these, 59 percent are operated as Rural Health Units (RHUs), by the Department of Health (DOH); 16 percent as MCH and Family Planning Clinics assisted by the Institute of Maternal and Child Health (IMCH); 8 percent under the direction of the Department of Labor's (DOL) program with private and public industries, and three percent by the Family Planning Organization of the Philippines (FPOP). Collectively these four agencies assist or direct 87 percent of the family planning clinics. Another 19 agencies or governmental bodies assist or operate clinics, but obviously the Department of Health has emerged as the primary provider of contraceptive services. With respect to these four agencies, IMCH ranks 13th among 23 in terms of new acceptors per clinic for September 1976; DOH, 18th; FPOP, 19th; and DOL, 21st.
- (b) Most of the clinics visited by the FHC team (approximately 50) were neat, of simple structure, modestly equipped, and not very busy. Indeed, while more patients and acceptors were found in the clinics around 9-11 a.m., in no instance in rural areas was a clinic visited which was crowded. In all RHUs, family planning services represent a minor part of the total range of services provided.

Basic drug supplies were generally very minimal, yet contraceptive supplies were in great abundance. A notable exception was in Capiz Province, where drug supplies, contraceptives supplies, and equipment were in low supply.

- (c) The FHC team was struck (as have other review groups) by the proximity of clinics, under the same or different sponsorship, within a poblacion. In one instance (Iloilo Province) a RHU clinic and IMCH clinic are housed in the same building. Both provide family planning services. In another (Cebu Province) a poblacion has two RHUs for the entire municipality. The two RHUs are 500 yards apart and have divided the municipality into two geographic areas. Patients from one area are served entirely by one of the two. Numerous other examples demonstrating the concentration of health and family planning services could be cited.
 - (d) The hospital facilities which are involved in the sterilization program are reviewed in Table 3.
- (2) Barangay Supply Points/Barrio Resupply Points
- (a) One of the primary purposes of the Outreach program is to establish Barangay Supply Points (BSPs): volunteer-staffed contraceptive outlets within barangays, recruited and trained by the Full-Time Outreach Workers in cooperation with barangay leaders. This concept is designed to provide easy accessibility to contraceptives supplementary to the available supplies in clinics and at the emerging Barangay Health Stations (satellite units of RHUs).
 - (b) Barrio Resupply Points (BRPs) have already been established by POPCOM in most of the TIDA provinces. A USAID document dated December 1976 states that 530 BRPs were established by the end of CY 1976. From data in other documents it appears that about one-half of these BRPs are in the seven TIDA provinces, notably Misamis Oriental and Laguna. The DOH BRPs were located mostly in the provinces participating in DOH's "Team Leader" experiment. BRPs were labelled "resupply" points because at the time the concept was programmed, non-physicians had not been given authority to dispense pills directly to new acceptors. Previously established DOH BRPs also charged 35 centavos per cycle OC, with proceeds being kept by the distributor (BRP); POPCOM

BRPs have been staffed on a voluntary basis. DOH later made the 35 centavo payment optional for users.

- (c) In FHC visits to established BRPs (no BSPs have yet been established), the team found non-uniform records, but ones that were neat and adequate. Supplies of contraceptives generally appeared sufficient for one-two month's usage at current rates. The majority of users of the BRPs were continuing condom users. OC continuing users were uncommon; they apparently continue to obtain their supplies from RHUs or other family planning clinics. In the Cagayan de Oro Model City Program, the BRPs were provided special storage chests and "Blue Lady" emblems to decorate the chests and their homes, along with a certificate. These items were deemed of value by the program administrators for giving psychic compensation to those willing to participate in the program on a voluntary basis.
- (d) POPCOM plans to convert all BRPs in TIDA provinces to BSPs; in other provinces, where the DOH presently operates BRPs within their own administrative structure, POPCOM regional officials told the team that conversion of BRPs to BSPs will depend on the present BRPs being able to meet POPCOM's BSP selection criteria. (POPCOM officials in one region similarly noted that, although midwives in Barangay Health Stations might be well-trained and well-placed to serve as BSP for the immediate barangay, the requirement that she live in the barangay being serviced might prevent POPCOM from selecting her.) In one region, the BRP/BSP controversy took the form of POPCOM claiming that DOH's BRPs had been phased out (along with the part-time motivators) while the health officials of the provinces concerned claimed that the BRPs (61 of them) were still very active. In order to avoid unnecessary duplication of barangay supply points (midwives and BSPs side-by-side) and to prevent the waste of a trained, available resource (present BRPs), it will be necessary for someone--if not POPCOM--to coordinate the establishment of system of contraceptive supply points at the barangay level.

(e) It will be equally important for the BSP to receive a firmer foundation, in both ability and authority, to dispense contraceptives directly to new acceptors. While the team noted widespread interest in this concept, it also encountered opposition to it--particularly from the medical community and DOH. FTOWs have been provided a very minimal training in the dispensing of contraceptives, and it was probably not sufficient for a sound lay-person distribution scheme. Considerably more discussion and training are necessary if the planned BSPs are to successfully supplant the former role of the BRPs, and to substantially improve the accessibility of remote population groups to contraceptive supplies.

(3) Public and Private Sector

The Philippine National Population Program exists because of the extensive pioneering by private agencies: Family Planning Organization of the Philippines and its predecessor agencies, Institute of Maternal and Child Health (IMCH), and numerous others. Over the years, the Department of Health (DOH) gradually increased its role in the delivery of family planning services. By September 1976, approximately fifty percent of the available family planning clinic outlets were under the direction of the DOH. About 43 percent of the new acceptors for September 1976 resulted from activities in these DOH clinics. IMCH with 377 clinics (down from nearly 500 a few years ago) accounts for one fifth of the new acceptors in September 1976. Without elaborating on the critically important, historical role of private agencies, the FHC team notes a gradual decline in the private sector participation. If this continues, a valuable pool of reasonably flexible, energetic talent will be lost.

(4) Commercial Sales

The condom commercial marketing scheme sponsored by PCF completely collapsed, mainly due to an aggressive media campaign. As explained previously, this then allowed Catholic lay group opposition to coalesce around an issue the public itself was surprised to

find in the open marketplace. The team was told by PCF that a second attempt at commercial sales will be designed for a more limited geographic area, perhaps in only two provinces.

Despite several attempts, the FHC team was unable to gain a full understanding of the total volume of oral contraceptive and condom sales through private sector commercial channels. Our visits to drug stores in both rural and urban areas documented that a variety of oral contraceptives and condoms are available for sale.

(5) Household Distribution by Project Compassion

- (a) Of growing interest and considerable controversy within GOP agencies and USAID are the emerging Project Compassion activities within selected areas. (Project Compassion is described in detail in Annex A). This program is under the direct sponsorship of the President's wife, Mrs. Imelda Marcos, and seeks to use "one channel" to provide four specific door-step services: improved nutrition, backyard gardening, family planning and improved sanitation. The program is directed by a very capable and dynamic individual with long experience in local government and community development activities.
- (b) Following agreement between POPCOM and Project Compassion (PROCOM), oral contraceptive supplies and condoms were provided from POPCOM to PROCOM for field distribution in those ten provinces where PROCOM had initiated its program. Within Iliolo Province, PROCOM has initiated the household distribution of oral contraceptives and condoms in some but not all of the municipalities of that province. A FHC team member followed the supply through the province to municipality to barangay levels, reviewing records and discussing issues. In this particular municipality, the RHU physician had insisted that the lay workers not distribute oral contraceptives. The physician indicated that he did not believe that lay persons (or paramedicals) could adequately assess the "cancer scare" potential of new acceptors. PROCOM officials accompanying FHC indicated

that similar action had been taken in other municipalities, but in still others they had been successful in providing a three-month supply of both oral contraceptives and condoms to most eligible households.

- (c) Further agreement between POPCOM and PROCOM will allow PROCOM to be the primary rural contraceptive delivery system within its ten provinces, utilizing workers trained in the four fundamental subjects mentioned above.

Current activities at this time are oriented more toward "contraceptive input" than toward "contraceptive-use output," but nonetheless may become one of the largest household distribution projects in Southeast Asia.

c. Information, Education and Communication (IEC)

CONCLUSION

A review of survey data indicates that enormous gains have been made in educating and informing, particularly the urban and semi-urban middle and upper classes; yet they substantiate that a considerable deficiency in family planning knowledge and attitudes exists among certain population segments: those living in remote rural areas with less educational attainment and lower literacy. Control of rumors has not been adequate and accounts in part for the increasing negative attitudes toward the oral contraceptives. As the entire program enters a rural orientation, so must there be a new rural focus to the IEC written and mass media. We note that other reviewers have emphasized the same point.

FINDINGS

- (1) The printing and layout technical quality of the IEC written materials (brochures, pamphlets) appears to be of very high standards.
- (2) Within rural clinics, however, the materials are in short quantity and often are not available in the locally spoken dialect. In some instances the material is available in a dialect that is understood locally yet one which is not commonly used in that area.
- (3) Clinic and field staff complain that Manila-based dialect translations do not conform to local usage of the dialect and, as a result, read awkwardly.
- (4) Clinic available IEC materials generally carried a picture of a couple or people, nearly always dressed in the style of the middle class. When asked repeatedly if villagers' clothes and hair styles were as the pictures, the answer was in the negative.
- (5) FHC noted few materials that deal specifically with the use of specific contraceptives and no materials that were designed to counteract both the rumors and realities of OC side effects.
- (6) Clinic personnel for the most part acted resigned to the OC side effects and only occasionally did we meet an individual who aggressively pursued sound health education techniques to assist a user with the temporary side effects of the OC or IUD.
- (7) Radio spots were generally judged by clinic staff and rural field staff to be useful. Most survey data indicates that radio is the most effective means of mass media.
- (8) Radio "soap operas" have been and continue to be developed for the family planning program. These are then "sold" to various advertising sponsors and placed on radio.

- (9) In one region, the IEC radio materials carry an extremely "soft sell" approach. The IEC Coordinator indicated that the radio soap operas will not refer specifically to family planning, contraceptives or POPCOM. He and his colleagues believe strongly in the TIDA concept: that an individual who understands his needs will eventually find family planning services and that the specifics of family planning can be provided best through the face-to-face contacts at the barangay level rather than through mass media.
- (10) FHC notes that an earlier plan to include IEC components in Phase II of Outreach has been deleted. Other donors and POPCOM must ensure an adequate input of IEC to support the programmatic field efforts, especially as these efforts are related to rural residents who are less well-educated than those who constituted the target population group in the period 1970-1974.
- (11) Interviews with newspaper editors in Manila indicate that IEC will have to be particularly well-designed for rural areas to dispel adverse "grapevine" publicity dealing with the side effects of OC use and IUD insertions.

3. PROGRAM MANAGEMENT

CONCLUSION

Supervision and management of the population program at the central level have been persistently weak and ineffective, at least for the past two years (1974-1976). The Commission on Population itself, however, cannot be said to be solely responsible for the broad range or the seriousness of the management problems. The lack of consistent and forceful organizational leadership within the top levels of the Philippines government, the changing policies and personalities representing foreign donor

support, and the bureaucratic complexity of the evolving program have all combined to produce a series of management ills, most of which have yet to be corrected. Because the population program has become such an extensive effort, involving the implementation of numerous detailed policies by almost every agency of the government, the team was unable to assess the management problems in exquisite detail. However, a general profile of the management deficiencies of the program can be summarized as follows:

- (1) Conflicting interpretation--by the POPCOM Secretariat, the POPCOM Board, NEDA, and higher government authorities--of POPCOM's specific authority in the overall planning and implementation of the population program (as defined in law by P.D. 79).
- (2) Lack of a clearly defined management role for POPCOM as "coordinator" of the programs of the participating agencies, leading to a lack of true coordination of field activities.
- (3) The diffuse nature of accountability--at all levels--for population program performance.
- (4) Lack of a systematic organizational process for analyzing management information, making decisions on policies and programs, executing those policies and programs in the field, and receiving feedback from the regional offices.
- (5) Fragmented and overlapping administration of programs, due in part to POPCOM's having control over logistics and funding (for participating agencies) without clear authority for actual program implementation.
- (6) Utilization of program-relevant social science and demographic research below its full potential as a management tool.

FINDINGS

- (1) Specific definition and delegation of authority to POPCOM for overall planning and implementation of the population program have been subject to conflicting interpretation for several fundamental reasons:
 - (a) Since the Commission on Population was originally constituted as an operational agency by Executive Order No. 171 in 1970, the governing structure of POPCOM has been revised several times; these changes resulted in explicit and implicit changes in policies and programs, but with no consistent interpretation of its authority.
 - (b) The mandate provided to POPCOM in 1972 (under Presidential Decree No. 79), when the government initiated large-scale budgetary support for population planning, delegated such a broad range of "duties and powers" to POPCOM--some of which apparently conflicted with statutory authorities of participating agencies (e.g., POPCOM was given authority "to employ physicians, nurses, midwives to provide, dispense, and administer all acceptable methods of contraception to all citizens...")--that it lost its usefulness as a document clarifying POPCOM's authority. The explicit language did not represent a true consensus among policymakers.
 - (c) The extent of POPCOM's actual authority was often determined by the outcome of an ad hoc, ongoing bargaining process among the participants of the program: NEDA, POPCOM, the foreign donors (principally USAID), and the participating agencies. Since the participants in this process rarely had a common perception of POPCOM's authority and function, the results of the bargaining often led to shifts in POPCOM's operations and policies--some dramatic, some subtle--without any clarification of its true authority.
 - (d) NEDA, the POPCOM Board, and the participating agencies have traditionally viewed POPCOM's role as "central coordinator" of the population program, responsible for "orchestrating" the efforts of the participating agencies. This role implies, perhaps quite deliberately, an indefinite degree of authority over the participants in the program; "coordination" is actually a

process or an objective, and does not indicate any specific authority.

Some examples of the implications of POPCOM's lack of consensus on its authority are as follows:

- Since its inception in 1972, the WHO/UNFPA Maternity-Centered Family Planning (MC-FP) Project had been operated independently of POPCOM, with funds flowing directly through NEDA to DOH, because the WHO refused to coordinate its assistance with any agency other than its sister agency, the Department of Health.
- After deciding to work through POPCOM for a renewal and expansion of the MC-FP, the UNFPA and DOH were unable to get such a project considered by the POPCOM Board, even though as many as six proposals of varying sizes were presented to the POPCOM Executive Director. Finally, the WHO/UNFPA project was supplanted by the USAID-assisted hospital-based project which is implemented through POPCOM.
- NEDA, and higher authorities within the government, agreed to the World Bank's plan to involve POPCOM only peripherally in the implementation of its \$25 million population loan. Presidential Decree No. 568 (dated 24 October 1974) was promulgated to specify the appropriation of the government's \$25 million contribution and to create specific authority for a Project Management Staff within the office of the Secretary of the DOH to implement the project. The P.D. required the coordination of the PMS and POPCOM, as did the loan agreement, but gave the POPCOM no authority or role in the operations or funding of the project.
- The policy and program preferences of key personalities and foreign donors (namely USAID) have been significant in POPCOM's assumption of specific authorities. A former executive director was able to put into effect policies and programs significantly different from those outlined in the four-year plan that had been designed by his predecessor and approved by the Board. With USAID assistance, POPCOM's Executive Director designed the Outreach program to "be

implemented (nationwide) by the Commission through its regional offices in coordination with local governments." Almost four months after signing the Project Agreement that included the above statement, the POPCOM Board repudiated the plan, arguing that POPCOM has no authority to "implement" programs, only to "coordinate" them, and that the program needed to be tested before being implemented nationwide. The Board subsequently agreed to nationwide implementation after USAID informed it that it had no choice, but the Board made it clear that local governments would "implement" the Outreach program since POPCOM had no "implementation" role.

(2) In the absence of specific, agreed-upon authority and clearly defined functions, POPCOM's role as an "umbrella agency," "coordinating and integrating the multiagency participation in the population program," has proved to be a difficult one. Creating an agency for "coordination" of a number of other agencies does not confer any inherent management or administrative functions on such an agency, especially in the absence of specific authority. "Coordination" could conceivably occur without creating an agency responsible for it. Each POPCOM Executive Director has searched for some adequate definition of POPCOM's role that might give some stability and permanence to its identity within the government bureaucratic structure:

- The present Director has called POPCOM a "broker/contractor," responsible for matching funds with the projects of other agencies and local governments working in family planning.
- His predecessor had programmed a new direction for POPCOM called the "Total Integrated Development Approach" (TIDA) which sought "to shift the approach from what had been dominantly a contraceptive-oriented program to a concept-oriented program..." explaining it in PCF's quarterly magazine as follows:

"The National Population Program has grown to such proportions that the existing level of planning, coordination, monitoring, and control has become inadequate...(in carrying

out its tasks the Commission has asked itself a number of questions)...Can the Commission carry out its objectives by merely orchestrating the development and administration of individual and joint projects? Or by merely riding on the population programs of other government and private agencies? Shouldn't the program have to stand on its own feet, have its own population and family planning structures through which barangays, barrios, and municipalities can be motivated, serviced, and monitored?"*

No direct answer was given to these rhetorical questions, but the article went on: "To respond to these operational problems, POPCOM has come up with TIDA, which it is currently implementing in seven pilot provinces."

- This Director's view of POPCOM's role was in contrast to that of his predecessor, who wrote, in POPCOM's "Four-Year Population Program, 1974-1977" report, explaining his view of "The Role of the Commission on Population:"

"Amidst all these plans, programs, and projects, there is need to restate clearly the role of the Commission. As in the past, this four-year program perceives the primary role of the Commission to be that of a central coordinator, orchestrating the development and administration of individual programs. While it remains as the central policymaking, planning, and funding agency of the government for population matters, it will refrain from direct implementation of projects and continue to utilize existing resources in all sectors of the community. Coordinating the various elements of a diverse and complex program into a meaningful and effective whole is the key role of the Commission on Population."**

* Amadis Ma. Guerero, "Beyond Population, Beyond Family Planning: The Commission on Population's Total Integrated Development Approach," Initiatives in Population, Vol. 2 No. 1, March 1976, pp. 9-11.

**Commission on Population, Republic of the Philippines, Four-Year Population Program '73-'74 Through '76-'77, Manila: POPCOM, 1974, p.19.

POPCOM's inability to define, to its own satisfaction, the detailed programmatic objectives of such a role in terms of their required day-to-day management functions was one of the reasons that "coordinating the...elements...into a meaningful and effective whole..." became an elusive organization goal. To be able to justify organizational success, POPCOM would have had to show that it had achieved "effective coordination" even if the "parts of the whole," e.g., clinical services run by IMCH, DOH, etc., had not been effective in implementing their own programs. When the only program outcome measures available showed new acceptors plateauing and services failing to reach rural areas (did this mean a failure of "coordination" alone?), the conclusion by POPCOM's former Executive Director that "the existing level of planning, coordination, monitoring, and control has become inadequate" may have been an apt diagnosis, but was not one which necessarily implied the cure prescribed (TIDA).

- (3) Accountability for program outcome and achievement of targets has been diffused among the many agencies at all levels of the program. As "central policy-making, planning, and funding agency" for the program, POPCOM appeared to assume responsibility for the results of programs being implemented by other agencies, even though a role as "coordinator," and especially as "broker/contractor," would not require such assumption of responsibility. By adopting a central, commanding role in the program, however, POPCOM in effect encouraged the participating agencies to expect POPCOM to be accountable for their programs' performance. This had real impact in the field. Participating agencies operated independently of the POPCOM regional offices (the POPCOM regional offices having no budgetary, administrative, or other authority over the line agencies), while POPCOM considers itself responsible for the program results, which it has conscientiously collected and tabulated, in terms of new acceptors, on its management information system. When the acceptor data and survey results showed the overall program to be stagnating, rather than call the agencies to account, POPCOM took it upon itself to create a program response independently of the agencies. The TIDA experiment, a quasi-prototype for the subsequent nationwide Outreach program, met resistance from POPCOM's partner agencies, because they believed POPCOM was usurping their functions.

- (4) There has never been a systematic organizational process--including both POPCOM and the partner agencies--for reviewing and analyzing available management information, for making decisions on policies and programs, for executing those policies and programs in the field, nor for receiving feedback from the regional offices.
- (a) POPCOM's computerized information system receives a variety of data on new acceptors by method by clinic, and on contraceptive stocks and flows by clinic. This information is reported monthly from all participating service delivery points in the family planning services program. In general, however, POPCOM's MIS has not been used for regular monitoring, review, or program/policy formulation purposes. Program service statistics generated by the system have included some degree of over-reporting. Even in unadjusted form they have not been made available to POPCOM's regional offices. The National Family Planning Office of the DOH continues to keep hand-tabulated records of acceptor information for its own clinics, even though this duplicates a service POPCOM performs, but does not share, with NFPO/DOH. The regional service agencies, and all provincial level offices, never have received any POPCOM program service statistics. The result has been that program and management decisions have been routinely taken by agencies without reference to basic program information that is available. The shift in emphasis on POPCOM's revised MIS--from recruitment of acceptors to continued protection of continuing users--may provide more policy- and program-relevant data, but the distribution and effective use of the information generated deserves more attention.
- (b) Mechanisms for policy development and program design within POPCOM, although incompletely institutionalized or formalized in early years, became internal, closed processes--often divorced from pragmatic considerations of day-to-day management needs--over the past two years. USAID, the participating agencies, and to some extent even POPCOM's Board of Commissioners, were not fully informed about the nature or dimensions of POPCOM's internal program plan-

ning exercises through 1975 and into 1976. During 1976, as experienced senior-level staff resigned from POPCOM, they were not replaced with personnel of equal competence; some slots remained vacant for months, and are only now being filled by the new Executive Director. Because of these shortcomings, when the POPCOM Board voted to curtail the Outreach program on October 6, 1976--in effect repudiating the Project Agreement between POPCOM and USAID--the POPCOM central office all but suspended operations until a new Executive Director took office on March 1, 1977. During this time, implementation of the Outreach program was in its most critical early stages: training and posting of some 3,500 FTOWs and their supervisors were underway in the regions, and the negotiations of some 130 sub-agreements between POPCOM and the provinces and chartered cities were being undertaken by regional staffs of uneven quality and experience.

- (c) The lack of an organized mechanism for the transference to field levels, of both POPCOM and the participating agencies, of statements of agreed-upon policies, procedures, and programs has resulted in counterproductive confusion and misinformation in the field offices of all agencies concerned with the family planning program. In FHC field interviews, most individuals who talked about this subject acknowledged that information on policies and procedures most often came in meetings, letters, telephone calls, telegraph messages, and memoranda. Very few could produce a file of the collective set of policies and procedures for the program, or its components, and those that could produced files which contained memoranda about policies which were conflicting or out-of-date. A large training manual has been developed and printed for use by FTOWs and their supervisors; it provides specifics regarding employment and personnel policies, training information, financial and logistics systems, contraceptive information, and general administrative data governing all aspects of the program. This manual might provide a nucleus around which a more complete set of POPCOM policies and procedures could be developed.

FHC was much encouraged in discussion with the new Executive Director to hear his concern for and plans to resolve this deficiency.

- (5) Although a certain degree of program coordination has taken place at the central level, the vertical, from-top-to-bottom, centralized form of organization of most participating agencies has greatly complicated coordination of field operations. The fragmented administration and functional duplication of programs at the regional level and below have been persistent deficiencies of the program. Participating agencies are only beginning to regionalize operations; in the meantime, POPCOM's efforts to coordinate agencies at a regional level down to the barangay level have complicated matters further. POPCOM's control of logistics and supply of contraceptives has in some areas made the service agencies resentful, and the rapid implementation of the Outreach program has often taken place without consulting or informing the provincial representatives of the participating agencies. Giving governors administrative control over the provincial population programs and the FTOWs will tend to further aggravate bureaucratic confusion; none of the provincial level representatives of the participating agencies are under the authority of the provincial governor.
- (6) The promotion and utilization of relevant demographic, social science, and operationally-oriented research have not reached their full potential as important management tools.

The Philippines, more than any other Southeast Asian country with a strong population policy, has had the benefit of a strong social science expertise--as demonstrated by individuals and institutions who have broadened the basic demographic characteristics. Annex B, "The State of Knowledge About Population and Family Planning Matters," summarizes briefly the variety and depth of these studies.

While this growth of institutional capability is heartening, on the basis of the team's brief contact with researchers and program managers, the impression was that a significant portion of the institutional research was academic and of little immediate value for program policy or operation.

Perhaps as the etiology of this, some observers note an inadequate communication or understanding between some researchers and program managers. An immediate problem is the need for closer collaboration among researchers and program managers: The Seva Area Study results provided very useful information, but the reports' format and the degree of coverage for the reports vary considerably among the three research institutions, making utilization by program agencies difficult.

The primary motivation for program-oriented, innovative research, i.e., program development, appears to lie with the Population Center Foundation, a non-government agency. But well-tested innovations must eventually be incorporated into public programs. Avenues for dialogue between PCF and POPCOM on these and other issues certainly exist, but the division of labor requires that communication be free and continual.

From FHC's limited observations, it was noted that program field testing (pilot tests) were incorporated into the planning process, but the team found no overall GOP effort to guide and enhance the type of operationally oriented research that could prove useful to an understanding of issues raised in this report and other reviews, e.g., the effect of rumors, lay distribution of oral contraceptives, and the degree of constraints resulting from inadequate field transportation.

With regard to a specific component of the current program, several operational problems will no doubt arise within the Outreach Program. At present, the team could discern no planned method to analyze a specific problem and rapidly field test an alternative as a means of resolving the problem. Issues of population coverage per FTOW, and of volunteer BRP/BSP staff versus "compensated" BRP/BSP staff are two problems that might emerge early in the implementation. Program management staff will require resources and identified research or evaluation capabilities to respond to these and other similar problems. The proposed USAID Project Paper includes a modest amount of funds for operations research, but the team was unable to identify a framework for allocating these resources.

C. SYSTEM PERFORMANCE

MEASURES OF PROGRAM PERFORMANCE

a. New Acceptors

New acceptors by contraceptive type, service agency, and geographic areas are reported to and analyzed by POPCOM's Management Information System (MIS).

New acceptors grew from approximately 10,000 per month in early 1970, increased monthly to over 50,000 per month in 1972, and generally fluctuated between 50,000-60,000 per month during 1973-1974 and thereafter.

Characteristically, December-February has been the low new-acceptor achievement months, while August-November are the better performance months. The spread from low to high performance months within a given year has not been as extreme as noted in other Southeast Asian programs, e.g., Indonesia.

Table 5 provides an overview of the annual incidence of new acceptors from CY 1970 through CY 1976. In essence, annual totals of new acceptors have been approximately 700,000 per year in each of the four CYs since 1973. This static annual incidence of new acceptors,

TABLE 5 NEW ACCEPTORS* BY YEAR, METHOD, AND REGION

REGION	NEW ACCEPTORS	PERCENTAGE DISTRIBUTION BY CONTRACEPTIVE TYPE							NEW ACCEPTORS AS PERCENT OF MWRA (15-44)**
		OC	IUD	Condom	Female Steril.	Male Steril.	Rhythm	Others	
I	56,110	46	5	37	3	<1	7	2	15
II	25,810	54	4	32	1	2	4	4	11
III	71,500	51	7	29	7	1	3	3	13
IV	225,860	41	8	31	12	2	4	2	18
V	54,010	48	4	32	1	<1	12	3	14
VI	48,280	41	5	31	2	3	10	8	11
VII	59,350	35	8	37	3	1	10	5	15
VIII	29,830	37	5	37	2	2	12	4	7
IX	23,090	46	8	30	1	1	10	4	8
X	55,200	45	6	27	3	1	14	3	12
XI	54,920	47	9	28	5	2	6	3	12
TOTAL CY 1976	703,960	44	7	31	6	2	7	3	13
1975	728,065	49	7	27	3	1	8	5	14
1974	751,268	51	10	24	-	-	9	5	15
1973	736,621	55	14	19	-	-	9	3	15
1972	616,938	56	15	16	-	-	11	2	13
1971	404,271	59	21	4	-	-	14	3	9
1970	172,960	53	23	5	-	-	17	3	4
Cumulative	4,111,081								

* Includes all new acceptors reported by Program Clinics. Approximately 15-20 percent of these indicate that they have previously attended a family planning clinic. "Overreporting" may be as high as 30 percent.

** Calculated for CY 1970 through CY 1975 by using 1976 MWRA of 5,274,521 and assuming its growth had been at the rate of 2.8% per year since 1970.

out of a continuously growing number of married women of reproductive age (MWRA), has resulted in a slight decrease in the rate of new acceptors in recent years: from 15 percent of MWRA in CY 1973 to 13 percent of MWRA in CY 1976. However, the level of "overreporting," including "ghost acceptors--transferrees from other family planning clinics and duplicates," as documented in the 1974 National Acceptor Survey (NAS), is of considerable significance and may alter the apparent small changes.

The report states:

"The implicit overall level of overreporting for the entire sample was 36.8 percent. This is probably the best estimate of overreporting among acceptors nationally. Further analysis indicated wide variations in overreporting by method:

Pills	30.5 Percent
IUDs	23.6 Percent
Rhythm	60.8 Percent
Condoms	52.2 Percent
Others	55.7 Percent

Because of the shift over time from IUD to condoms, the overreporting rate may have increased between 1970 and 1975; however, the estimated increase was not great and might have been entirely cancelled by the concurrent increase in DOH clinics, where overreporting was lower than average."

Assuming that the levels of overreporting were somewhat stable over time, the reader can note from Table 5 the gradual decrease in the percentage of new oral contraceptive users among all new acceptors from the mid 50 percent in

the early 1970s to 44 percent in 1976; the percentage of new IUD acceptors dropped from over 20 percent in the early 1970s to 7 percent in 1976; the percentage of new condom acceptors increased dramatically from 5 percent in 1970 to 31 percent in 1976; the percentage of new other (withdrawal, foam preparations, etc.) has remained relatively stable; and the percentage of rhythm new acceptors had declined from 17 percent in 1970 to 7-9 percent over the past four years. Female sterilizations in CY 1976 comprise 6 percent of new acceptors; male sterilization new acceptors, 2 percent. These sterilization rates approximately doubled in the period CY 1975 to CY 1976.

Table 6 provides a review of the age-parity changes of new acceptors in the CY 1970 through CY 1976 period. With every fertility control method, there has been a gradual yet consistent decline in both the median age and median parity (living children) of new acceptors. The 1976 all new acceptor median age is 27.8 years, down nearly three years from 1970; the 1976 all new acceptor median parity (living children) is 2.7, down 1.4 from 1970. For both median age and median parity, the oral contraceptive and IUD new acceptors are lowest, followed by condom and rhythm new acceptors. As expected and as

TABLE 6 AGE-PARITY ANALYSIS OF NEW ACCEPTORS

	CY 70	CY 71	CY 72	CY 73	CY 74	CY 75	CY 76
ORAL CONTRACEPTIVE NEW ACCEPTORS							
Median Age	29.7	29.4	29.0	28.4	27.6	27.1	26.6
Median Parity (Living Children)	4.0	3.9	3.6	3.3	2.9	2.6	2.4
IUD NEW ACCEPTORS							
Median Age	30.7	29.8	29.6	28.8	28.2	27.5	26.9
Median Parity (LC)	4.3	4.0	3.9	3.6	3.2	2.9	2.6
CONDOM NEW ACCEPTORS							
Median Age	31.9	31.5	30.9	30.3	29.9	29.2	28.3
Median Parity	4.3	4.2	3.8	3.6	3.3	2.9	2.7
RHYTHM NEW ACCEPTORS							
Median Age	31.8	31.7	31.8	31.6	30.7	30.0	28.9
Median Parity	3.9	3.8	3.7	3.6	3.4	3.1	2.7
FEMALE STERILIZATION NEW ACCEPTORS							
Median Age	NA	NA	NA	NA	32.6	32.6	32.5
Median Parity					4.8	4.6	4.5
MALE STERILIZATION NEW ACCEPTORS							
Median Age	NA	NA	NA	NA	34.1	33.8	33.4
Median Parity					4.9	4.4	4.3
OTHER NEW ACCEPTORS							
Median Age	31.8	31.8	31.8	31.4	31.1	28.7	28.1
Median Parity	4.3	4.1	3.9	3.7	3.7	2.9	2.7
ALL NEW ACCEPTORS							
Median Age	30.5	29.9	29.7	29.2	28.6	28.2	27.8
Median Parity	4.1	3.9	3.7	3.4	3.1	2.9	2.7

NA: Not available

SOURCE: MIS/POPCOM

usual, sterilization acceptors are of the highest median age and parity.

Current data regarding the socioeconomic characteristics of new acceptors are not available.

With regard to the geographic dispersion of new acceptors, the new acceptor rates by regions indicate lower rates for Region 7 (Central Visayas) and Region 8 (Eastern Visayas). Of even greater importance is the marked differential of new acceptor rates between urban and rural, or more specifically as a function of the distance from the clinic, which until recently was nearly always located in the poblacion, the urban part of the municipality. The 1973 National Demographic Survey (NDS) data demonstrated a nearly twofold difference between rural and urban ever users and current users. Yet, the differential between awareness of rural populations and the awareness of urban populations was relatively small.

As noted earlier, FHC concurs with the belief of several program administrators that the new acceptor rates will drop further in 1977, primarily because of the loss of the part-time motivators from the DOH clinics in December 1976, several months prior to the deployment of the Full-Time Outreach Workers. This judgment is based primarily on examination of the November-December 1976

compared with January-February 1977 records of those clinics visited by the FHC team members.

Further, the team noted that new acceptors are not infrequently designated as condom new acceptors, although they intend to return within a few weeks to change to the OC or IUD after the menstrual period has been confirmed. Hence, the reported new condom acceptor rates may overstate their use while the OC and IUD new acceptor rates may perhaps be understated.

b. Contraceptive Effectiveness

The 1974 National Acceptor Survey (assessing a sample of new acceptor cases reported in CY 1970-1972) concluded that IUD acceptors consistently had the highest first method continuation rates and the lowest pregnancy rates. Condom acceptors had the lowest continuation rates and the highest pregnancy rates. "Pill and rhythm rates generally fell approximately midway between these two extremes and were similar to each other; neither was consistently higher than the other."

Combining the expected period of protection per acceptor and the effectiveness (i.e., the degree of fertility reduction when the contraceptive is being used) of the contraceptive, Laing calculated the months of effective protection following acceptance (but before becoming pregnant).

His results were as follows:

<u>Method</u>	<u>Months of Effective Protection (MEP) From First Method Only</u>	<u>MEP From First or Later Methods</u>
Oral Contraceptive	21.4	29.1
IUD	41.5	61.9
Rhythm	21.8	26.3
Condoms	4.8	11.0

In terms of MEP, the IUD was twice as effective as the OC, OCs and rhythm were about equally effective, and condoms were by far the least effective method.

Family Health Care cautions the reader that these data do not indicate that the theoretical effectiveness of the rhythm method is high, but rather than the continuation rates and appropriate use of the OC have declined to the point that it is now equal to the pregnancy protection provided by the rhythm method.

This study, based on a sample of CY 1970-1972 new acceptors, did not provide an opportunity to assess sterilization acceptors because the sterilization program had not yet been initiated on a significant scale.

c. Prevalence of Fertility Control Users

Though the program administrators had placed heavy emphasis on the enumeration of new acceptors in early

years of the program, there is now a commitment to utilize the prevalence of current contraceptive use as the primary program monitor. The modified management information system, now in field testing, places a much higher and more well-defined emphasis on measuring the number of couples currently protected from the risk of pregnancy.

The historical record of contraceptive prevalence rates in the Philippine program provides only reflections, in that the various means used to estimate contraceptive use prevalence have provided considerably contradictory results.

The 1968 National Demographic Survey (NDS) disclosed contraceptive prevalence of approximately 16 percent of married women aged 15-44. The 1973 NDS, using different questions and probably measuring only program-obtained methods, indicated a current contraceptive prevalence of approximately 19 percent of married women aged 15-44.

Estimates of current contraceptive use by Zablan at UPPI for 1973 and 1975, based on POPCOM MIS data (adjusted for overcounting, sterility, mortality, method shifts, and continuation rates), provide contraceptive prevalence rates of about six percentage points below the survey data for 1973 and 1976, i.e., 13 percent in 1973 and 16 percent in 1975.

The preliminary analyses of the Seven Area Survey provide the most recent survey data. These seven provinces were selected for the survey primarily because the provinces were TIDA (Total Integrated Development Approach) provinces. The seven provinces do not represent a random sample useful for a national estimate, yet the seven provinces do represent the general spectrum of more and less prosperous provinces.

Listed below are the contraceptive prevalence rates from the 1976 (January) Seven Area Survey:

<u>Province</u>	<u>Within Region</u>	<u>Contraceptive Use Prevalence</u>
Pangasinan	1 (Ilocos)	20.1
Nueva Ecija	3 (Central Luzon)	22.1
Laguna	4 (Southern Tagalog)	30.1
Capiz	6 (Western Visayas)	18.2
Negros		
Oriental	7 (Central Visayas)	31.8
Southern		
Leyte	8 (Eastern Visayas)	33.1
Misamis		
Oriental	10 (Northern Mindanao)	<u>30.2</u>
	AVERAGE	25.2

Because of the significant role of the rhythm method and withdrawal as "countable" program methods, it is essential that the disaggregated prevalence rates be examined. With reference to the seven provincial studies noted above, the prevalence of contraceptive use varies from 18 percent (Capiz) to 33 percent (Southern Leyte); but 33 percent of

the Capiz prevalence rate is comprised of rhythm current users, and 42 percent of the Southern Leyte contraceptive rate is made up of rhythm current users. The current contraceptive prevalence rates by fertility method type vary as follows:

- OC: 4 (Capiz) to 14 (Laguna) percent
- IUD: 1 (S. Leyte) to 4 (Laguna and Misamis Oriental) percent
- Rhythm: 2 (Nueva Ecija and Pangasinan) to 14 (S. Leyte) percent
- Condom: 1 (Laguna and Capiz) to 2 (S. Leyte, Misamis Oriental and Negros Oriental) percent
- Sterilization: 1 (Capiz and Pangasinan) to 3 (Laguna) percent
- Withdrawal: 2 (S. Leyte) to 6 (Nueva Ecija and Capiz) percent

For the seven provinces, the average prevalence of current use estimates are:

OC:	10	percent	of	MWRA	(aged	15-44)
IUD:	3	"	"	"	"	"
Rhythm:	6	"	"	"	"	"
Condom:	1+	"	"	"	"	"
Sterilization:	2	"	"	"	"	"
Withdrawal:	4	"	"	"	"	"
Others:	<u>1</u>	"	"	"	"	"

25 (Does not sum due to rounding and weighting.)

In comparing the January 1976 Seven Area Survey (SAS) with the September 1976 POPCOM MIS data (Table 7), several differences become apparent. Some, but not all, might be

TABLE 7 ESTIMATED PREVALENCE OF CONTRACEPTIVE USE

	SEPT. '74	SEPT. '75	SEPT. '76		
	Users (000s)	Users (000s)	Users (000s)	Percentage Distribution	Percentage of Users Among MWRA (5.27 million)
Oral Contraceptives	550	574	569	48	11
Condom	94	184	156	13	3
IUD	203*	216*	200	17	4
Sterilization	---	30	75	6	1
Rhythm	66	151	171	14	3
Other	Combined w/IUD*	Combined w/IUD*	17	1	<1
TOTAL	915**	1,157	1,188		22

* "Other" is combined with IUD.

** May not add up due to rounding.

SOURCE: USAID documents as reported by POPCOM MIS data.

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accounted for by the difference in time of estimation. Oral contraceptive use is similar (comparing SAS of January 1976 with POPCOM MIS estimate for September 1976); condom use per POPCOM MIS is three times higher than the SAS; IUD is similar; and rhythm prevalence is twice as high per the SAS as per the MIS. Withdrawal constitutes 15 percent of survey-reported prevalence, yet is not included specifically in the MIS data and sterilization prevalence of two percent per the survey is nearly twice that reported by MIS at a point nine months later.

Finally, UPPI/POPCOM, on March 4, 1977, released their judgment of the demographic parameters for 1976. They estimate the 1975 contraceptive prevalence at 23 percent of MWRA; the 1976 contraceptive prevalence at 24 percent of MWRA. The UPPI/POPCOM national 1976 estimate is about one percentage point or four percent lower than the average of the seven province study. After reviewing these data, FHC concurs with the estimate of 24-25 percent prevalence of contraceptive use in 1976.

Data regarding the socioeconomic characteristics of current contraceptive users are not available.

There is general consensus that the contraceptive use prevalence rates are highly correlated with distance from the poblacions in which clinics are generally located.

Current use prevalence declines from roughly 33 percent within three kilometers of the poblacion (presumably with at least one clinic) to below 5 percent ten kilometers from the poblacion. Yet, those living far from a poblacion--with low levels of current use prevalence--are a significant segment of the total population. The spatial distribution of ever-married women (aged 15+), as determined by the 1973 NDS, was as follows:

<u>Kilometers From the Poblacion</u>	<u>Percent of Ever-Married Women</u>
0-5	58%
6-10	18%
11-15	6%
16+	18%

d. Level of Knowledge and Attitudes Toward Family Planning/Population

The primary data sources for levels of attitudes and knowledge regarding family planning are the 1968 and 1973 National Demographic Surveys conducted by the U.P. Population Institute and the 1972 Assessment of Family Planning Acceptability conducted by the Philippine Census Bureau (now the National Census and Statistics Office). There were differences in the two sampling processes, but general trends can be discerned.

By 1973, 87 percent of MWRA were aware of or had heard of family planning. In urban areas, 94 percent of MWRA were aware of family planning, but in rural areas only 84

percent of the MWRA were aware of family planning. This differential in 1973 was considerably less than found in the 1968 NDS survey (75 percent for urban areas; 58 percent for rural areas). By 1973, the oral contraceptive was the most recognized method (83 percent), followed by the IUD (68 percent), and rhythm (52 percent). Yet, the percentage of women who knew how to use contraceptives was considerably lower: OC, 33 percent; IUD, 25 percent; rhythm, 22 percent; condom, 18 percent; any method, 51 percent.

The following four tables present additional data demonstrating the considerable differential of knowledge and attitudes by geographic location and educational status. Table 8, "Percent Who Approve of Family Planning," demonstrates that the overall increase between 1968 and 1973 in the percentage of women approving family planning was due almost entirely to higher approval levels in the urban sector and higher approval among those with high school and college education. This indicates that much of the IEC impact over the 1968-1973 period was felt only in those select population sub-groups.

Table 9, "Percentage with Knowledge of a Family Planning Clinic in 1973," demonstrates that the differential impact of the rural health centers based program is very evident in both geographic and social--i.e., education--terms. Only half of the rural target population knew the

TABLE 18 PERCENT WHO APPROVE OF FAMILY PLANNING
(CURRENTLY MARRIED WOMEN AGED 15-44)

CHARACTERISTIC	YEAR	
	1968	1973
ALL WOMEN	58.4	62.6
<u>CURRENT RESIDENCE</u>		
Urban	70.7	76.0
Rural	57.1	56.9
<u>DISTANCE FROM POBLACION</u>		
0 - 1 Kilometer		75.1
2 - 3 "		65.5
4 - 5 "		61.8
6 - 7 "		62.3
8 - 9 "		58.0
10 +		49.9
<u>EDUCATION</u>		
None	39.6	34.9
Primary	55.8	53.1
Intermediate	65.1	62.5
High School	71.0	72.3
College	78.8	82.4

SOURCES: 1968 and 1973 National Demographic Surveys

TABLE 9 PERCENTAGE WITH KNOWLEDGE OF A FAMILY PLANNING CLINIC IN 1973 (CURRENTLY MARRIED WOMEN AGED 15-44)

CHARACTERISTIC	PERCENTAGE
<u>PLACE OF RESIDENCE</u>	
Urban	71.9
Rural	52.0
<u>EDUCATIONAL ATTAINMENT</u>	
None	17.8
Primary	44.8
Intermediate	59.2
High School	71.4
College	82.1
<u>LITERACY</u>	
Read and Write	62.2
Illiterate	23.8

SOURCE: 1973 National Demographic Survey

location of a family planning clinic in 1973; 72 percent of urban women knew the location of the family planning clinic. Less than one in five had this knowledge among women with no education, while four of five college women knew a clinic's location. Similarly, there was a very sharp knowledge differential between the literate and illiterate.

Table 10, "Percentage Who Learned About Family Planning from Medical or Paramedical Sources," demonstrates the considerable gradient around the poblacion. The fraction gaining knowledge of family planning from medical or paramedical sources declined from one-half near the poblacion to one-fourth among those living ten or more kilometers from the poblacion (and the site of the clinic). The distance gradient of approval of family planning (Table 10) is much less than the gradient on percentages who learned of family planning from medical or paramedical sources.

The percentage of age groups learning about family planning from medical and paramedical sources takes a U-shaped pattern in both 1968 and 1973, with the greatest proportional impact at ages 25-34. Between 1968 and 1973, considerable improvement is evident among women below the age of 25.

TABLE 10 PERCENTAGE WHO LEARNED ABOUT FAMILY PLANNING FROM MEDICAL OR PARAMEDICAL SOURCES, 1968 AND 1973 (CURRENTLY MARRIED WOMEN AGED 15-44)*

CHARACTERISTIC	YEAR	
	1968	1973
<u>DISTANCE FROM POBLACION</u>		
0 - 1 Kilometer	NA	49.0
2 - 3 "	NA	42.7
4 - 5 "	NA	34.6
6 - 7 "	NA	29.5
8 - 9 "	NA	27.8
10 + "	NA	25.3
<u>CURRENT AGE</u>		
15 - 19	12.0	28.7
20 - 24	18.4	35.2
25 - 29	23.7	41.7
30 - 34	25.8	41.6
35 - 39	30.3	37.1
40 - 44	24.8	32.8

* Base is those who claimed knowledge of family planning.

SOURCES: 1968 and 1973 National Demographic Surveys

Encouraging evidence of changes in family size attitudes is evident from Table 11, "Indicators of Family Size Attitudes in Relation to Numbers of Living Children." The median of living children held steady at about 3.7 over the 1968-1973 period, but fertility desires dropped 22 percent from 5.1 to 3.9 children.

Expectations changed as well. "Children expected" exceeded "children desired" by 13 percent in 1968, but by only three percent in 1973. Finally, the proportion of women who said that they wanted more children declined over the 1968-1973 period.

Table 12 provides further insights into the changing family size desires as correlated with varying socioeconomic values.

e. Estimated Births Averted

Table 13 provides Laing's most recent analysis of births averted by method for the period CY 1973-1976. Births averted are here defined as the future births averted by actions taken during that year, not births averted in that year from actions in prior periods. Laing estimates that the births averted by program actions prior to CY 1973 were approximately 400,000. On a cumulative basis, this analysis suggests that approximately

TABLE 11 INDICATORS OF FAMILY SIZE ATTITUDES IN RELATION TO NUMBERS OF LIVING CHILDREN, 1968 AND 1973 (CURRENTLY MARRIED WOMEN AGED 15 - 44)

INDICATOR	YEAR	
	1968	1973
	<u>Medians</u>	
Living Children at Present	3.73	3.72
Desired Children	5.06	3.93
Preferred Children	5.18	4.11
Expected Children	5.73	4.03
	<u>Percents</u>	
% With Enough Children	51.3	57.4
% Who Want Fewer	5.9	10.9
% Who Want More	42.8	31.7

SOURCES: 1968 and 1973 National Demographic Surveys

TABLE 12 SOCIO-ECONOMIC DIFFERENTIALS IN FAMILY SIZE DESIRES
(PERCENTS DESIRING FOUR CHILDREN OR LESS), 1968 AND
1973 (CURRENTLY MARRIED WOMEN AGED 15-44)

CHARACTERISTIC	YEAR	
	1968	1973
<u>PLACE OF RESIDENCE</u>		
Metropolitan Residence	54.7	79.4
Urban	35.0	59.8
Rural	48.2	73.9
<u>PLACE OF BIRTH</u>		
Urban	37.5	62.5
Rural	46.7	68.8
<u>EDUCATIONAL ATTAINMENT</u>		
None	25.6	39.4
Primary	34.9	55.3
Intermediate	39.7	64.3
High School	50.1	71.5
College	59.3	80.7
<u>OCCUPATION</u>		
White Collar	NA	77.7
Blue Collar & Services	NA	80.3
Farmers	NA	48.6
<u>LITERACY</u>		
Read and Write	NA	66.5
Read Only	NA	50.0
Illiterate	NA	44.1
<u>CURRENT AGE</u>		
15 - 19	51.1	88.3
20 - 24	51.1	87.6
25 - 29	44.2	71.8
30 - 34	35.8	60.2
35 - 39	30.4	49.9
40 - 44	35.0	48.3

NA - Not available

SOURCES: 1968 and 1973 National Demographic Surveys

TABLE 13 ESTIMATED BIRTHS AVERTED, 1973-1976 (CALENDAR YEARS)

METHOD	TYPE OF UNIT	BA PER UNIT	1973		1974		1975		1976	
			Units	BA	Units	BA	Units	BA	Units	BA
Sterilization	Acceptors	2.2	---	---	10.0	22	40.7	90	52.3	115
IUD	Acceptors	1.07	101.2	108	77.6	82	51.2	55	47.1	50
	Shifters	1.40	14.3	20	9.8	14	7.9	11	7.0	10
Rhythm	Acceptors	.311	66.6	21	69.8	22	62.5	19	50.4	16
	Shifters	.793	28.5	23	26.6	21	27.8	22	25.0	20
Pills	Cycles	.0271	4,704.0	127	6,245.0	169	6,883.0	187	6,240.0	169
Condoms	Pieces	.00135	?	10?	?	20?	?	30?	18,600.0	25
TOTAL BA				309		350		414		405

SOURCE: John Laing memorandum dated March 7, 1977.

1.9 million births have been or will have been averted by program actions initiated in the nine-year period prior to CY 1977. (In recent years there have been approximately 1.5 million births per year.) Births averted attributable to oral contraceptive use represented 40-45 percent of the total in recent years. Births averted secondary to sterilizations have risen dramatically from 10,000 in CY 1974 to 115,000 (28 percent of the annual total) in CY 1976.

f. Estimates of Fertility, Mortality, and Population Growth Rate

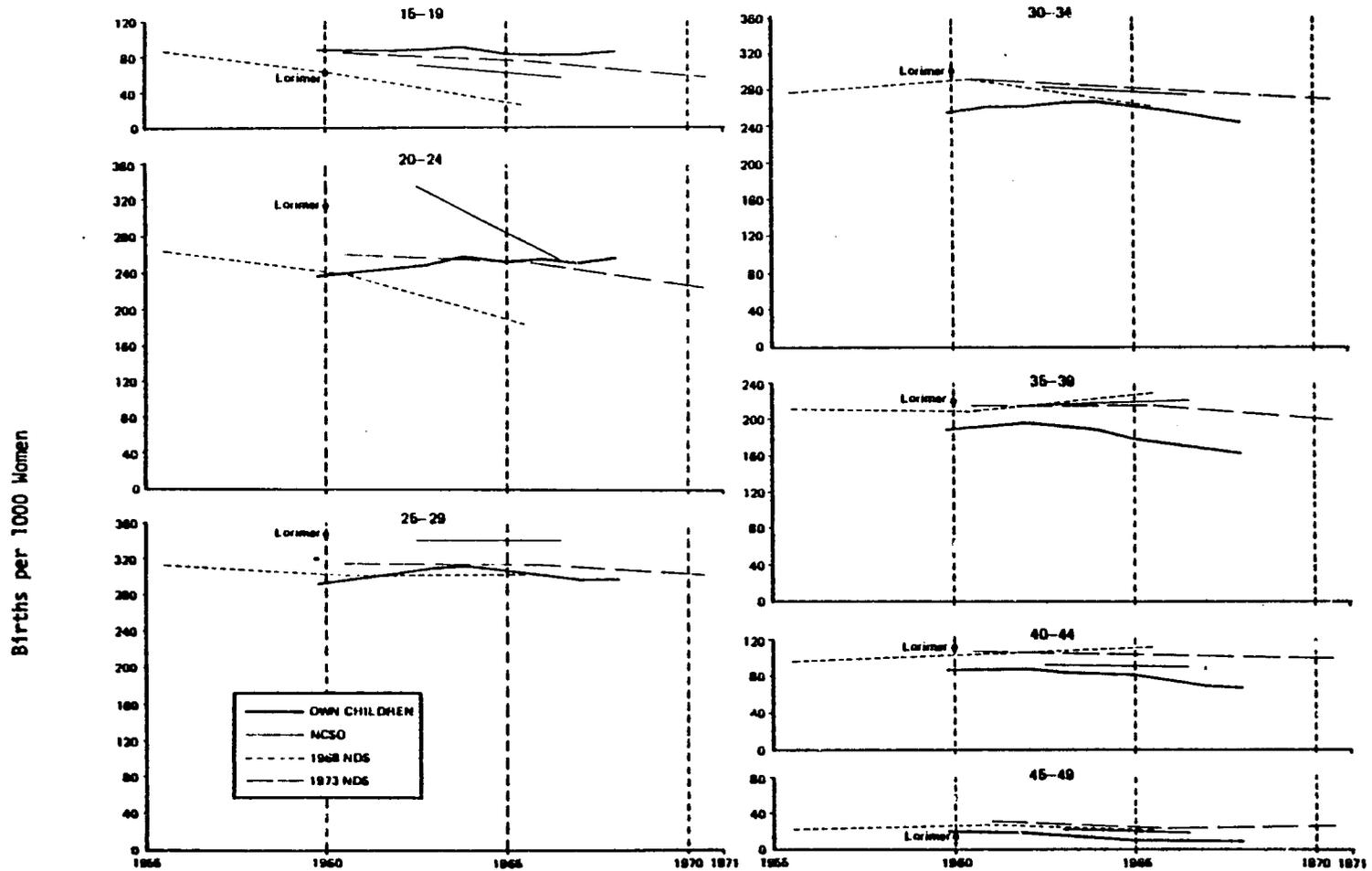
(1) Fertility

The estimated birth rate nationwide in 1900 was close to 50/1,000, but Lorimer's estimate for the period centering around 1960 was about 45/1,000, and more recent estimates, reviewed below, are lower. Analyses carried out on the basis of the 1968 National Demographic Survey and accompanying analyses of census information suggest that all or nearly all the change across the century had been due to changing marriage patterns rather than to declining fertility within marriage. In fact, the 1968 survey presented some evidence of rising marital fertility in the last decade or two.

The several estimates of age-specific fertility before 1970 are depicted in Figure 1: a fair amount of incon-

Figure 1

Five-Year Central Age-Specific Birth Rates, 1955-1972.



Reference: For Large Table and Graphs:
 Engracia, L., Retherford, R., Smith, P.C. and Cho, L.J. "Own Children Estimations from the 1970 Census" forthcoming paper from the National Census and Statistical Office, Philippines, 1977.

Figure 1 (Sources)

Five-Year Central Age-Specific Birth Rates and TFRs, 1953-1972: Various Sources (Rates per Thousand)

Period	Source	Age Group							TFR
		15-19	20-24	25-29	30-34	35-39	40-44	45-49	
1953-1957	1968 NDS	86	263	312	278	215	92	23	6345
1959-1961	Lorimer	61	313	348	300	217	109	13	6805
1958-1962	1968 NDS	60	240	301	290	208	104	25	6140
1958-1962	1973 NDS	84	260	313	290	211	107	27	6460
1960-1964	NCSO (1974)	71	336	340	282	216	93	20	6790
1963-1967	1968 NDS	26	186	303	262	229	112	20	5690
1963-1967	1973 NDS	74	254	313	281	216	101	20	6295
1965-1969	NCSO (1974)	59	255	340	277	222	90	19	6310
1968-1972	1973 NDS	56	227	302	272	199	100	22	5890

Data Source: The 1968 NDS estimates are taken from Flieger, Wilhelm, "Fertility Levels and Fertility Trends," in Flieger, Wilhelm, and Smith, Peter C., eds., A Demographic Path to Modernity (Quezon City: University of the Philippines Press, 1975), Table 4.4. The 1973 NDS estimates are taken from Concepcion, Mercedes B., "Changes in Period Fertility as Gleaned from the 1973 NDS," Research Note No. 13, University of the Philippines Population Institute, Manila, 1974. Lorimer's estimates are taken from Lorimer, Frank, "Analysis and Projections of the Population of the Philippines," in University of the Philippines Population Institute, ed., First Conference on Population, 1965 (Quezon City: University of the Philippines Press, 1966), p. 237. The NCSO estimates are taken from National Census and Statistics Office, "Age and Sex Population Projections for the Philippines: 1970-2000," UNFPA-NCSO Population Research Project Monograph 2, National Census and Statistics Office, Manila, 1974, Table 6.

sistency is evident; Lorimer's estimate is high relative to all others; and the 1973 NDS estimates by age are uniformly higher than those from the 1968 survey (probably reflecting greater accuracy in the latter round). Own-children based estimates are very close to those from the 1973 NDS and suggest fertility decline in the years before 1970. However, the authors of the forthcoming report on these estimates suggest that the decline in the two years preceding the census (1968 and 1969) is spurious and reflects only undercounting of infants and young children in the census.

Table 14, using NDS data, indicates a slight increase in marital fertility rates between the 1958-1962 and 1968-1972 periods.

Thus, although the past long-run pattern is clear, national-level fertility estimates present ambiguous results for the recent past. Sub-national fertility estimates show further ambiguities. Dual records' results from Misamis Oriental, which are available for six-month periods from 1971 to 1975, indicate an urban birth rate declining from 43 to 36 over the period. Somewhat puzzling is the measured drop in rural fertility from 46 in 1971 to about 30 in 1975. This decline seems implausibly great, though it may be attributable to a rural electrification project in the area.

TABLE 14 TOTAL MARITAL FERTILITY RATES FOR WOMEN BY GEOGRAPHIC AREA OF RESIDENCE, FIVE YEAR PERIODS FROM 1958 to 1972

GEOGRAPHIC AREA	PERIOD		
	1958-62	1963-67	1968-72
PHILIPPINES	9.56	9.67	9.63
Metropolitan	9.15	8.92	8.51
Other Urban	9.14	9.55	9.08
Rural	9.74	9.86	9.96
Luzon	9.43	9.69	9.26
Visayas	9.49	9.59	9.97
Mindanao	10.14	10.12	10.44

SOURCE: 1973 National Demographic Survey as reported in The Demographic Situation in the Philippines: An Assessment in 1976, Concepcion and Smith, a forthcoming paper of the East-West Population Institute, Paper Series.

Dual records' results from Bohol province, available for three six-month periods, provide the following results:

	<u>1st Round</u> <u>Apr-Oct 75</u>	<u>2nd Round</u> <u>Oct 75-Mar 76</u>	<u>3rd Round</u> <u>Apr-Oct 76</u>
<u>Fertility Rate</u>			
CBR	39.1	37.2	35.9
<u>Mortality Rate</u>			
CDR	8.5	10.3	10.6
IMR	65.9	65.1	75.5
<u>Growth Rate</u>			
Rate of Natural Increase	3.1%	2.7%	2.5%

The most recent attempt to measure fertility levels through a survey is the Seven Area Study--an annual survey of seven provinces; the first round was conducted in January 1976 and results were available in September of that year. For five of the seven provinces, birth rates are reported, and these range from 33/1,000 to 39/1,000. These rates are difficult to interpret alone--they cannot be combined into an estimate of the birth rate nationwide, for example. However, when these rates are juxtaposed with estimated national-level rates for the 1958-1962 and 1968-1972 periods (see Table 15), a broad pattern of fertility decline seems to emerge.

UPPI/POPCOM estimates that the nationwide 1976 CBR was 37 per 1,000. FHC's review of data resulted in our conclusion of a 1976 CBR of 37 or 38 per 1,000.

TABLE 15

SOME ESTIMATES OF THE CRUDE BIRTH RATE,
TOTAL PHILIPPINES AND GEOGRAPHIC AREAS,
1958 - 1975

Region	YEAR		
	1958-1962	1968-1972	1975
	(1)	(2)	
1 Ilocos	42.0	34.8	32.8 (Pangasinan)
2 Cagayan Valley	49.1	35.85	
3 Central Luzon	42.9	37.3	39.2 (Nueva Ecija)
4 Southern Tagalog	43.0	35.3	
5 Bicol	43.4	37.5	33.2 (Laguna)
6 Western Visayas	43.1	38.3	35.6 (Capiz)
7 Central Visayas	42.0	38.1	37.0 (Bohol Project Area)
			36.0 (Negros Oriental)
8 Eastern Visayas	44.9	42.55	32.8 (S. Leyte)
9 Western Mindanao	55.7	50.9	
10 Northern Mindanao	52.7	49.0	30.5 (Misamis Oriental)
11 Southern Mindanao	51.2	47.4	
12 Manila	43.1	33.6	
PHILIPPINES	44.95	39.3	

SOURCES: 1958-1962 and 1968-1972, PREFP Research Note No. 65; 1975, Bohol MCH Project data provided by Nancy E. Williamson, Evaluation Advisor; data for TIDA provinces from reports of the respective research organizations

METHODS: 1958-1962 and 1968-1972, 1973 NDS ASFRs applied against persons by age and sex given in the 1960 and 1970 Censuses (forthcoming UPPI Research Note by E. A. de Guzman); 1976, Bohol and Misamis Oriental estimates based on dual records methodology; 1975 Seven Area Survey (TIDA provinces) data from analytical reports on survey results.

Though we did not review vital registration trends prior to 1960, the data from the past decade are encouraging. Birth registration, as measured nationally, is still incomplete (approximately 70 percent), but the percentage has increased significantly over the past few years. Within some provinces registration approaches 90 percent. Considering the recent data, the median parity of mothers reporting a birth has declined from 3.5 in 1965 to 2.6 in 1974. The median age of mothers reporting a birth has declined from 28.0 in 1965 to 27.1 in 1974. Finally, the percentage of mothers reporting a first birth has increased from 21 percent in 1965 to over 27 percent in 1973. If there are not significant age or parity differences between those mothers who register births and those who do not, the data provides supplementary reflections of declining fertility.

Even if a downward shift in the birth rate can be inferred from the available data, it cannot be concluded that this change is due solely to family planning activity either within or outside the program. One major source of fertility change other than family planning is delayed marriage. Data from the 1968 and 1973 National Demographic

Surveys make this clear, as do data from the Seven Area Study.*

A number of fertility estimates will become available shortly: the second round results of the Seven Area Survey (to be expanded to five regions rather than seven provinces), including representation of five regions, are expected to be available by September 1977; own-children estimates based upon the 1975 census should also be available by September or so; a World Fertility Survey round will be conducted in January 1978 and should provide fertility estimates by late that year; and lastly, dual records' estimates for Bohol province should continue to be available on a semi-annual basis through 1980.

* The mean age of marriage in the Philippines has historically been higher than in many other LDCs and it is continuing to increase. The relatively high percentage of women never marrying remains steady. Based upon national census reports, the singulate mean age of marriage for females in 1970 was 22.8, up 0.5 years from 1960; for males: 25.4 in 1970, up 0.4 years since 1960. (Note: The singulate mean age of marriage, because of methodological issues, is slightly higher than the mean age of marriage as determined by surveys. Both, however, should clearly show trends in change.) For females in 1970, 89 percent of those ages 15-19 were still single; 50 percent of those ages 20-24 were single; 7 percent of women ages 45-54 never married. Though there was a slight decrease in the percentage of women never marrying, the percentage of those still single at ages 15-24 rose from 2 to 6 percentage points in the 1960-1970 period.

SOURCE: 1973 National Demographic Survey as reported in The Demographic Situation in the Philippines: An Assessment in 1976, Concepcion and Smith, a forthcoming paper of the East-West Population Institute, Paper Series.

(2) Mortality

The estimation of mortality levels and trends is the weakest area in Philippine demography. Vital statistics on deaths are highly deficient--even in the recent past some 20 percent or so of all deaths have gone unreported. The mortality estimation efforts of the past fall into three areas: long-run trend estimation on the basis of the vital statistics series; estimation of current levels by indirect procedures; and, estimation of current levels on the basis of dual records approaches. These are reviewed very briefly below.

The trend of mortality decline is clear in the vital statistics, even if the level at any particular time is not. Adjustments to the vital statistics time-series (Aromin 1961) suggest that the crude death rate was between 25 and 30 per thousand at the turn of the century, and that it declined to just above 20 per thousand by World War II. Rapid decline in the period since Independence in 1946 has brought the death rate to about 10 per thousand in the 1970s (Osteria and Baltazar, 1976). Lorimer (1966) placed life expectancy in 1960 at 52.5 years, while Engracia's (1976) analysis of 1970 census data suggests a life expectancy then of about 58.0 years.

Indirect estimation of mortality has been made possible by recent developments in formal demography (especially by various "Brass" techniques). These methods yield very mixed results when applied to Philippine data. In reported results based on 1968 and 1973 NDS data (Zablan, UPPI Research Note) and on Misamis Oriental survey data (Magidan et al.), the effects of age-sex misstatement and other kinds of error are very pronounced. The level of mortality, in particular, is not well estimated; but one interesting result does emerge regarding the mortality trend--there is some indication that the long-run mortality decline may have ceased in the late 1960s and early 1970s.

Direct dual records estimates of mortality are available for the provinces of Misamis Oriental and Bohol. In the case of Misamis Oriental, where six-month estimates are available from 1971 to 1975, the crude death rate rises from around 7/1,000 to around 9.5/1,000. The investigators believe that this rise reflects improvements in the data system rather than a genuine rise in mortality. Further questions are raised by a "randomized response" experiment conducted in 1973 which suggests that nearly half of all deaths were not being captured by the dual records system, and that the true crude death rates were around 11 or 12 per thousand.

Dual records estimates for 1976 are available for 22 Bohol municipalities. These estimates place the crude death rate

for this province at 9 or 10 per thousand, with a rate as low as 5 or 6 per thousand in the islands' major town and as high as 14 per thousand in the most remote districts.

The Misamis Oriental and Bohol crude death rates may be nearly correct, but it is impossible to infer the national mortality trend from data from these two provinces. UPPI/POPCOM in their March 1977 memorandum estimated the 1976 crude death rate at 10.6 per 1,000. FHC concurs with this estimate.

(3) The National Growth Rate of Population

From an annual rate of growth below 1.5 percent in the previous century, the nation's population growth rate expanded to 2.1 percent per annum over 1903-1939, to 2.5 percent over 1939-1960 (despite severe wartime disturbances), and to 3.0 percent over 1960-1970. There is no question that most of this trend reflects mortality improvement in the period prior to 1960; but, measurement of the rate of growth and interpretation of its components have become more complex in the recent past. Following is a brief review of the issues.

On the basis of information available in 1965, Frank Lorimer projected a 1970 population of somewhere between 37.7

million and 37.4 million (his high and low projections, respectively), and a 1960-1970 annual growth rate of about 3.2 percent. The 1970 census suggested only 36.7 million people in that year, and, therefore, an average annual growth rate of only 3.0 percent. It could not be determined whether the Lorimer projection was too high, or the 1970 census undercount unexpectedly great.

Preliminary 1975 census returns released by the NCSO suggest an average 1970-1975 annual growth rate of 2.66 percent, but subsequent upward revisions (with 56 of 73 provinces in final form) place the average 1970-1975 annual growth rate at about 2.77 percent. NCSO demographers suggest that when final adjustments have been made the 1970-1975 growth rate will be about 2.8 percent. Questions have been raised regarding both the 1970 and 1975 censuses (the former was conducted in the face of extreme, last-second budget cuts, for example, and the latter utilized the "barangay" political structure for the first time); but on balance there does seem to be evidence of a declining growth rate beginning sometime in the late 1960-1975 period.

In March 1977, UPPI/POPCOM estimated that the 1976 population growth rate was 2.64 percent. FHC believes that this estimate is reasonable.

g. Program Target Achievement

The Commission on Population's "Four-Year Population Program, 1973-74 to 1976-77" states that "the overall demographic targets through fiscal year 76-77 are the reduction of the birth rate from an estimated level of 43.2 per thousand in 1970 to 35.9 per thousand in 1977, and the consequent reduction of the population growth rate of 3.01% in 1970* to 2.47% by 1977." The data presented above indicate that the 1977 birth rate target may not be achieved (37-38 for 1976) and the estimated growth rate target of 2.47% by 1977 will probably not be achieved (estimated 2.64% for 1976 per UPPI/POPCOM).

The same document states new family planning acceptor targets as follows:

FY 73-74:	513,600	new family planning acceptors
FY 74-75:	643,729	new family planning acceptors
FY 75-76:	776,929	new family planning acceptors
FY 76-77:	834,382	new family planning acceptors

In consideration of the annual new acceptor achievement described in this section and that those figures may be as much as 30 percent "overreported," FHC concludes that the previously stated new acceptor targets have not been achieved to date. The loss of the part-time motivators

* An annual growth rate of 3.01% is more accurately the average annual growth rate for the 1960-70 period, not the 1970 rate.

in December 1976 and the delays in fielding the Outreach workers nearly preclude the possibility of achieving over 800,000 valid new family planning acceptors in FY 76-77.

III. RECOMMENDATIONS

The FHC team is reluctant to offer a set of comprehensive recommendations which may purport to offer definitive answers to issues raised during its brief visit to the Philippines. Its recommendations, therefore, should be taken more as a dialectic than as a set of explicit recommendations. The concerned parties (USAID/Philippines and POPCOM) may want to consider them in terms of sorting-out urgent program priorities over the next several months.

1. Re-examine the organizational relationships which link POPCOM to the Office of the President, to PCF, to NEDA, and to partner agencies. Specific responsibilities and authorities should be clarified. The active collaboration between POPCOM, Project Compassion, NEDA, and USAID should be increased to minimize confusion at the field level and to smooth out cooperation at the policy level in Manila.
2. Maintain the highest possible degree of flexibility to forestall the difficulties in the implementation of the Outreach Project. This will be especially needed as expectations with respect to cost-sharing arrangements with provinces/cities will prove a difficult task. Too, the ratio of siting FTOWs to married women of reproductive age may have to be changed to conform to rural-urban population disparities vis-a-vis their accessibility to population planning services.
3. Examine alternative methods to broaden and improve population policy formulation by the POPCOM Board, and consider broadening the Board membership to include the Department of Local Government and Community Development and the Department of Labor.
4. Continue the noteworthy efforts to integrate family planning within other basic development efforts, particularly health and nutrition. Yet, never lose

sight of a basic requirement to provide family planning information and contraceptives, especially to rural, non-poblacion population groups.

5. Consider development of a comprehensive POPCOM-administered Research and Development Project under USAID (and possibly other donors') financial assistance.
6. Maintain a combination of frequent, streamlined area surveys for rapid feedback. The National Demographic Survey/World Fertility Survey studies could then be used less often. The former surveys offer timely, accurate fertility measures representative of limited areas (provinces; regions), but provide little by way of independent variables and offer limited opportunity for causal analysis. The latter surveys have slower turn-around but allow a wide range of casual analysis. The present combination of annual area surveys and quinquennial NDS/Surveys seems reasonable.
7. Assess the vital registration system as an approach having potential long-run payoffs, but not one which will yield useful fertility (or mortality) estimates within the next several years.
8. Encourage the NCSO to prepare computer user files from its 1970 and 1975 censuses. To be useful for fertility analysis, these files should contain own-children information, information on children-ever-born and still living, and a range of socioeconomic characteristics. A one-record format for each ever-married female could contain information for her as well as her spouse.
9. Encourage the NCSO to add "contraceptive prevalence" questions to its quarterly survey of households.
10. Improve the coordinated reporting of the "Seven-Area Study" series and the subsequent prototype rounds. Attempt to provide coordinated data and information of greatest relevance to program managers and of long-term research interest.
11. Strengthen project development through a vigorous, pragmatic, low-cost, operationally-oriented research and development activity. Seek methods to enhance effective communication between researchers and project managers.

12. Clarify, through written directives from the Department of Health, the use of trained paramedicals and lay-persons in the distribution of oral contraceptives.
13. Identify means to enhance oral contraceptive use by improved health education and patient counseling methods. Make positive efforts to identify and neutralize contraceptive-specific rumors detrimental to the program.
14. Reconsider the current policy assigning responsibility to FTOWs for the supply of consumable contraceptives to DOH clinics.
15. Enhance relevance of rural population oriented IEC materials by creating prototypes at the national level for appropriate adaptation at regional levels.
16. Determine extent to which recent upheavals in POPCOM have adversely affected the FTOWs who have been posted following their training programs. Conduct regional/provincial workshops for FTOWs and supervisory personnel. The purpose of these workshops can be educational as well as social. The field personnel will have to come together every now and again to interact with POPCOM regional and central office staff in order to be reassured that the problems they are experiencing individually are shared, in one form or another, among their peers. Too, FTOWs need to be able to physically keep in touch with "the big picture" and to identify with a cohesive programmatic theme.
17. Fill current approved POPCOM job positions with competent staff as quickly as possible.
18. Use experienced management consultants, on short-term contract if necessary, to address pressing management needs; e.g., policies and procedure manuals; logistics; sterilization training/certification coordination; and obligations and expenditures to date (both GOP and donors).
19. Acknowledge that (1) the current management problems did not occur overnight--they will not be resolved quickly; and (2) management alone, as narrowly defined, cannot resolve problems of inadequate collaboration and program planning.

20. Continue the important efforts noted during the FHC team visit to maintain a reasonable integrity to the Bohol Province Maternal Child Health/Family Planning Project by excluding from the test area new initiatives, e.g., PROCOM. Avoid any actions (of omission or commission) that would detract from this extremely important field experiment of international and Filipino concern and relevance. Continue the field implementation of the Midwife Maternity Care Monitoring Form which provided current information on the reproductive behavior of rural populations, their pregnancy care, and outcome. This could give essential data for the Philippine MCH/FP program and add considerably to the current efforts of WHO/International Fertility Research Program to improve understanding of family formation, family development, family health, reproductive loss and reproductive timing.
21. Acknowledge that the Catholic Church may disagree with components of the population program, and consider the establishment of continuous dialogues with Church leaders to avoid misinterpretation of new program initiatives.
22. Place a high priority on the completion of the Outreach Project Paper. FHC believes the project plans are conceptually sound, i.e., field personnel at the barangay level focusing on family planning information, motivation, and the delivery of services. On the other hand, the internalization of this concept within the Government, the administrative issues, organization structures, financial mechanisms, and the concerns of the Church are seen by FHC as questions which still persisted at the time of the team's field visit and which can diminish considerably the chances for program success.

ANNEX A: ISSUES OF CURRENT CONCERN

ANNEX B: THE STATE OF KNOWLEDGE ABOUT POPULATION
AND FAMILY PLANNING MATTERS IN THE
PHILIPPINES

ANNEX C: BIBLIOGRAPHY

ANNEX D: INSTITUTIONS VISITED BY FAMILY HEALTH
CARE, INC.

ANNEX A

ISSUES OF CURRENT CONCERN

1. Program Financing

Local governments' responsibility for helping to finance the population program was delegated to them by Letter of Instruction No. 435 (dated July 20, 1976) which directed the DLGCD, the Secretary of Finance, and three other high government agencies "to facilitate implementation of the program of POPCOM by authorizing the provinces and cities to gradually and progressively assume the responsibility of funding the costs of all population and family planning related activities and projects agreed upon by the POPCOM and the Provincial Governors and City Mayors for their respective jurisdictions."

The January 1977 (Revised Draft) Project Paper for Population (Phase) II makes an assumption that the increased costs of Project Outreach can be met by the Philippine government. After estimating that total program costs "might reach \$23 million per year" by the early 1980s (versus about \$17 million annually now) and declaring that "these are very large sums for the Government to pay on a continuing basis for a recent and still novel program," the Project Paper states that "as government expenses go, they are relatively minor, and there is no doubt that the GOP can find the necessary resources if P/FP is accorded sufficient priority."

About potential sources of financing, the Project Paper says that "much of this cost can be absorbed by local governments and by cooperating agencies into which family planning is integrated, such as medicare-funded sterilizations." As the first in its list of "Indicators of end-of-project status," the Project Paper put:

"--Absorption of major share of field program costs into provincial and charter city budgets."

The Project Paper does not present any analysis of the capability of local governments to assume the projected costs, nor does it discuss the implications of their attempting to, in respect to competing claims for public funds, e.g., other social services. A brief analysis of the financial situation of local governments, and of their options for raising additional operating funds for population programs, shows that their collective ability to assume a share of population program costs will largely depend on the availability of the central government assistance, and on their own willingness to forego spending on other development priorities in favor of spending on population.

Powers and Resources of Local Governments

The weaknesses of local governments in financing their own, and others', programs was described in a

World Bank country economic report on the Philippines:

"A distinctive feature of the Philippine government's administrative structure is the local government's lack of power in the area of taxation and financing. Local governments are unduly dependent on national financial aid, though the larger units, particularly the cities, are less so. The lack of financial independence has been one of the main stumbling blocks to more effective involvement in development on the part of local governments. Only a few services are undertaken locally; most are administered by the national government through its field agencies. The bulk of the resources that local governments do expend come from the national government. Although the Decentralization Act was intended to promote the autonomy of local units by increasing their powers and resources, during 1967-74 local revenues declined from 17 to 11 percent of combined government revenues, and expenditures declined from 20 to 15 percent of combined expenditures."*

The report went on to note that "the shortage of trained personnel in local and municipal governments" when added to their lack of financial resources and limited expenditure powers "have been important constraints to development."

* World Bank, The Philippines: Priorities and Prospects for Development, Washington, D. C., IBRD, June 1976, p. 90. This report elsewhere elaborated the Decentralization Act of 1967 on p. 427:

"The Decentralization Act of 1967 represented one attempt to revitalize local governments. It stated that 'the policy of the State (is) to transform local governments gradually into effective instruments through which the people can in a most genuine fashion govern themselves and work out their own destinies.' Although the act sought to provide local governments more functions and some additional financial resources, the results have been disappointing, and local dependency on national financial aid has in fact increased. Local government receipts and expenditures did rise noticeably in current prices after the act was passed, but there was hardly any per capita rise in real terms until FY 74."

As a mechanism for diverting some of the fiscal demands that Outreach will make on the central government budget, the attempt to get local governments to assume program costs will thus be severely hampered by the local governments' lack of resources, and lack of power to raise revenue. The Letter of Instruction No. 435 may have eliminated an obstacle by "authorizing the provinces and cities...to assume...the costs," but it did not give them the capacity to carry out the authorization. None of the agencies to which the LOI was directed had taken any substantive action toward implementing the "authorization," until POPCOM approached the DLGCD's Provincial Development Assistance Program (PDAP) for assistance in early 1977.

PDAP was designed to overcome the complex of problems associated with the fiscal and administrative weaknesses of local governments; it is being implemented through the DLGCD with USAID assistance. Since only about one-third of the 72 provinces currently participate in PDAP, it was to use this PDAP mechanism in a phased manner, that USAID originally proposed in its 1976 ProAg (Phase I of Outreach) that:

"Initially, the project will be implemented by the Commission through its regional offices in coordination with the local governments. Following negotiations between the POPCOM and the provincial"

"governments, management of the project will be gradually turned over to the provincial governments. Starting with 1977, the project will be funded through the provincial budget in all participating PDAP provinces. This practice will be extended to all other provinces by 1980."

The ProAg did not elaborate on the extent to which the provinces were expected to assume costs, the pace at which such cost-sharing was to proceed, and the steps by which they were expected to acquire the management and fiscal capacity, as well as the incentive to implement the program. The issue of local government responsibility did not seem to be a priority concern until the Director General of NEDA wrote to the POPCOM Board Chairman (on October 26, 1976) that it was the Board's "consensus (that POPCOM) shy away from project operation and implementation" and that "measures be taken to ensure that implementation of Project Outreach be placed in the hands of Local Governments." He suggested that "specific guidelines be adopted by POPCOM to provide basis for Memoranda of Agreement that the Commission would conclude with Local Government authorities."

To assist POPCOM in implementing this directive, USAID provincial development staff drafted a proposed memorandum of agreement between POPCOM and DLGCD which would facilitate that implementation of Outreach through the provinces and cities and would help to finance the program

by giving local governments permission to use "P.D. 144 funds" for their share of Outreach costs. While FHC was in Manila, the DLGCD was negotiating this agreement with POPCOM, with the assistance of USAID staff. According to provincial officials interviewed by FHC in the field, however, POPCOM's use of "P.D. 144 funds" is not welcomed by the provincial governments since it effectively diverts funds away from other provincial development priorities--in effect, using funds earmarked for capital projects instead for current operating (salary) expenses.

National Government Allotments in Local Government Revenue

As a percentage of total revenue received by local governments from all sources, revenue from local taxation was about 40 percent in 1975. It had dropped steadily from over 50 percent in 1955, to 33 percent in 1974. Over this same period, revenue in the form of national government assistance has increased steadily as a percentage of total local government revenue.

About two-thirds of national assistance to local governments has come in the form of an "internal revenue allotment," which consists of fixed portions of total collections of various national government taxes. Allotments to local governments are distributed according to a prescribed formula; changes in the formulas effected by Presidential

Decree No. 144 (on March 3, 1973) reduced the amount of the allotment, and redistributed it to channel more revenue to resource-poor provinces/cities.

P.D. 144 declared that:

"Twenty per centum of the collections from national internal revenue taxes not otherwise accruing to special funds and special accounts in the general fund shall accrue to local governments to be computed on the basis of the collections of the third fiscal year preceding the current fiscal year."

Additional provisions stipulated that the local governments set aside 20 percent of their annual shares of the allotment for development purposes:

"Each province, city and municipality shall appropriate in its annual general fund budget no less than twenty per centum (20%) of its annual allotment for development projects.

The development plans of the local units shall be subject to the approval of the Secretary of Local Government and Community Development, who shall issue the necessary guidelines for the purpose.

In addition, five per centum (5%) of the collections from national internal revenue taxes not otherwise accruing to special funds and special accounts in the general fund shall accrue to a local government fund which shall be released by the President as financial aid to local governments or to projects.

There are a number of problems--administrative, fiscal, political--which may make it difficult for local governments to use "P.D. 144 funds" for population programs. The principal obstacles noted by the FHC team were:

- (1) Regulations issued in the past by the DLGCD as guidelines for the implementation of P.D. 144 prohibited local governments from using any of the "20 percent development fund" (of the internal revenue allotment) for recurrent, operational expenses, and from applying those funds to finance any new civil service positions. The fund was to be used strictly for capital development purposes, according to priorities set by the province/city, and approved by the DLGCD.
- (2) Permission to use the "20 percent development fund" for population programs would not only require a waiver of the above regulation, but would also require that both the DLGCD and the province/city declare population to be a development priority. The suggestion that provinces/cities make population planning a priority is indeed contained in LOI 435, but so far the previously established development priorities have yet to take into account population planning in most provinces/cities.
- (3) The amount of money available through the "20 percent development fund" does not represent any new source of revenues; the amount in that fund for any local government will not increase faster than its overall internal revenue allotment. (The redistributive nature of the allocation formula has actually reduced the allotment for some of the more resource-rich provinces.) In order to allocate money from that fund toward population activities, a local government would have to change its previous decisions on how to allocate the fund, i.e., it would have to reduce capital expenditures on rural roads, agriculture, or whatever had been its local development priority, in order to spend a portion of the fund for population. The evidence is that many local governments would do this reluctantly, which could well have an impact on the vigor with which they would implement population programs.

Illustration of the potential fiscal demands which are implied by local government cost-sharing are presented in Table A. Making the assumptions made by the Draft Project Paper, this table shows

TABLE A

PROJECTED IMPLICATIONS OF LOCAL GOVERNMENTS'
ASSUMPTION OF "MAJOR SHARE" OF TOTAL POPULATION
PROGRAM COSTS BY 1981 ON THEIR BUDGETS

(Share of Projected Program Costs as a Percentage of Projected Revenues)
(Budget Figures in Millions of Pesos)

(1) Year	(2) Projected Local Government Tax Revenue a/	(3) Amount of P.D. 144 Funds b/	(4) Amount of P.D. 144 "20 Percent Development Fund" c/	(5) Sum of (2) + (4) d/	(6) Total Population Program Budget e/	(7) Phased Cost Assumption By Local Governments f/	(8) Total Population Costs Assumed By Local Governments g/	(9) Local Government Population Costs as Percentage of "20 Percent Development Fund" h/	(10) Local Government Population Costs as Percentage of (5) i/
1975	1,050	564.2	112.8						
1976	1,050	670.3	134.0	1,184.0	125.0				
1977	1,287	796.3	159.2	1,446.2	132.3	10%	13.2	8.3%	0.9%
1978	1,578	946.0	189.1	1,767.1	139.6	20	27.9	14.8	1.6
1979	1,935	1,123.8	224.7	2,159.7	146.9	30	44.1	19.6	2.0
1980	2,372	1,335.1	267.0	2,639.0	154.2	40	61.7	23.1	2.3
1981	2,908	1,586.1	317.2	3,225.2	161.5	50	80.8	25.5	2.5

TABLE A

NOTES

- a/ From Table 15.3: "Revenue Projections of National and Local Government Taxes and Social Security Contributions," on p. 396 of source. Local government tax revenues increase at average annual rate of 22.6 percent.
- b/ From Table 15.14: "Major Sources of Revenue of Local Governments," on p. 429 of source. "Internal revenue allotment" constituted 31.1 percent of local total local government revenues of ₱ 1,814 million in 1975, or ₱ 564.2 million.
- c/ These amounts represent 20 percent of Column (b)--P.D. 144 funds--and assume that P.D. 144 funds increase annually at the same rate as overall national government tax revenues, projected to increase at an average annual rate of 18.8 percent through 1985 by the World Bank.
- d/ These amounts represent the total amount of money available to local governments from two sources: their own tax revenues (Column (2)), and the "20 percent development fund" (Column (4)).
- e/ Total population program costs, including foreign donor assistance, assuming annual increase of \$1 million dollars, an estimate presented in the January 1977 Revised Draft of the Population II Project Paper, USAID/Philippines.
- f/ Phased cost assumption of "costs of all population and family planning activities" by local governments implied by Project Paper (Revised Draft January 1977). "End of project status indicator" -- "absorption of major share of field program costs into provincial and charter city budgets."
- g/ Percentage of Column (7) applied to costs in Column (6).
- h/ These percentages represent the share of total costs assumed by local governments as a percentage of the total amount of the available "20 percent development fund." This is not to imply that such cost-sharing by local governments should, or will, be financed exclusively through the "20 percent development fund"; it merely provides a relative measure for purposes of comparison.
- i/ These percentages represent the share of total costs assumed by local governments as a percentage of the total amount of (1) local tax revenues, plus (2) the "20 percent development fund."

Source: World Bank, The Philippines: Priorities and Prospects for Development (Washington, D.C.: IBRD, June 1976), pp. 307-448.

that if local governments assume half of total program costs estimated at P161.5 million by 1981, this amount will represent one-fourth of the total amount of the "20 percent development fund" available at the time, even assuming that the "20 percent development fund" increases at the same rate as national tax revenues are projected to increase--18.8 percent annually (World Bank estimate). Adding this "20 percent development fund" to the projected amount of local tax revenues to be available (these local tax revenues themselves increasing at 22.6 percent per year (World Bank estimate), we find that the increase in the fiscal burden on local governments (from P13.2 million in 1977 to P80.8 million in 1981) will represent an increase from 0.9 percent to 2.5 percent of the sum of local tax revenues and "20 percent development fund."

- (4) The requirement that local governments use the "20 percent development fund" for population activities will increase the proportion of their expenditures over which they have only indirect control. The World Bank Country Economic Report stated:

"About a fifth--lately even a fourth--of expenditures (by local governments) has been for other outlays that are mainly statutory obligations on the part of local governments, that is payments to agencies and corporations of the national governments, as well as transfers to local government corporations."*

Perhaps many of these administrative, fiscal, and political problems are amenable to resolution. At the time of FHC's departure from the Philippines, the DLGCD and POPCOM were close to finalizing an agreement to open the way for P.D. 144 financing of population programs by local governments. However, the process that has been implemented already to involve the provincial and city governments,

* The World Bank, ibid., p. 432.

through the signing of sub-agreements, will not be quickly or easily adapted to any DLGCD/POPCOM agreement without more involvement of the provinces and cities in the decisions over the financing of the population program.

The Local Government Sub-Agreements

Table B shows the budgets of the programs of the various provinces and cities, including the relative shares to be borne by POPCOM/USAID and by the local governments themselves, according to information held by POPCOM through March 1, 1977. Table C is a summary of Table B data by region, and shows that province/city counterpart contributions in the aggregate constitute 18 percent of the total budgets of all those provinces/cities who were contributing (and whose budgets were known).

Several issues should be noted:

- Very few, if any, of the counterpart contributions listed represent anything more than pledges of support. A review of the budgets revealed that many of the pledges represent valuations of in-kind contributions. Actual budget appropriations, or authorizations, of local government contributions to the population program were limited to a few of the resource-rich provinces.
- The phased assumption of cost schedules, although agreed to in principle, are subject to change, since the sub-agreements are to be renegotiated every year.
- Sub-agreements do not represent binding contracts between POPCOM and the local governments. Either can abrogate the agreement on 30 days' notice.

TABLE B (CONTINUED)

PROJECT OUTREACH BUDGETS, PERSONNEL DEPLOYMENT, AND
PHASED COST-SHARING FROM SUB-AGREEMENTS PROVIDED
BY POPCOM AND PROVINCES/CITIES (BY MARCH 1,1977)

(in pesos)
Page 2

REGION	PROV/CITY	TOTAL BUDGET (a)	USAID/POPCOM CONTRIBUTION	PROV/CITY (b) CONTRIBUTION	PERSONNEL DEPLOYMENT						PHASED-COST ASSUMPTION BY PROV/CITY (c)														
					PPO	PPC	CPO	CPC	DPO	MPO	FTOW	Year of Project													
													1	2	3	4	5	6	7	8	9	10	11	12	
5.	Province Sorsogon	313,599	313,599	--																					
6.	Province Negros Occ.	*686,516	634,408	22,200	1	1			12			64	8	10	30	50	80	100							
	Guimaras	* 53,792	53,792	(16,640)		1					5	-	-	-	-	5	10	20	30	40	50	60	70	80	75
	Antigue	*251,416	251,416	136,700		1			3		27	-	-	-	10	20	30	40	50	60	70	80	80	100	100
	Aklan	*220,706	220,706	--		1			4		21	-	-	-	-	-	10	20	40	60	80	80	100	100	
	City																								
	Bacolod	205,379	136,799	46,300																					
	Bago	62,495	53,015	10,862					1	2	13	23	25	30	50	80	100								
	La Carlata	* 44,119	41,119	14,326					1		5	-	-	-	-	-	10	30	50	70	80	100	100	100	
	Cadiz	* 62,840	62,840	16,000							4	-	-	-	-	-	-	-	-	-	-	-	-	-	-
	San Carlos	* 70,049	56,669	13,380					1		7	-	-	-	10	20	30	45	50	75	85	100	100	100	
	Silay	* 60,114	60,114	--					1		5	24	-	-	-	-	-	-	-	-	-	-	-	-	100
	Iloilo	*157,471	157,471	14,900					1		6	-	-	-	-	-	10	20	30	40	50	100	100	100	
	Roxas	* 66,943	66,943	10,000					1	2	13	-	-	-	30	50	80	100							
											5	-	-	-	-	-	10	20	40	60	80	100	100	100	
7.	Province Seguigor	46,188	38,808	7,380																					
	Cebu	*928,719	828,719	100,000	1	1			14		80	0	20	40	60	80	100								
	City																								
	Dumaguete	*100,759.72	72,782.22	12,984.10																					
	Cebu	423,157.40	322,453	40,000																					
	Davao	63,638.20	48,781	11,990																					
	Toledo	77,770.56	57,153.36	20,000																					
8.	Province N. Samar	287,878	261,737	23,811	1				4		25	10	20	30	40	55	70	85	100						
	E. Samar	*225,568	201,757	23,811		1			3		20	0	10	20	30	40	55	70	85	100					
	W. Samar	*305,923	282,112	23,811	1				5		29	10	20	35	50	75	100								
	Leyte	*1,229,552	1,205,741	23,811	1	2			22		124	0	20	35	50	75	100								
	Biliran	*159,075	135,264	23,811		1			2		14	0	10	20	30	40	55	70	85	100					
	S. Leyte				1	1			4		18														

TABLE C (PART I)

SUMMARY OF PROVINCE/CITY FY 1977 BUDGETS
AND PERCENTAGE OF COUNTERPART CONTRIBUTIONS
TO POPCOM/USAID OUTREACH PROJECT
BY REGION

REGION	CITIES' TOTAL BUDGETS	CITIES' TOTAL BUDGETS (ONLY OF CITIES CONTRIBUTING)	CITIES' TOTAL CONTRIBUTIONS	IN-KIND CONTRIBUTIONS	PROVINCES' TOTAL BUDGETS	PROVINCES' TOTAL BUDGETS (ONLY OF PROVINCES CONTRIBUTING)	PROVINCES' TOTAL CONTRIBUTIONS	IN-KIND CONTRIBUTIONS
1	270,679.5	270,679.5	28,026.20	Most	960,702	601,834	67,342	Most
2	-	-	-	-	1,227,666	1,227,666	68,568	Most
3	505,407.30	505,407.30	66,272.15	15,000	3,257,189	2,597,160	1,095,805	?
4	368,186	368,186	119,684	Some	1,388,558	1,270,997	286,542	Some
5	-	-	-	-	313,599	-	0	-
6	729,374	669,255	125,768	100,342	1,212,430	1,158,638	158,900	Most
7	632,595.28	632,595.28	84,774.10	?	974,907	974,907	107,380	Some
8	298,606	298,606	71,433	Most	2,086,611	2,086,611	119,055	Most
9	470,928	470,928	50,864	Little	1,221,849	1,221,849	113,275	Little
10	523,033	523,023	112,454	Little	1,886,502	1,886,502	350,644	Little
11	935,541	873,900	172,508	?	1,314,097	1,314,097	184,638	Little
	4,734,350	4,612,580	831,783.45		15,844,110	14,340,261	2,552,149	

TABLE C (PART II)

SUMMARY OF PROVINCE/CITY FY 1977 BUDGETS
AND PERCENTAGE OF COUNTERPART CONTRIBUTIONS
TO POPCOM/USAID OUTREACH PROJECT
BY REGION

REGION	NUMBER OF CITIES	CITY SUB-AGREEMENTS	NUMBER OF SUB-AGREEMENTS WITHOUT CONTRIBUTION	PERCENT CONTRIBUTED BY THOSE CONTRIBUTING	NUMBER OF PROVINCES	PROVINCIAL SUB-AGREEMENTS	NUMBER OF SUB-AGREEMENTS WITHOUT CONTRIBUTIONS	PERCENT CONTRIBUTED BY THOSE CONTRIBUTING
1	4	4	0	10.4%	7	5	2	11.1%
2	-	-	-	-	7	3	0	5.6
3	4	4	0	13.1	6	5	1	42.2 ^{a/}
4 ^{b/}	8	4	0	32.5	11	5	1	22.1
5	3	0	-	-	6	1	1	-
6	8	8	1	18.8	6	4	1	13.7
7	9	4	0	13.4	4	2	0	11.0
8	3	3	0	- ^{c/}	6	5	0	- ^{c/}
9	4	4	0	10.8	5	5	0	9.3
10	8	4	0	21.5	10	7	0	18.6
11	3	3	1	19.7	7	3	0	14.1
TOTALS:	54	38	2	18.0%	75	45	6	18.1%

Source: Compiled from data provided by POPCOM Planning Division

^{a/} If the Bulacan Province is excluded, this figure becomes 10.7%.

^{b/} Does not include Metropolitan Manila.

^{c/} In-kind contribution for province/city is the same for each in region, even though total budgets range from P 75,000 to P 1,230,000. Thus, the percentage here would be of more dubious validity than for the rest.

- These sub-agreements were negotiated one-by-one by POPCOM regional staffs, and the formats of the conditions and budget itemizations were not completely standardized. Of those 83 for which there were budget figures available, only 51 had actually been signed.
- Sub-agreements for all of the TIDA provinces, which had initiated the cost-sharing concept one year earlier in seven provinces, had not been signed; budget figures for those provinces were not available either. POPCOM officials reported that the governments in those provinces had fallen behind in providing their agreed-upon shares to the programs.
- Of the 51 sub-agreements that had been signed by March 1, 1977, only 3 provinces/cities were scheduled to assume 100 percent of program costs by 1981 and only 25 were scheduled to assume at least 50 percent of such costs by then. These schedules of "gradual and progressive absorption of the total cost of population and family planning activities" are primarily a reflection of the Standard Provisions of the Sub-Agreement, which specified "absorption of total costs...shall be done based on the following schedule:
 1. First Class Provinces/Cities--
not more than five years
 2. Second Class Provinces/Cities--
not more than ten years
 3. Third Class Provinces/Cities--
not more than fifteen years."

Classification of provinces is based on a formula reflecting the fiscal management capacity of its government. Virtually all of the 51 sub-agreements examined had agreed to assume total costs by Year 11 or 12 of the project.

Future Counterpart Financing of Population Programs

The foregoing discussion of the complex issue of local government absorption of program costs has sobering implica-

tions for the prospects of the Philippines' government ability to support and carry out Phase II of the National Family Planning Outreach Project. These implications deserve the prompt attention of planners at both USAID and POPCOM; further delay in fully exploring the issues, and in inviting the provinces and cities' participation in their resolution, could jeopardize the entire program. Any exploration of the program financing issues should recognize the following points:

- (1) Utilization of the "20 percent development fund" of the P.D. 144 funds is, in itself, an insufficient solution to the local government financing requirement. P.D. 144 actually effectively decreased (both absolutely and relatively) the total amount of internal revenue allotment to local governments; as a percentage of total local government revenues, the allotment dropped from 44 percent in 1974 to 31 percent in 1975. Local governments' jump from assuming 10 percent to 50 percent of the program costs by 1981 will be an absolute increase equivalent to a jump from about 8 percent to about 26 percent of the "20 percent development fund" allocation available to provinces/cities in that period. Using that fund exclusively for population program financing would not just divert funds away from other local development priorities, but it would do so in ever greater proportions (even if the fund increased as much as 20 percent per year).
- (2) A great many provinces simply do not have the resources, nor the prospects for raising sufficient revenues, to finance even a "major share" of the total costs of the program on their own. If they are, as a result, forced to resort to utilization of P.D. 144 fund mechanisms exclusively to finance their full share, their disproportionate loss of P.D. 144 funds (relative to what resource-rich provinces will use from P.D. 144) will have an effect contrary to the specific redistributive intent of P.D. 144.

- (3) Incentives complementary to the LOI 435 directive, which was addressed to central government officers and agencies and not to the local governments themselves, are intangible at best. Provinces are encouraged to participate in the DLGCD's rural roads project (one very important application of "20 percent development fund" expenditures) with an incentive of a possible 75 percent cost reimbursement if DLGCD specifications are followed. Aside from interim financial support for the program, administrative responsibility for the Outreach workers is the only incentive given to provinces/cities, and that is tempered by the accompanying agreement to finance increasing proportions of their operational costs in the coming years.
- (4) The requirement stated in LOI 435 was that local governments absorb the "costs of all population and family planning related activities...agreed upon by the POPCOM and (local government leaders)." For POPCOM to pursue such a request, as it has in several provinces, is unreasonable, if only because it is budgetarily and administratively unfeasible. Moreover, even if sticky questions of administrative authority over the various local representatives of the line agencies were resolved, successful implementation might result in greater national savings (in educational and health expenditures, for example) than savings in local government expenditures. That local governments should bear such a double cost would be unfair.
- (5) There is some evidence that local governments are being pressured for funds because of the inability or unwillingness of USAID and POPCOM to allocate sufficient funds to cover the high costs of a program that had been planned and initiated without too much attention paid to cost. The alternative of reducing the scope and pace of the program might be considered, if doing so might offer a reasonable chance of avoiding the collapse of the program altogether.

2. Coordination and Integration of Programs

Program documents explaining the Philippines' population program have made extensive use of the terms "coordination" and "integration."

The first issue of the PCF's quarterly magazine, Initiatives in Population, contained an article which began:

"The Philippine population program is distinctive for its policy of integration and multi-agency participation. Participating in the program are some 40 government and private agencies. Their coordinator is the Commission on Population (POPCOM), which serves as the central policymaking, planning, and funding agency of the government for population activities."

Another article in that magazine a year later discusses the program's "policy of integration" which "differentiates (it) from the population programs run by most other developing countries" and which "reflects an awareness by the government that the population problem cannot be solved in isolation and that, to be truly effective, the Program must link itself with a wide range of development efforts." The article continued:

"During the first years of the Program, the term 'integration' tended to be used primarily in an institutional sense: the recruitment and coordination of different agencies into the family planning program, and within these agencies, the fitting of family planning activities into their respective priorities and programs of action. The two main areas where integration was carried out were in the public health and social welfare systems."

"Over the past two years, the policy of integration has been applied to the local and community levels and in other development areas as well.

Integration at the local level is best seen in the growing role of the regional offices of the Commission, and the establishment of management structures at the provincial and municipal levels."

Just to the right of the above was another article entitled: "Project Compassion: A Model for Integration." It described a new "social development program integrating the four major concerns of Mrs. Marcos--nutrition, food production, environmental management, and family planning. Using a single organizational channel, the project reaches out to the rural areas with a four-program package which it delivers to the rural family's doorstep."

On the next page was an article describing POPCOM's new "Total Integrated Development Approach" ("TIDA"), "which seeks to relate the population problem to the development schemes of all provinces."

These program policies appear to have grown from a philosophy similar to the one enunciated by the U.S. Congress. Note Section 104b of the Foreign Assistance Act of 1961, as amended:

"(b) Assistance provided under this section shall be used primarily for extension of low-cost, integrated delivery systems to provide health and family planning services, especially to rural areas and to the poorest economic sectors, using paramedical and auxiliary medical personnel, clinics and health posts, commercial distribution systems, and other modes of community outreach;"

"health programs which emphasize disease prevention, environmental sanitation, and health education; and population planning programs, as well as delivery of family planning services and which are coordinated with programs aimed at reducing the infant mortality rate, providing better nutrition to pregnant women and infants, and raising the standard of living of the poor."

Reports of the United States Senate Committee on Foreign Relations and the House of Representatives' Committee on International Relations provide additional clarification that the intent of Congress is to further the coordinated planning for population, health, and nutrition activities and the integrated approach to the delivery of services.

However, as noted elsewhere in this report, actual coordination of planning between the health, population, and nutrition sectors by the GOP is far from ideal at the national, regional, and provincial level, even though they are approached as one "integrated" sector by NEDA. As often as "integration" and "coordination" are espoused as policies, or even as purposes of various institutions or programs, the words seemed (to the team) to be used rather loosely; during several FHC interviews, government officials, when asked their meaning, would use one term in defining the other. In few cases has specific or sufficient authority been granted to an effort at "integration," and the lack of agreed-upon authority is especially troublesome to efforts at "integrating" family planning into overall development.

Within the range of activities currently operating within the Philippines, FHC noted a spectrum of activities that were "coordinated" and "integrated" service delivery activities. Besides the two examples mentioned:

- The Department of Health provides (through its NFPO and minimally through its PMS) family planning services within the context of their expanded rural health services system. In some areas, a casual observer can note a vigorous family planning effort. In others, the integration of family planning into health services has been theoretically accomplished, but the visibility and apparent priority of the family planning component is low. DOH's part-time motivators were replaced by POPCOM's "integrated" TIDA program and then by the Outreach Project.
- The Institute of Maternal and Child Health assists a service program which concentrates entirely on an integrated approach to maternal child health and family planning.
- The Department of Labor's activities are generally toward the integration of family planning services into an industry's health care services, through use of a project management staff.
- Those institutions that are hospital-based and are focusing primarily on sterilization tend to be more oriented toward fertility control services, yet in almost all instances, the services are provided within the context of a broader health care system.

It is rare for family planning services to be provided totally separate from all other phases of developmental activities or human needs. On the other hand, the spectrum listed above of integrated activities includes those where family planning is very clearly in a predominate position, and

those where the visibility of family planning services, within the range of services provided, is most difficult to discern. Therefore, the "integration" of family planning with other social services is not the question within the population program. The controversy lies in determining the appropriate level and priority of family planning services within the specific organizational functions of each agency engaged in developmental activities, and, perhaps more importantly, in matching appropriate authorities with effective implementation capacity.

The tendency of the TIDA "concept" to envelope within its responsibilities the broad range of rural development activities detracts from any firm thrust toward the provision of family planning information and services. It is this broad scope assumed by TIDA which has caused the USAID Mission to assume a narrower interpretation of the extent to which AID population program resources can be appropriately utilized.

The differences over appropriate structures for, and over the appropriate level of, "integrated" services has created considerable tension between various Philippine agencies and USAID; discussion has focused on restrictions associated with concomitant financial support. The issues are still alive, and programmatic

dialogue between the various groups (GOP and donors) needs at least a clear understanding of the need for coordination and integration of development activities, and a better appreciation of the requirements for their successful implementation.

There is a danger that an excessive emphasis on "integration" of activities can lead to a neglect of basic requirements of efficiently organizing a system for the accomplishment of specific, defined purposes and activities-- i.e., the delivery of particular services, like nutrition, education, family planning, etc. It is useful to remember that a multi-purpose worker may be unable to perform any one task particularly effectively; added responsibilities will tend to dilute the time and attention that can be spent on each one. "Integrated" services can be performed by well-coordinated groups of single- or dual-purpose workers. But "integration" of separate functions in project management, to be successful in implementation, usually requires that the program components being "integrated" are organized, effective programs in their own right, and that competent, experienced program administrators are given specific, detailed authority for management functions required by the "integrated" approach. In the Philippines, government officials of all agencies and at all levels spend a great

deal of their time attending meetings and conferences to "coordinate" and "integrate" plans and programs, all the while very little actual "coordination" and "integration"-- in the true meanings of the words--are evidenced in field activities. (TIDA and PROCOM, as programs of "integrated" development, are discussed in the next sections.)

3. TIDA: POPCOM's Role in "Integrated Rural Development"

After the new executive director took office at POPCOM in 1974, there occurred a noticable shift in the focus of POPCOM's activities and in the direction of its policies and programs. As described in the PCF quarterly, "Essentially these changes will move around a shift in strategy from delivery of family planning services purely through the clinics, to the delivery of these services through barrio bases."* Although they were to be "logical extensions of the basic policies that have guided the program over the last five years," the changes that "are being introduced this year are radical in the sense that they involve a large-scale reorganization and reorientation in all areas of family planning activity."

In an interview in the quarterly, a POPCOM Board Member declared that the shift had two major aims: "the creation of new management structures closer to the field level, and the development of a new type of family planning

* Unless otherwise noted, all quotations in this section are from:

Galang, Rosalind M. "To the Barrios! The New Course Charted by the National Population Program," Initiatives in Population, Vol. 1, No.1, September 1975, pp. 2-12; and

Guerrero, Amadis Ma. "Beyond Population, Beyond Family Planning: the Commission on Population's Total Integrated Development Approach," Initiatives in Population, Vol. 2, No. 1, March 1976, pp. 8-15.

worker who will be the front-liner to the program in the barrio." To implement the changed policies, POPCOM was to decentralize and regionalize its operations. The management structure and associated policies for implementation of this program were labelled the "Total Integrated Development Approach."

"Mini-Commissions on Population will be established in the provincial governments, in much the same way that the Commission was established as an office under the President of the Philippines. These Provincial Population Offices (PPOs) shall coordinate all population program activities in the provinces. Representatives and workers of the various agencies serving the rural areas will meet periodically in council to inform one another of what each is doing, and coordinate their efforts with one another. In general, they will attempt to achieve, at the local level, the coordination and integration which the national agencies have achieved."...

"According to the revised national plan of action for the population program, the PPO will 'work closely with the provincial governor and become a partner of the Provincial Development Staff towards the setting up of a structure which is deemed necessary to implement a total provincial development plan into which the population program can be integrated.'

A municipal population office and a council of population workers in the municipality will implement the provincial plan at the municipal level. The barrio will be served through the barangay development center under a full time family planning worker.

After a time, the provincial government will be expected to take over the 'functions of planning, implementing and funding population program activities in the province, while the coordination and facilitation/maintenance of support services for more effective and efficient implementation'

"of the program will remain the central responsibility of the Commission on Population.'

These management structures have to be set up first before the program can reach out to the rural areas."

It was pointed out in a footnote to the above that the "proposed national plan of action" presents a "general framework (that) is more or less final...the details of implementation are still being refined."

In a later article in the PCF quarterly in March 1976, after TIDA had been "declared operational in seven (pilot) provinces in July 1975," the functions of the Municipal Population Officers (MPOs) were detailed:

"The MPOs will organize a Municipal Coordinating Council of the Population Program (MCCPP), a Barangay Development Council (BDC), and a Team of Development Workers (TDW). The MPOs will form the councils with the help of municipal mayors; community leaders will be identified and invited to join the MCCPPs and the BDCs.

The MCCPP will function essentially as a consultative and planning body on population matters, while the BDC will focus its attention on the barangay, the basic political unit in the country. The BDC will function as a point for motivation, service delivery, and follow-up maintenance, and as a source of data.

The TDW, on the other hand, will be composed of (though will not necessarily be limited to) the Commission's partner agencies. Each one will have a specific area of expertise, ranging from agriculture to nutrition."

This lengthy description of TIDA is necessary to provide some background for a discussion of the many issues it has raised concerning the organization and management

requirements of supervising a large number of field motivators, specifically those issues as they relate to the Outreach program design. During its visit, the team encountered considerable confusion among officials in the field, at POPCOM, and at USAID about TIDA and how it related to Outreach. One source of confusion was that USAID originally supported TIDA and contributed some \$400,000 to the first year of TIDA's operation in seven pilot provinces (64 percent of the total budget), but later, after programming Outreach, withdrew support for TIDA--not because the experiment failed, but apparently because it was not understood. The January 1977 draft of the Project Paper for Population II, discussing TIDA under "Project Issues," said:

"USAID support for TIDA has been assiduously cultivated, but to date, Mission personnel have felt uncertain that they understood the full meaning and implications of TIDA. They have accordingly steered clear of it, excepting a modest trial program in seven provinces under the predecessor project."

Implementation of TIDA in the seven provinces had begun (with the help of USAID financing) after a Joint POPCOM/USAID Review Team, in April 1975, had made as its initial recommendation:

"POPCOM/USAID support should be given to a proposed plan of reaching the rural areas through an integrated development strategy tied closely to the existing provincial government structure."

To the extent that this statement implies endorsement of TIDA, and the PP statement implies the opposite, there is an unelaborated implication that USAID believed the subsequently programmed Outreach program to be incompatible with TIDA. Having "accordingly steered clear of (TIDA)," USAID nevertheless explicitly accepted "the adoption, or non-adoption, of a TIDA overlay" as a matter for the Philippines government to decide.

A "TIDA overlay" on the Outreach program may well have an impact on its effectiveness, one that cannot be "finessed," as described in the PP, "by adhering to neutral Outreach terminology..." This analysis will focus on assessing the potential role and impact of TIDA, in relation to the Outreach project in particular and to the whole population program in general, by analyzing the rationale for TIDA and the implementation issues it has encountered during its first year of operation in seven provinces.

a. Rationale for TIDA

There were three basic program purposes that were intended to be solved by the adoption of TIDA. According to FHC's reading of program documents and articles about TIDA, these were (1) to improve the effectiveness of extension workers working in family planning motivation and information; (2) to establish an organizational structure

under POPCOM that would have responsibility for coordinating the population program at the provincial and municipal levels; (3) to operationalize a new orientation or ideology of programming family planning--one that was described as being "concept-oriented" rather than "contraceptive-oriented."

(1) In 1975 POPCOM sought to revise the use of "integrated" workers for motivational activities. At the time there were about 2,500 DOH clinic-based part-time motivators and 3,850 at-large motivators from the Departments of Social Welfare, Local Government and Community Development (DLGCD), and Agriculture. The main shortcomings of the existing motivators, according to POPCOM, were:

- That the clinic-based motivators did not even spend full-time in family planning and could never be programmed to serve most of the rural areas where need was identified to be greatest; and
- That the at-large motivators "were not really very effective in most of the family planning duties assigned to them (being) overburdened with their own special responsibilities...their interests were divided, and naturally, their loyalty was to the parent organization, not the population program." A full-time family planning worker, "based in the community and supervised by midwives or nurses in the health stations," was identified as being needed by the population program.

(2) Implementation of the population program at the provincial and municipal level was constrained by the lack of

any organizational structure or mechanism below the regional level that could coordinate and integrate the various population activities of the various participating agencies. Some kind of an organization and management structure had to be designed, particularly if the new cadre of family planning extension workers was to be at all effective in its field activities.

(3) A perception that the population program was lagging or stagnating led to a decision to redirect POPCOM's efforts and to rejuvenate its morale. There was a concerted campaign by the Executive Director to fashion an ideology or philosophy as a foundation for the program that would:

- Inspire family planning workers to work selflessly for family planning;
- Create a rationale for population to serve as the keystone agency in "integrated rural development" efforts; and
- Answer critics who claimed that only development can bring reduced fertility by creating a logic which said that family planning, when pursued as an integral and inseparable component of a community's development, can itself help to bring about development.

This latter rationale, POPCOM's need to reorient its program to the TIDA "concept," was "taught" extensively in training of POPCOM's field workers from

mid-1975, and it served as both an explanation of the role of family planning workers as structured in the TIDA provinces in an overall development effort, and as a logic for persuading potential acceptors of the importance of family planning. It is the role of this "concept" in POPCOM's overall programming efforts that has caused puzzlement both within USAID and within the participating agencies.

The meaning of "concept" orientation was amplified by the POPCOM Executive Director in a magazine interview:

"The concept carries two basic assumptions. One is, that the common denominator of all development efforts is population, and the ultimate objective of all these efforts is the improvement of the quality of life.

The other is, that the needs of people, whether urban or rural, are the same--food, shelter, education, and income. They only differ in degrees or priorities. These needs are closely interrelated; one is affected by the other or the rest."

b. Implementation Issues

The process of implementing the TIDA "concept" in the seven provinces chosen for the initial phase revealed some problems in translating the abstract theory into practical reality. The experiences of the seven provinces in trying to operationalize the "concept" perhaps were significant in USAID's decision to "steer clear of it,"

because they raised serious questions of policy and purpose. Major problems which showed up in implementation were, in FHC's view, principally the following:

(1) POPCOM had programmed itself to assume a leading role in organizing and coordinating the broad range of community development activities at the municipal level by arguing that its "TIDA concept" warranted giving POPCOM (i.e., the Provincial Population Office) responsibility for "integrating" and "coordinating" all other agencies' efforts toward developing the barangays. It is unclear that POPCOM sufficiently involved its partner agencies in the process of programming TIDA to fashion a policy consensus at the central level to ensure a minimum of coordination of activities at the field level; no other agency actually endorsed it. To say that the PPO should "work closely with the provincial governor and become a partner of the Provincial Development staff towards the setting up of a structure which is deemed necessary to implement a total provincial development plan into which the population program can be integrated," is not to imply, as TIDA does, that the PPO should lead all the other

agencies in this effort, using the family planning field workers "to cater to all the people's needs."

(2) This effort to assume a lead in rural development activities resulted in friction between POPCOM and other agencies at the provincial level. POPCOM had not tried to conceal its intentions of assuming a more central role among development agencies as it moved toward a provincial-level organizational structure; in announcing the plans in the magazine article, it stated: "Because of these changing needs and situations, the Commission on Population has had to move slightly from its original position of a purely coordinating body for the national program...major changes will be effected in due time...Full-time family planning workers will come directly under the Commission (which) will also exercise some amount of supervision over integrated workers connected with other agencies." After TIDA had been operational in the seven provinces for perhaps six months, a subsequent magazine article admitted to problems with the participating agencies:

- "We encountered initial resistance from POPCOM's partner agencies; they believed we were usurping their functions."
- "We had to erase lingering concepts of some workers that they are part of an agency, and not of the population program as a whole."

- "There has been some resistance to (monitoring)... some agencies resent monitoring. They feel they are checked on when all we want is to get accurate data and know what is going on in the clinics."

(3). In fact, full-time family planning workers never were placed directly under the Commission's control or administrative supervision under TIDA. The goal of moving ultimately toward local government financing of all population activities required that the provincial governor be given administrative control over the population workers within the province (with POPCOM retaining technical supervision responsibilities). TIDA's Municipal Population Officer (MPO) was not given supervisory responsibility over any "full-time motivators"--there were none, as such, in the TIDA provinces. The MPO, assigned one per municipality, could conceivably have responsibility for as many as 75 barangays; with responsibilities (according to the TIDA "concept") for organizing the MCCPP, and BDCs and TDWs in every barangay, the MPO could not conceivably focus more than part-time attention on organizing Barrio Resupply Points (BRPs) or on family planning motivation and information activities at the household level--functions that were identified as needs in the programming of TIDA. In practice, the fact that the PPOs were responsive administratively to the provincial governor meant that the nature and dimensions of MPO's

activities varied greatly from one TIDA province to another. For example, the MPOs in Nueva Ecija and Misamis Oriental put relatively high priority on establishing BRPs, and as a result were able to increase substantially the number of new acceptors for 1975-1976 over the period 1974-1975. The other five provinces put higher priority, in varying degrees, on establishing Barangay Development Councils and on associated "total" development pursuits, and as a result new acceptor recruitment declined substantially over what it had been when other motivators--DOH part-time and other agencies' at-large motivators--had been working in those provinces. Table D shows the impact which implementation of TIDA had on new acceptor recruitment in the seven provinces. According to the TIDA "concept," new acceptor recruitment may well drop off, because "most of their (MPO's) duties and functions go beyond the population sphere, dealing with the purely social, economic, or developmental." But once the people understand that family planning is integrally related to overall development, the rates should theoretically increase again.

(4) Because of the lack of specificity in the authority and role of Provincial Population Offices, vis-a-vis the provincial representatives of the partner agencies, the

TABLE D

NEW ACCEPTOR RECRUITMENT
PPO (TIDA) PROVINCES

PROVINCE	FY 1975-76	FY 1974-75	% Increase (Decrease)
Misamis Oriental	18,248	12,263	48.8%
Negros Oriental	10,217	13,584	(24.79%)
Leyte Sur	1,732	3,761	(53.95%)
Capiz	2,789	5,841	(52.25%)
Laguna	12,191	16,169	(24.60%)
Nueva Ecija	17,858	9,323	91.55%
Pangasinan	8,125	17,300	(53.03%)
TOTAL	71,160	78,241	(9.05%)

SOURCE: MIS Unit/Planning Division, POPCOM.

provincial government, and POPCOM's regional office, the development of systematic and uniform recognized management procedures, linking POPCOM's regional offices to the province has been hampered. Instead, working relationships among the various bureaucracies and political units have been fashioned in an ad hoc manner, and seem to have been based more on the establishment of interpersonal relationships than on an institutional consensus regarding policy and procedure. This problem will have greatest impact in the area of financing; although the TIDA "concept" involved phasing-out of POPCOM's responsibility for funding provinces within a decade (or thereabouts), the operation of TIDA in the first seven provinces has shown little evidence of a systematic or concerted approach toward getting the provinces to share TIDA's cost. At the time of FHC's visit, POPCOM reported that several TIDA provinces were behind in assuming the minor share of the cost for the first year, and the extent to which the provinces had made any specific binding obligations to POPCOM was unclear.

(5) The all-encompassing scope and abstractness of the TIDA "concept" have resulted in confusion about the denotation, "TIDA." Although several POPCOM advocates

of "TIDA" claimed that it is an advantage that "TIDA" can mean so many different things to different people, it is unlikely that this characteristic of the "concept" is conducive to clarity of organizational purpose or efficiency of project management. The term "TIDA" has been used commonly to describe both a "structure" of organization at the provincial level and a "process" by which family planning ought to be pursued; thus the guiding TIDA "concept" often has been used to imply a particular provincial organizational structure as much as it has been used to imply the program process. When discussing TIDA implementation issues, as have been raised above, it proved rather confusing for the team, as presumably it has for USAID, when "TIDA" was being referred to. Such confusion was particularly frustrating in light of the "spiritual" dimension that appears to animate one's adherence to the TIDA "concept." For example, in describing the progress with TIDA, one POPCOM regional official said:

"TIDA is succeeding beyond our expectations. We have ignited something spiritual, making people feel it is their moral obligation to adopt a family planning approach to bring about development. The MPOs walk as far as 40 kilometers to the barrios just to organize barrio resupply points, which is one of their main functions. Some of them even fainted. The majority of them are women--beautiful and fragile-looking. But they can really slug it out!"

The fact that USAID referred to a "TIDA overlay" in its Outreach program document is indicative of some disagreement over the "TIDA" denotation. For, although it is quite likely that USAID was referring to no more than a neutral stance regarding "TIDA" as a "structure," the use of the word "overlay" implies a non-acceptance of "TIDA" as "process" to the extent to which it is seen to threaten what USAID desires as the goals of Outreach.

c. TIDA and the Programming of Outreach

From interviews with USAID and POPCOM officials, the team learned that the process of designing the Outreach program during the spring of 1976 was characterized by friction and frustration on both sides. POPCOM's Executive Director was in favor of extending the TIDA "concept," already in implementation in seven provinces, to more provinces, and USAID favored a different approach. The TIDA "concept" did appear to be directed at achieving USAID support objectives as outlined by its Population Office.

In particular, for example, Nos. 4 and 5 of the "Draft USAID/POP Support Objectives," dated October 1975:

- "4. Integrated Delivery System. The objective is to link P/FP action programs to other GOP development programs in a mutually-beneficial fashion, particularly at the"

"grass-roots level. Program reinforcement, rather than pooled resources, is the key, as viewed by POPCOM and NEDA.

5. Provincial Population Officers (PPOs). A POPCOM-designed program wherein specially-trained population officers are assigned to province, district, and municipality levels to promote and coordinate P/FP activities. This experimental scheme departs from conventional GOP line-authority government, but may be what is needed to revitalize the plateaued GOP program."

However, USAID contended that TIDA contained characteristics which were contrary to the support objectives--e.g., TIDA MPOs were not "full-time motivators" (a key support objective) in a strict sense, since they covered too much population and had too many other functions to be considered "full-time motivators." Moreover, USAID could argue that the TIDA management structure (PPO) could be accepted for the most part without necessarily accepting the "total" development orientation of the MPOs under the TIDA "concept." In fact, USAID did accept the TIDA PPO structure for Outreach; it was stated in the Project Agreement:

"A supervisory and logistical supply network, initiated last year in seven of the country's 72 provinces, will be expanded nationwide with one District Supervisor for each 10,000 married couples of reproductive age (530 DPO's total), and Provincial Population Officers (100 total) responsible to the local governor in each province."

Nowhere in the Project Agreement, however, is TIDA mentioned, either to adopt or preclude it as an element of the program. Although the top of the PPO management structure is used in the Outreach Project Agreement (Provincial Coordinators and District Supervisors), no mention is made of MPOs being included in the Outreach management system. Nevertheless, in planning the implementation of Outreach, POPCOM included an MPO level of supervisors in its preliminary planning and recruitment of field workers; in the seven TIDA provinces, it was planned to merely add a number of FTOWs roughly equal to the existing number of MPOs above and beyond the number of PPOs, DPOs, and FTOWs which POPCOM had committed itself to in the Project Agreement. Although this would have substantially increased the basic salary costs of the Outreach program, it was not until after the October 6 suspension of Outreach that the MPO level was eliminated. It was not until November or December that the TIDA provinces were notified that MPOs would become FTOWs and would undergo training just as would newly recruited FTOWs; in at least one TIDA province visited by FHC, the FTOW applicants that had been recruited and tested for the FTOW positions still had not been notified, at the time of FHC's visit that the FTOW positions had been taken by the MPOs.

In practice, it has proved difficult for POPCOM to implement only the TIDA-PPO management structure trained to supervise USAID-designed Outreach workers, but stripped of the POPCOM-designed TIDA "concept." Training for FTOWs and their supervisors has been conducted by the same group, the Economic Development Foundation, Inc. as trained all the TIDA PPOs, DPOs, and MPOs. The FTOW training manual contains a description of, and numerous references to, the TIDA "concept." TIDA MPOs who were retained to be FTOWs testified to FHC that the training was essentially the same as they had been through a year earlier, and that they still preferred to be called MPOs, since they saw themselves more as "community development" workers than as "family planning" workers. Newly trained FTOWs sported T-shirts in one region proclaiming the "TIDA-PPO-Outreach Program." All were readily familiar with the TIDA "concept."

In summary, although both POPCOM and USAID appear to make a distinction between the Outreach and TIDA (note the October 6, 1976, decision of the POPCOM Board to designate 17 "Outreach provinces" and 17 "TIDA provinces"), in the implementation of what is called the "National Family Planning Outreach Project," there seems to have been a blurring of the distinction. POPCOM regional officials are quite familiar with the TIDA "concept," many of them were participants in the POPCOM internal programming processes

that designed it, and many of them appeared, during interviews with FHC, to be committed to the TIDA "concept." In several regions, FHC encountered veiled resentment toward USAID for its insistence that FTOWs focus "only on family planning."

There is considerable room for debate over whether the best approach to "rural outreach" is TIDA, or the "Outreach Project," or even Project Compassion, which is discussed in the next section. Resolution of the outstanding disagreements may well have to wait until program outcome measures indicate the net effect of the numerous implementation difficulties that have been encountered; but in the meantime the controversy has tended to create an atmosphere of confusion and has created uncertainty among both the local governments and POPCOM's field workers about their proper roles and responsibilities. This uncertainty raises serious questions as to whether the program targets and purposes can be achieved and whether the various measures of program outcome will be adequate to assess program efforts.

4. Project Compassion: PCF's Role in "Integrated Rural Development"

The Population Center Foundation (PCF) was founded in 1972 "as a private, grant-making institution established to increase the participation of the private sector in the country's efforts to bring about timely and effective solutions to its population problem."* Foreign donors helped to finance construction of PCF's "elegant building," and a substantial endowment was raised to establish a source of income for making grants to achieve its purpose of "assisting private institutions and individuals (to) perform a basically innovative function within the National Population Program." In programming its "beyond family planning" orientation, PCF sought to "assist in the development of new schemes that integrate population with fields such as nutrition, human settlements, environment, and social welfare," as well as in the "development of mechanisms for the delivery of family planning services in the rural areas through community-based organizations and through non-health structures."

* All quotes on this and the two following pages are from Population Center Foundation, Population Center Foundation Annual Report 1974-1975, Manila: Division/PCF, 1975.

a. Project Compassion

Project Compassion, otherwise known as PROCOM, is a "major program" supported by the Population Center Foundation. It is a program designed to integrate delivery of services from the four social service programs which are of the most direct concern to the First Lady, Mrs. Imelda Marcos--nutrition, food production (backyard gardening), environmental planning (water-sealed toilets), and family planning. It is regularly described by program literature and officials as being a "single organizational channel reaching the rural family with its four-program package through doorstep delivery;" other features are that it "emphasizes the utilization of private resources to complement government efforts...(and) places the primary responsibility of planning and implementing project on the local governments."

PROCOM explanations of the rationale and purpose of the family planning component of the program sound virtually identical to the rationale and purposes put forward by POPCOM for using the TIDA "concept": "Project Compassion is a social development program designed to solve the problems of outreach, integration, and community-based support." Thus, PROCOM can be an effective way to deliver family planning services because it provides solutions to:

- Outreach--"even if fully utilized, the clinic-based system of delivering family planning services cannot provide full coverage for the rural population;"

- Integration (Structure)--"there are very few service programs which reach the barrios directly and which could provide a channel for family planning diffusion...and (those that do) are not often integrated with one another...no structures are developed in the barrios to ensure self-generation of efforts;" and
- Philosophy of Approach--"the resources and persuasive power of (existing extension) programs are not combined into a coordinated program which could respond to the whole range of needs of the community... the concept of Project Compassion...will be disseminated through the mass media to enlist broader involvement from local governments as well as from the private sector."

PROCOM was initiated in nine provinces and two cities, on a pilot basis, in early 1976. POPCOM apparently participated in PCF's program design process, and the management structure is similar to that in TIDA, except PROCOM does not have a "district" level of managers between the provincial and municipal levels. The PROCOM program in each province is directed by a Provincial Family Development Officer (PFDO), who is executive secretary and "action officer" of the Provincial Family Development Committee (PFDC) and responsible to the provincial governor. The PFDC is made up of the provincial heads of all the government and quasi-government agencies participating in PROCOM, plus several private sector representatives appointed by the governor. The PFDC meets monthly to discuss implementation problems, to coordinate their programs, and to decide on projects to be done jointly. A similar organization, the Municipal Family Development Committee (MFDC), operates

in parallel fashion at the municipal level, the Municipal Family Development Officer (MFDO) serving in the same capacity as the PFDO at the provincial level.

All PFDOs and MFDOs are contract employees of the respective provincial or municipal governments; their salaries and general administrative expenses are paid for out of provincial and municipal funds, while training costs are borne by PROCOM central funds. Financing of project activities comes exclusively from within the budgets of the participating agencies, or in contributions (in cash or in-kind) from the barangays participating in the projects decided upon. The main responsibilities of the MFDOs, other than to moderate the meetings of the MFDC, are to establish arrangements with all barangay captains (elected leaders) within the municipality to select and train "unit leaders" who would be responsible for serving as the service delivery link between the barangay captain and 20-family "units" (puroks) in every barangay; the barangay captain would obtain supplies from the MFDO (i.e., nutrition packets, vegetable seeds, contraceptives, etc.) and would distribute them to the "unit leaders" who would in turn distribute them to families. "Unit leaders," once selected, receive three days' training from PROCOM trainers.

When PROCOM was being planned, POPCOM's participation in the planning process ensured that PROCOM would not be pilot-tested in any provinces, or ever adjacent to any

provinces, where TIDA had already been initiated. It was thought that such a separation would avoid duplication of effort, and would permit a comparison of the two approaches to delivering family planning services in an "integrated" structure. However, PROCOM was not involved in, nor informed about, the planning of Project Outreach; and PROCOM claimed, in a document explaining the PROCOM-POPCOM agreement of January 31, 1977, that PROCOM was informed of Outreach only "when it was too late to make any suggestions to avoid the chaos that might well result if the two programs were implemented simultaneously in one province."

As described in the PROCOM document: "The POPCOM Board, at its meeting of October 6, 1976, resolved this problem by utilizing the Compassion network and appointed PROCOM as the agent to carry out Outreach in PROCOM provinces." It was at this POPCOM Board meeting that the members voted to restrict implementation of Outreach to 17 provinces, to keep Outreach out of 17 TIDA provinces (adding ten to the existing seven TIDA provinces), and to integrate Outreach workers (FTOWs) into ten PROCOM provinces.

In a letter from the POPCOM executive director to USAID, renegotiation of the Project Agreement (of June 18, 1976) was requested in order to implement this decision by the Board, which was intended "to compare the three

above-mentioned approaches (in recognition of) the possibility that the Outreach project may not be the only effective way of reaching the majority of the married women of reproductive age in the rural villages of the country." Subsequently USAID's refusal to renegotiate the Project Agreement led to the POPCOM Board's decision, on November 15, 1976, to go ahead with nationwide implementation of Outreach. Agreement between PROCOM and POPCOM on the integration of Outreach into PROCOM provinces and on the financing arrangements for such provinces were the subject of continued negotiation between the two parties until a detailed agreement was signed on January 31, 1977.

During the team's visit, however, field interviews with PROCOM and POPCOM officials, and interviews with USAID officials, revealed that misunderstandings about lines of authority, financing arrangements, and implementation details continued to exist where Outreach was underway in PROCOM provinces. Some of the outstanding issues encountered by the team, and their implications for the family planning program, are analyzed below:

- (1) The initial failure of POPCOM to coordinate its Outreach program implementation plans with PROCOM for provinces where PROCOM was already operating led to confusion and disruption in the field, and generated friction between POPCOM and PROCOM leadership. It is not known, and perhaps may not be relevant,

whether this failure to coordinate was a conscious, intended effort by POPCOM; the Project Agreement, moreover, which was signed by NEDA and USAID as well as POPCOM, made no mention of PROCOM, nor of the need to coordinate the Outreach program with that private/public effort spearheaded by Mrs. Marcos.

At any rate, FHC's reading of PROCOM and POPCOM documents, and its interviews in the field, revealed that POPCOM's initial implementation of Outreach during the summer and fall of 1976 included plans to set up a full complement of FTOWs and supervisors in provinces which already were implementing Project Compassion. USAID's Gantt Charts did, after all, require nationwide coverage by Outreach according to a specific, paced schedule, and POPCOM's agreement with PROCOM of the previous year only obligated them not to operate TIDA in PROCOM provinces; Outreach was something else. Regional POPCOM officials, who generally had little or no contact with PROCOM, went ahead with implementation plans as they received them from POPCOM/Manila.

At the end of September 1976, PROCOM and POPCOM officials finally worked out an agreement which was signed on October 6 and was an integral part of the POPCOM Board's decision that day to restrict Outreach (which had the effect of temporarily suspending it until a month later when the Board reversed itself).

(2) Agreement between POPCOM and PROCOM (on implementation of Outreach in PROCOM provinces) was revised at least once

since the October 6 accord, but the substance of the agreement had been elusive even up to the time of the team's departure from the Philippines. Lack of agreement was evidenced by (1) lack of formal endorsement of any POPCOM/PROCOM agreement by USAID, the principal funding agency of Outreach; and (2) evidence in the field that PROCOM seeks to expand its program beyond provinces it is already working in, even though PROCOM's stated policy is to avoid expansion. The October 6, 1976 "Memorandum of Understanding" between POPCOM and PROCOM had the following provisions:

- PROCOM became the "implementing agency" for POPCOM of Project Outreach in PROCOM's "existing places of coverage," which were nine provinces, three chartered cities, and two additional municipalities;"
- POPCOM would turn over funding for those areas listed;
- All existing PROCOM personnel would become Outreach personnel, and Outreach's additional DPO level of managers would be recruited and trained;
- Recruitment, selection, and training of additional Outreach workers, and the training and logistics support for PROCOM's family planning component shall, within the listed areas, be the responsibility of POPCOM.

Incompatibility in the nature and basis of various policies and procedures of PROCOM and POPCOM at the field level, however, required that the October 6 agreement be substantially expanded and somewhat revised; this was done in a document

entitled, "Implementing Details re the Integrated PROCOM-Outreach Project," which was signed January 31, 1977. This agreement added eight new cities and deleted one municipality from the October 6 Memorandum. The document described the "nature of the organizational relationship" as: "the local government, PROCOM, and POPCOM through a tripartite contract will effect the existence of the Province/City OUTREACH/COMPASSION Project."

The letter to the POPCOM Board from the PROCOM President, accompanying the proposed "Implementing Details," presented a justification for the adjustments in the list of areas covered (among other reasons it said, "All of the local government officials in the cities and capitals named have expressed their desire to be covered by PROCOM."), asked that the document be confirmed "as soon as possible to avoid the present confusion taking place in the provincial and city governments," and requested that the PROCOM provinces and cities forego recruitment of the DPO level of supervision required by Outreach ("...we would like to use the money appropriated for the district officers for the training of unit leaders.").

The POPCOM Board approved the "Implementing Details." But USAID informed POPCOM in a February 14 letter that using money intended for DPOs in PROCOM provinces instead for unit leader training would be contrary to the bilateral agreement

between POPCOM and USAID. A week after that the POPCOM President wrote directly to USAID, referencing the February 14 letter to the acting POPCOM Executive Director, to clarify the January 31 "Implementing Details." Enclosed with the letter was a document entitled, "Background of POPCOM-PROCOM Agreement on Outreach," which explained the process of disbursement of funds from POPCOM to PROCOM and how it would ensure that PROCOM would not spend money in ways contrary to the POPCOM/USAID bilateral agreement. It also revealed in some detail PROCOM's need for additional financing, presenting arguments that POPCOM should help defray PROCOM's "heavy" training expenses in covered provinces, and, again, that PROCOM be allowed to forego the deployment of DPOs in PROCOM/Outreach provinces so that money could be used for training PROCOM "unit leaders." PROCOM argued that this level of Outreach supervisors is unnecessary, will prove costly to local governments who will ultimately be required to pay supervisor's salaries, and is contrary to the PROCOM focus at the family level.

At the time of the team's departure from the Philippines, the issues raised by the attempt to reach agreement among POPCOM, PROCOM, and USAID on implementing Outreach in the PROCOM provinces were still outstanding. However, USAID had written a letter to the PROCOM president on March 11 requesting a meeting of all parties in order to reach a

"consolidated master agreement between POPCOM and PROCOM, cleared by DLGCD, NEDA, and USAID in lieu of (previous agreement documents)."

(3) At a time well after PROCOM had signed several documents of agreement (mentioned above) which made PROCOM the "implementing agency" for POPCOM of the Outreach program in PROCOM provinces, the PROCOM President presented (at least in an interview with the FHC team) PROCOM's case, vis-a-vis POPCOM/Outreach, in more of a competitive than a cooperative tone. In the interview, the President criticized POPCOM's training program, saying that the EDF trainers lacked experience suggesting that some of the training material might be of questionable value. He argued that the PROCOM "unit leader" plan was an approach toward delivering family planning at the barangay level which was superior to the Outreach Barangay Supply Point approach. He claimed that the FTOW recruitment process has been politicized in several areas, and that even though POPCOM had sent telegrams to all governors of PROCOM provinces trying to dissuade them from participating in PROCOM, the governors unanimously prefer to work with PROCOM. He argued that the Philippines will be unable to afford to continue Outreach after USAID funding is discontinued because it is too expensive. A similar competitive tone characterized interviews with some PROCOM field

staff. All this evidence suggests that PROCOM, as "agent" for POPCOM in implementing Outreach in certain provinces, does not fully share the interests of the "principal" POPCOM--even though that is the way the PROCOM President characterized the POPCOM/PROCOM relationship in his letter to USAID.

(4) While the above events took place in Manila, there were problems in the implementation of Outreach in PROCOM provinces. Ironically, the provincial-level confusion over POPCOM and PROCOM sharing responsibilities and functions put the provincial governors in the position of having to mediate and coordinate the recruitment, selection, and training processes, which were the main subjects of dispute between POPCOM and PROCOM at the central level. The extent to which governors attempted, or were able, to enforce cooperation in Outreach implementation, varied substantially from province to province. During FHC's visit to Iloilo Province, a PROCOM province in Region 6, PROCOM and POPCOM staffs appeared to have reached a workable accommodation of the procedures for the implementation of "Project Outreach Compassion." On the other hand, in Albay Province, a PROCOM province in Region 5, the FHC visit occurred in the midst of an unresolved dispute between POPCOM regional staff and PROCOM staff over responsibility for selecting DPOs and FTOWs for Albay. This dispute apparently

arose because of communication breakdowns between POPCOM/Manila and POPCOM/Region 5, and between the POPCOM Region 5 office and the Albay provincial governor. At the time of FHC's visit, it had not yet been decided whether nine DPOs, already recruited and trained by POPCOM, would actually be posted by PROCOM in Albay under the POPCOM/PROCOM Outreach merger, or whether PROCOM would select and train a different group of DPOs; PROCOM officials made it clear that it wanted at least some of its MFDOs promoted to the DPO slots.

The FHC field visit to Region 5 also raised doubts as to whether the list of PROCOM provinces, cities, and municipalities cited in the January 31 "Implementing Details" document was actually the limit of PROCOM's program. In an interview with the Governor of Caramines Sur, a province which had just days earlier started the Outreach program, FHC learned that the Governor had requested PROCOM to also implement its program in Caramines Sur. Although the Governor said that no favorable response had been received, PROCOM had sponsored a three-day "live-in seminar" for provincial officials to orient them to the PROCOM concept. A "resource speaker" was the Undersecretary of the DLGCD from Manila (the DLGCD Regional Development Officer in Legazpi had earlier told FHC that PROCOM was indeed coming to Caramines

Sur Province). The POPCOM Region 5 RPO claimed that she had no knowledge about the "rumors" that PROCOM was coming to Caramines Sur. The Governor told FHC that he did not think PROCOM represented a duplication of the Outreach approach, and that he would provide whatever coordination may be necessary in the event PROCOM did implement its program in Caramines Sur.

(5) At the time of the team's departure in mid-March 1977, a number of implementation issues regarding the way Outreach will be implemented in general, and the way FTOWs will be used in particular, remain to be worked out during the PROCOM/Outreach merger.

- (a) The POPCOM MIS reporting system and logistics supply network will apply differently to the FTOWs than to the MFDOs, since the MFDOs are programmed to be more "input-oriented" (distributing contraceptives and nutri-paks, etc. to "unit leaders") while FTOWs are programmed to be more "output-oriented" (servicing and maintenance of protection from unwanted pregnancy to a group of 2,000 MWRA; the MFDO was assigned responsibility for the unit of municipality, while the FTOW is assigned responsibility for a segment of the municipal population--only 2,000 MWRA.
- (b) The functions of newly recruited FTOWs and previously placed MFDOs are different. PROCOM will be required to supervise a mixed cadre of field workers, some of which will have functions of delivering nutrition, environmental sanitation, and backyard gardening services to the barangays as well as family planning, while others will be exclusively (at least in theory) in family planning.
- (c) The MFDOs, which are to be converted to FTOWs, presently have higher salaries than FTOWs: ₱484 per month for MFDOs versus ₱350 per month for FTOWs.

- (d) PROCOM PFDOs and MFDOs are contract employees of the respective local governments, while FTOWs are civil servants. Local government assumption of costs of the Outreach program may be jeopardized by this difference in status.
- (e) Provincial and municipal contributions to PROCOM have been appropriations budgeted by provincial governments, while provincial contributions to Outreach, according to sub-agreements with POPCOM, are in effect pledges of support. The sub-agreements are not binding contracts between POPCOM and the provincial or city governments.

c. The Future of PROCOM and Project Outreach

There can be little question that Project Compassion is innovative, both as a structure and as a program, in dealing with the problem of delivering some essential social services to rural households. It is a "private sector" program using ostensibly "non-governmental" instruments--i.e., contract employees--to organize a delivery system that is financed largely by government funds and operated largely through regular government channels.

One could argue whether a program which professes a private, non-governmental character, but which depends for its potency solely on the power and legitimacy implicitly conferred by the interest of the President's wife, is in fact best-suited to develop "structures...in the barrios to insure self-generation of efforts" or to "solve the problems of...community-based support."

The uncertain locus of accountability for PROCOM program efforts, and the implications of a non-governmental organization trying to "integrate" governmental efforts, may have little significance in a political environment where the distinction between public and private power is rather blurred. But there are reasons to question whether a centrally-conceived, high-powered program such as PROCOM is appropriately designed to succeed in strengthening local governments or in mobilizing rural communities for their own development.

The conflict between POPCOM and PROCOM over the implementation of the Outreach Project in PROCOM provinces appears to have its basis in organizational relationships and the struggle between POPCOM and PROCOM over funds and influence. Under these circumstances, it is difficult to imagine that an agreement among all parties to cooperate in implementing Outreach in "PROCOM-covered" areas is likely to be strictly adhered to in the field. It is reasonable to assume that Governors in non-PROCOM provinces will show increasing interest in PROCOM, just as has the Governor of Caramines Sur, even as they are becoming involved in implementing the first year of Outreach. They may wish to be associated with an important project of the First Lady.

Even if meaningful agreement can be reached in Manila between POPCOM and PROCOM, to the satisfaction of USAID,

DLGCD, and NEDA, the events of the last six months have created an atmosphere of competition, charged with some bitterness, between the major institutions and leaders involved in the Philippines' population program. This atmosphere is not conducive to achievement of a greater degree of coordination and integration of efforts in the program, which has long been recognized by all parties as a critical need, and which has been found in this report to be as great a need as ever.

5. The Role of the Catholic Church*

Many Catholics think not only that artificial conception control is at times permitted, but that it may also be necessary for them to practice responsible parenthood. This position is perhaps best summarized in the report of the Papal Birth Commission. Bishops and experts from the fields of theology, medicine, psychology, demography, sociology and economics made up this Commission. They submitted their report to the Pope in June 1966. The Commission did not achieve unanimity, but the majority of its members agreed with the position set down in its report entitled On Responsible Parenthood. The work of the Commission is referred to in Humanae Vitae and parts of the report, especially on the value of marriage and the meaning of responsible parenthood, have been incorporated into the encyclical.

The introduction of On Responsible Parenthood states that technical progress is a characteristic of modern man and is something very much in accord with the will of God. The Commission draws the conclusion that for many couples to preserve and foster the values of marriage and "achieve a responsible, open and reasonable parenthood," the regulation of conception appears to be a requirement.

On Responsible Parenthood states that a couple should

choose that method of conception control which best enables them to express their love for one another and preserve the values of their married life. A less satisfactory method may sometimes have to be employed because of the unavailability or prohibitive cost of the preferred means. Thus, On Responsible Parenthood allows the use of artificial conception control when this is called for by the need to preserve and develop marriage values. The reason for this position is that the report does not hold that each and every marital act must be open to the transmission of life.

Part II of On Responsible Parenthood treats of various pastoral needs: the task of educating people; the application of the doctrine on marriage to different parts of the world; the population problem; and finally further development of means for educating married couples and young people. Abortion and other means seriously suspected of being abortive are to be avoided. This, however, as is clear, is not really a question of conception control but of eliminating offspring already conceived. Permanent sterilization, since it is an extreme method, is generally to be excluded.

Because of the authoritative position of Bishops in the Roman Catholic Church and their role as teachers of the Christian message, their reservations on the papal condemnation of artificial conception control are of special significance and interest. During its field visit to the Philippines, FHC interviewed five Bishops, and the Archbishop of Manila, Jaime Cardinal Sin, on this subject. The consensus of these interviews

was:

1. None was against the use of OCs, condoms, IUDs, etc., but all were opposed to any inducements which were used to gain new acceptors or to keep continuing users.
2. Most wanted Catholics to use the "accepted, natural methods" for family planning...but if that proved a method failure, then other methods could be used.
3. They all opposed sterilization because of:
 - a. the incentive schemes
 - b. the belief that it would lead to abortion services in the Philippines.

FHC believes that the deployment of incentive schemes are related in the Bishops' minds to involuntary methods of contraception and this poses a direct challenge to their role as authoritative teachers of the Christian message. The Bishops frequently mention 'responsible parenthood', and this undoubtedly underscores their endorsement of On Responsible Parenthood and the Bishops' of the Roman Catholic Church's interpretation of Humanae Vitae.

This is of signal importance for the population planning program in the Philippines. The Bishops are not against the program per se; they are against the linkage of its means to its ends in any manner they perceive to be involuntary. They feel there is nothing organic in such a union (individual will and State purpose), and compulsion must repeatedly be applied to maintain the artificial bond.

If incentives and other forms of involuntary acceptance of fertility control methods are removed, the Bishops would

feel free to endorse implicitly, on the basis of their contributions to the Papal Birth Commission, the government program. The themes developed in their document, On Responsible Parenthood, could be a powerful incentive in themselves to the cultural acceptance of population planning in the Philippines, including sterilization procedures.

*Source: H. Paul LeMaire, S.J., "Artificial Conception Control: State of the Question in the Roman Catholic Church Today," published in Department of Labor, Population/Family Planning Seminar Workshop Manual for In-Plant Labor/Management Coordinating Committee Members, Manila.

ANNEX B

THE STATE OF KNOWLEDGE ABOUT POPULATION AND FAMILY PLANNING MATTERS IN THE PHILIPPINES

A. THE DATA BASE

The major source of Philippine population data is the national census. Enumerations were made in 1903, 1918, 1939, 1948, 1960, 1970, and 1975, though the first four are of limited analytic value now.

The 1960 Census results were not fully available until 1965, but have been utilized heavily since then, most importantly for national fertility and mortality estimates and as the base for an important projection of the national population to the year 2000 (Lorimer 1966). The potential value of the 1950 Census will never be fully realized, however, because only minimal tabulations were published and the original punched cards were destroyed, prematurely. All that remains is a 0.5% sample at the Population Institute, University of the Philippines.

The 1970 Census, conducted in May of that year, became available in the form of advanced reports in 1972, and was fully available by 1974. Initial analysis of the 1970 enumerated total and the national age-sex composition has raised doubts about overall accuracy. Nevertheless, the 1970 Census has been and will be a key source of planning data on population, especially for characteristics of local areas. The 1970 Census

tabulation plan, both published and unpublished, is very extensive and provides cross-classifications of population not heretofore available. Finally, a 1975 bi-census has been taken, and basic tabulations for 56 of 73 provinces are now available. This census contains recent local-area data of major importance to the family planning program, whose impact on local areas should have been measurable by 1975.

The vital statistics system in the Philippines is badly deficient--the current birth rate from these data is but 60 percent of its probable true level. Death registration is about 80 percent complete but marriage registration is possibly lower than that for births. The lack of even moderately reliable vital statistics data constitutes a major gap in demographic information, one which must eventually be filled. On several occasions pilot systems have been initiated to evaluate coverage in selected local areas--a USAID-Census Bureau five-year study of 50 municipalities is one of these--but there has never been an attempt to revitalize the system nationwide through an overall restructuring. The "registration area" concept, for example, might have been introduced, but has not been. Useful demographic analyses based on Philippine vital statistics are rare.

A semi-annual national survey of households (the Bureau of the Census Statistical Survey of Households, or BCSSH), has been conducted by the government since 1956, yielding a useful

series of national level estimates of the labor force. Periodically these surveys have included questions on socio-economic characteristics, e.g., literacy and other topics. The survey rounds of May 1956, 1958, 1963, 1968 and 1973 provided information on fertility and/or family planning knowledge, attitudes, and practices. The BCSSH has recently been placed on a quarterly basis, increasing its value for labor force analysis (especially re seasonality of participation), and its sample size has been increased from about 7,000 to about 15,000 households, making results more reliable and enabling more elaborate tabulation (for each of the planning regions, for example). This survey will continue to provide regular labor force data for economists and demographers, but will provide other population data (e.g., fertility) only when funds for this purpose are made available. The U.P. Population Institute, for example, conducted its National Demographic Surveys in May 1968 and 1973 or add-ons to the BCSSH survey. Similarly, a World Fertility Survey round is planned for January 1978.

B. STUDIES COMPLETED AND IN PROGRESS

What follows is an exceedingly brief overview of population studies in the Philippines. We have broken the large body of completed studies into four groups. Early analyses, mostly conducted during the post-war period up to about 1968, and largely since 1960, focused on identifying the main outlines of the population problem. Many of these studies were designed to

demonstrate to government officials the seriousness of the problem and the existence of a large group of women interested in family planning. Recent fertility analyses, especially those emanating from the National Demographic Surveys of 1968 and 1973, have provided a much more refined picture of fertility trends and variations, and have raised some new issues for program planners. Family planning evaluation studies have come, of course, since the program's inception in 1970. These include national-level KAP surveys, follow-up surveys among acceptors (the National Acceptor Surveys of 1972, 1974 and 1976), and analyses of the program's service statistics. Other studies have generated much useful information, especially on internal migration streams, social mobility, rural-urban movement, the urbanization process and labor-force characteristics. The first three groups of studies are reviewed in the succeeding sections.

1. Early Analyses. The earliest studies of fertility levels and trends in the Philippines are local (town or barangay) level surveys conducted by the U.P. Statistical Center or the U.P. School of Public Health in the fifties and early sixties. Extensive fertility data were available from the 1939 Census, but were not examined carefully until Taeuber's work in 1960. The first national level analysis is by Concepcion, who utilized the BCSSH survey results of 1956 and 1958. The Concepcion study, completed in 1963, stands as a benchmark in Philippine fertility

analysis. Fertility levels were shown to be high, and a number of important fertility differentials (by education, income, etc.) were identified. The 1960 Census 0.5 percent sample became available at about this time, and Regudo's regional analysis of fertility levels is based on these data.

Information concerning the contraceptive knowledge, attitudes, and practices (KAP) of the population was first obtained in May of 1963 in the BCSSH round (available September 1965). Another BCSSH fertility and KAP round was conducted in 1965 (available May 1966). Four KAP surveys were conducted by the U.P. Population Institute over the 1964-1967 period, involving local areas in several regions of the country. Urban KAP surveys were conducted in 1966 (Manila) and 1967 (Dumaguete City). Numerous KAP surveys have been conducted since this time, the most important of which are the National Demographic Surveys of May 1968 and May 1973.

An important set of population projects was made public by UPPI in 1965, based upon the work of Frank Lorimer, a visiting population specialist provided by the Population Council to UPPI. Lorimer assessed all the population data available at that time, including the fertility surveys mentioned above, and estimated the birth rate for the period of time centering on 1960 to be 45 per thousand, the death rate at 13 per thousand, and the rate of growth at about 3.2 per cent per annum.

The Lorimer projections to the year 2000 were very important in an information campaign which was initiated among

Filipino opinion leaders in 1965 and which culminated in the formal government adoption of a policy of population control in 1970. The projections--which served as the central discussion paper of the nation's first conference on population in 1965--included several alternate series and clearly demonstrated the beneficial of fertility decline on both age-structure and total population. The early KAP surveys, the results of which became available during the 1965-1968 period, were also instrumental in the information effort; they showed political leaders that a sizable segment of the married female population wanted fewer children (four or five) than they were likely to have (about seven). They also showed that most women over thirty did not want additional children. A great deal of ignorance about family planning was also evident, along with much receptivity to information and little open opposition.

During this period a number of analyses appeared relating population and economic change. Their usefulness was largely polemical, however, since they consisted simply of inserting population change as an annual growth rate into a macro-economic model.

2. Recent Fertility Analyses. The National Fertility Survey of 1968, conducted by the U.P. Population Institute in collaboration with the Census Bureau, opened a new phase in Philippine demographic analysis. This was the first large-scale national survey for which schedule design, data processing, and

analysis were in the hands of demographers. The survey marked two important developments in Philippine population analyses: the existence of trained demographers in a functioning research institution, and the presence of a computer installation capable of handling the data processing required.

National Demographic Survey results for 1968, which became available in late 1971, have provided interesting new perspectives on the fertility situation, at a time when new and much more detailed analyses were badly needed. The principal NDS results at that time included the following insights: a) while overall fertility was lowest for the highest strata of Filipino society, marital fertility was slightly higher in the high SES groups, i.e., the negative association between fertility and socio-economic level became a positive association when differences in marital exposure (proportion married) were controlled; b) trends in marital fertility for successive cohorts yielded some evidence of rising marital fertility; c) in the course of the twentieth century there has been a significant rise in the mean age of marriage of Filipino women; d) ethnic and area differences in both fertility and marriage behavior are evident and important.

The 1973 NDS results began to be available in 1974 and provided further evidence of fertility differentials and family planning behavior. However, no evidence of significant fertility decline was discernable from this survey.

The Seven Area Survey, a joint research effort by three demographic research groups (UPPI, San Carlos University, and

Xavier University) is the most recent fertility resource. Preliminary results of this survey (January 1976) are provided within this report.

In subsequent years this survey will be repeated bi-annually and will be expanded. Current planning calls for extending the survey base from seven provinces to five regions (43 percent of the national population in CY 1978). Thereafter the survey will be expanded again to eight regions representing 65 percent of the population.

3. Family Planning Evaluation Studies. A sample survey of clinic acceptors was conducted in early 1972, from which was obtained badly needed one-year continuation rates specific by contraceptive method. The Commission on Population's five-year plan underwent revision in the light of these rates, and the new plan expressed targets in terms of "births averted" rather than acceptors. This first national survey of acceptors also yielded data on the accuracy of the clinic records on acceptors. Some 25 percent of recorded acceptors were found to be unreal.

The National Acceptor Survey of 1974 provided further suggestions for modifying the program, and a 1976 NAS is now undergoing data processing: preliminary reports are not yet available.

ANNEX C

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ANNEX D

INSTITUTIONS VISITED
BY
FAMILY HEALTH CARE, INC.

Asian Development Bank (ADB)

Asian Institute of Management (AIM), Makati

Barangay Health Station, Cawit, Marinduque

Barangay Resupply Point (BRP), Ayala

Barangay Resupply Point (BRP), Lower Jasaan

Barangay Resupply Point (BRP), San Isidro

Barrio Health Center (BHC), Ayala

Barrio Health Center (BHC), San Isidro

Bicol River Basin Development Project

Brokenshire Hospital

Bulletin Today

Capiz Province: Capiz Provincial Hospital
Pilar Sugar Central Family Planning Clinic
3 clinics
Provincial Governor's Office

Catholic Hierarchy - various members, Manila and Mindanao

Central Santos Lopez Sugar Mill

Children's Medical Center, Manila

College for Public Administration, Manila

Congregation of the Virgin Mary, Social Services Dept., Manila

Daily Express, Manila

Department of Agriculture, Region VI, Cebu

Department of Health Clinics, Bulacan Province

Department of Health: Region 5
Region 8
Region 10
National Family Planning Office
Training Division
Project Management Staff

Department of Education and Culture: Population
Education Office

Department of Labor, Population/Family Planning
Project Office

Department of Labor, Region 10

Department of Local Government and Community Development
(DLGCD): Manila and Region 5

Development Academy of the Philippines (DAP), Center for
Development Information

Development of People's Foundation

Dona R.T.R.M. Maternity Hospital, Tacloban

Economic Development Foundation, Inc. (EDF)

Economic Officer, United States Embassy, Manila

Episcopal Commission on Family Life

Family Planning Organization of the Philippines (FPOP)

First Secretary, United States Embassy, Manila

FTOW Training Program, Region 3 and Region 11

Family Planning International Assistance (FPIA), Manila

Family Planning Organization of the Philippines (FPOP)

Ford Foundation

Government Services' Insurance System

Governor's Office, Caramines Sur Province

Governor's Office, Albay Province

Governor's Office, Marinduque Province

Governor's Office, Nueva Ecija Province

Governor's Office, Misamis Oriental Province
Iglesia ni Cristo, Manila
IMCH Center, Balingasay
IMCH Center, Pitak
IMCH Center, Upota
IMCH Center near Barrio Obrero Clinic
IMCH Family Planning Clinic, Tacloban
IMCH Clinic, Davao City
International Institute for Rural Reconstruction (IIRR)
International Committee on the Management of Population
Programmer (ICOMP), Makati
Institute of Maternal and Child Health, Bulacan Province
Institute of Philippine Culture
Iloilo Regional Hospital
Luz Pharmacy, Maasin
Manila City Health Department
The Medical Care Commission
Mindanao Center for Population Studies (MCPS), Xavier
University, Cagayan de Oro City
Municipal Health Office, Mahadeg
Municipal Health Office, Baybay
Municipal Family Development Office, Santo Domingo
National Economic Development Authority (NEDA), Manila
National Tax Research Center, Manila
NEDA, Region 1
Region 6
Region 7
Region 10

NFPO, Region 6

Population Center Foundation

Population Council, Manila

Population Commission (POPCOM): Manila
Region 1
Region 2
Region 3
Region 4
Region 5
Region 6
Region 7
Region 8
Region 10

Philippine Medical Association (PMA)

Peace Corps

Provincial Development Assistance Project (PDAP)

Provincial Health Office: Marinduque
Cebu
Bulacan
Caramines Sur

Provincial Population Office: Southern Leyte
Caramines Norte
Misamis Oriental

PPO-TIDA-Outreach Program, Caramines Norte Province

Project Compassion (PROCOM): Albay Province
Region 4
Region 5
Iloilo
San Juan, La Union
Naguilian, La Union

Press Foundation of Asia, Manila

Rockefeller Foundation

Rural Health Unit (RHU): Baybay
Basey
Boad
Janiuay, Iloilo (+ Puericulture
Center)

Rosary Hospital/IMCH Clinic

Balingasay
Villanueva
Tagoloan - FPOP Clinic
Carcar, Cebu
San Fernando, Cebu
Naga I & II, Cebu
Maasin
Mingomilla
Tigbauan

Share and Care Apostolate
Society of Jesus
Sycip, Gorres, Velayo & Co. (SGV), Manila
Speaker Daniel Romualdez Memorial Hospital, Tacloban, Leyte
Social Security System
Sterilization Clinic, Mary Johnson Hospital, Tondo, Manila
TIDA Outreach - Malasigue, Pangasinan
Mapandau, La Union
UNICEF/Philippines
United Pulp and Paper Company, Family Planning Clinic,
Bulacan Province
United States Embassy, Manila
UNFPA/Philippines
University of the Philippines: Population Institute
Department of Economics
University of Santo Thomas, Institute for the Study of
Human Reproduction
UNDP/IBRD Regional Planning Project, NEDA
WHO, Family Planning Office
World Bank