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# Philippines

## USAID Population Assistance Strategy

1993-1998

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Formula for Success

Revised: June 1993

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PHILIPPINES POPULATION  
ASSISTANCE STRATEGY

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## **I. INTRODUCTION**

The Philippine Family Planning Program has undergone several external reviews in recent years. Those wishing to study the program in detail are referred to: (1) "New Directions in the Philippines Family Planning Program," World Bank Report No. 9579-PH, dated October 1, 1991; "Philippine Case Study; Evaluation of A.I.D. Family Planning Programs," A.I.D. Technical Report No. 4, dated October, 1992; and "Midterm Evaluation of The Family Planning Assistance Project (492-0396): Philippines, POPTECH Report No. 92-166-146, DRAFT dated March 11, 1993. The Mission's bilateral Family Planning Assistance Project ends December 31, 1994. In September, 1993 the USAID Mission plans to develop a new, 1994-1998 bilateral project authorization called the Integrated MCH/FP Project. During the last two weeks of March, 1993, Keys MacManus and William Johnson from the A.I.D. Office of Population visited the Philippines to assist the Mission to develop a population assistance strategy, in preparation for project development. This draft report is a product of that visit.

The Philippine Family Planning Program (PFPP) is at a crossroads. Since its launch in 1968, it has had some success in increasing contraceptive prevalence and reducing fertility. But political commitment and program implementation began to wane in the late 1970s and have never fully recovered. As a result, the program lags behind almost all of its Asian neighbors. The slow progress in family planning has increased pressure on the environment and undermined socio-economic development.

Now a number of factors have changed to present an historic opportunity for a major leap forward in family planning over the next few years. First, President Fidel Ramos has unequivocally declared his strong support for the program. Second, Health Secretary Juan Flavio Velasco has put family planning among his top priorities and is providing the type of leadership which creates a climate for progress. Third, the devolution of the Department of Health, which puts roughly two thirds of funds, delivery facilities and personnel in the hands of the provinces and municipalities, introduces new resources for mobilizing to provide services. Fourth, providing assistance in this critical area is high priority of the U.S. administration, the USAID Mission, and the A.I.D. Office of Population in Washington, D.C. For all of these reasons, we have a window of opportunity to assist the Philippines make a significant and long overdue leap forward in family planning. President Ramos' term of office is 1992-1998, and the Constitution limits Presidents to one six year term. The Governors will face re-election in around three years. If the Department of Health (DOH) and A.I.D. are to capitalize on the challenge presented, decentralized planning for program mobilization must begin now, and program support must be expanded. The degree of success the DOH has in this endeavor will have a profound effect on the quality of life of the next generation of Filipinos.

The objectives of A.I.D.'s population program are three-fold:

**To enhance individual freedom to choose the number and spacing of their children by improving information about and access to family planning options;**

**To provide critical health benefits for mothers and young children through improved birthspacing; and**

**To contribute to sustainable development by promoting population growth rates that are in balance with available economic and natural resources.**

In 1992, the A.I.D. Office of Population ranked A.I.D.-assisted countries according to their total need for family planning. Total need for family planning is identified by an index that combines three factors:

**Unmet need:** the number of women who are not using contraceptives but wish to postpone their next child or want no more children.

**High-risk births:** the number of births that fall into at least two of the following high-mortality groups: less than two years since last birth, fourth birth or higher, mother younger than 18 or older than 34.

**New users needed:** number of new contraceptive users needed between 1990-2025 to track the UN low fertility projection.

This analysis indicated that 20 priority countries account for 81 percent of total global need among A.I.D.-assisted countries. The Philippines is ranked number 9 among these 20 priority countries. This means that requests for assistance from the Philippines will be evaluated on the basis of its priority as well as other social, political, and programmatic considerations. In a nutshell, sound family planning proposals from the Philippines which have good potential to impact significantly on program objectives should compete well for scarce donor resources.

The USAID Mission has also recently developed a new country strategy. Strategic objective 2 is improved health and economic well-being of targeted populations. This objective outlines five program outcomes, with outcome 2.1 being increased utilization of family planning services. Family planning is a high priority for the Mission's development assistance agenda.

As President Ramos said in his keynote speech at the National Workshop for "Implementing the Philippine Agenda 21 for Sustainable Development: Response to the Earth Summit" in Manila on September 1, 1992: "I believe that we must once and for all accept the basic premise underlined in Agenda 21 that the serious imbalance that today threatens the sustainability of both our economy and our environment has arisen primarily from our pervasive and proliferating population growth. For too long, we have paid lip service to the issue. Now is the time to face it by implementing an earnest family planning program that will provide our people room for choice in planning their families."

It should come as no surprise that President Ramos, Secretary Flavier, the USAID Mission and A.I.D./Washington all agree that family planning is an urgent development priority. As outlined in the Country Overview which follows, rapid population growth has a tremendous impact on the health status, environment, and socio-economic well-being of the people. Yet, other factors such as female education, employment of women, social attitudes, and demand for services suggest a population ready and eager to accept family planning services when they are made accessible.

## **II. EXECUTIVE SUMMARY**

The population of the Philippines has grown from 36.7 million in 1970 to 67.1 million in 1993. In spite of high (93.5%) literacy, relative good female participation in education (attendance exceeds that of males up to age 18) and employment (34.6% of female household population over 15 is employed), total contraceptive prevalence is only 36% with modern method prevalence being under 22%. The total fertility rate is 4.0 and the estimated growth rate is 2.4%.

Rapid population growth over the past few decades has slowed socio-economic development and accelerated environmental degradation in the Philippines. Although surveys indicate the population is ready to accept family planning, pressure from the Catholic Church combined with political sensitivity, lack of continuity in program leadership, and weak program implementation have created a growing gap between demand and supply of services.

There are an estimated 8.9 million married women of reproductive age (MWRA). In 1968 when the family planning program began, there were an estimate 4.1 million MWRA. By putting family planning on "the back burner" for the past 15 years, the Philippines has inherited a large unmet need for family planning. From the standpoint of maternal health risk and desired fertility preference, there is an unmet need for family planning among at least 3 million women. A more realistic figure is probably 4 million. If the family planning program makes steady progress and increases contraceptive prevalence by 1.5% to 2.0% per year, it will take around 17 to 22 years to fulfill unmet need for 3 million women and obviously somewhat longer to reach 4 million.

Now a number of factors have changed to create an historic opportunity for a major leap forward in family planning over the next few years. First, President Ramos has unequivocally declared his strong support for the program. Second, Health Secretary Flavio is providing dynamic leadership in support of the program. Third, the devolution of the Department of Health puts roughly two thirds of funds, delivery facilities and personnel in the hands of provinces and municipalities, thereby introducing new resources for mobilization. Fourth, providing assistance in this area is a high priority of the current U.S. Administration, USAID Mission, A.I.D./Washington, and Congress. For all these reasons, we have a window of opportunity to assist the Philippines make a significant and long overdue leap forward in family planning. The degree of success achieved in this endeavor will have a profound effect on the quality of life of future generations.

To achieve success in this sector, plans must be based on program requirements necessary to generate the required impact. In essence, we must plan for success rather than plan to program available funds. With this in mind, the Mission has recently developed a draft population assistance strategy.

The **goal** of the strategy is to reduce unmet need for family planning. The **purpose** of the strategy is to increase contraceptive prevalence and minimize high risk childbearing.

The strategy calls for a package of project and program support through three components. **The first component of private sector and NGOs will provide project support to NGOs and the private sector social marketing program. The second component will provide project support to national services such as: information, education & communication; contraceptives; logistics; training; voluntary surgical contraception; management information system; operations research; and policy planning.** Much of the first two components extends important work initiated under the current Family Planning Assistance Project. These inputs could be considered enabling factors to support local government services. **The third component is performance based, program support for challenge grants to local government units. This support will facilitate a managed grants competition.** Local governments will be encouraged to submit proposals that DOH will review based on priority, potential to reduce unmet need and local resource contribution. A.I.D. will use project funds to support a technical assistance team and to finance performance monitoring. A.I.D. plans to tranche funds annually based upon progress toward reducing unmet need. This progress would be measured by annual surveys done by the National Statistics Office and by DOH progress reports outlining output level progress achieved by the local governments.

### **III. COUNTRY OVERVIEW**

The population enumerated in various censuses in the Philippines has grown in nine decades from 7 million to over 60 million as is shown below:

<u>Date of census</u>	<u>Population (millions)</u>
1903	7.635
1918	10.314
1939	16.000
1948	19.234
1960	27.087
1970	36.684
1975	42.070
1980	48.098
1990	60.703

In addition, the pace of growth has accelerated over time. During the thirty years from 1918 to 1948, the population grew by 186%. During the thirty years from 1960 to 1990, the population grew by 224%. This growth is somewhat understated. The 1990 Census Evaluation Survey suggests an estimated 3% undercount of the 1990 enumerated population. Such an undercount puts the 1990 population at 62.5 million and the estimated 1993 population at 67.1 million. This rapid population growth has slowed socio-economic development and accelerated environmental degradation in the Philippines, as will be seen in many of the indicators which follow.

#### **1. Geography**

The total land area of 300,000 square kilometers is scattered over 7,100 islands. However, two islands account for 81% of the land. Luzon accounts for 47% and Mindanao accounts for 34% of total land area.

#### **2. Administrative/Political Divisions**

At the time of the 1990 census, there were 14 regions, seventy-three provinces, 2 sub-provinces, 60 cities, 1,537 municipalities, and 41,292 barangays (villages).

### **3. Urban/Rural**

The population is 48.6% urban.

### **4. Ethnicity/Religion**

- a. Tagalog is the mother tongue of 27.9% of households, followed by Cebuano with 24.3%, Ilocano around 10.0%, Ilongo at 9.3% and various other dialects.
- b. Roman Catholics make up 82.9% of the population, with Islam and Protestants accounting for 4.6% and 3.9% respectively. The balance is divided between Aglipay and Iglesia ni Cristo faiths.

### **5. Literacy**

Literacy (ability to read and write a simple message in any language or dialect) is 93.5%, 93.7% for males and 93.4% for females.

### **6. Education**

Of the household population age 7 and older, 28.5% have finished at least a high school education and 6.4% hold academic degrees. School attendance of males and females is roughly equal with females having a slight edge (more than 50%) up to age 18 and males having a slight edge thereafter.

### **7. Employment**

57.7% of household population over 15 is gainfully employed (88.2% of males and 34.6% of females). The workforce is estimated to have grown from 23.8 million in 1975 to 38 million in 1990. For professional, technical, and clerical occupations, women's wages are higher than men's. For all other occupational categories, men's wages exceed women's wages, especially for managerial workers and laborers.

### **8. Occupation**

Farmers, forestry workers and fishermen constitute the largest component of the workforce at 31.2%. Professionals comprise about 7% of the workforce.

## **9. Migration**

The 1990 Census found that among the population age 5 and over, 93.2 percent were residing in the same city or municipality where they had lived exactly five years ago. 56% of inter-regional migrants are women.

## **10. Household Conveniences**

- a. 66.4% of households own a radio or radio-cassette (72.7% urban and 60.4% rural).
- b. 32.7% of households own a television (52.6% urban and 13.5% rural).
- c. 20.7% of households own a refrigerator, 7.9% own a motor vehicle, and 3.6% own a working telephone.

## **11. Sanitation**

- a. 73% of households have a source of potable water.
- b. 58.1% of households have water-sealed toilets.
- c. 54.6% of households burn garbage. Garbage collection by truck is enjoyed by 15.8% of households.

## **12. Environment**

- a. Wood or charcoal is used for cooking fuel by 40% of urban and 84% of rural households.
- b. Logging and increased upland settlements have reduced forest cover. The upland areas, which contain around 30% of total population, are projected to increase from 18.2 million population in 1990 to 21.4 million in 2000.
- c. Natural forest cover has fallen from 10.4 million hectares covering 34% of the land area in 1972 to 6.16 million hectares covering 20.5% of the land area in 1990. The country is estimated to be losing 119,000 hectares of forest each year. If this rate of depletion continues, existing forests would be depleted in about 12 years.

- d. The coastal population has increased from 28.7 million in 1980 to 36.3 million in 1990, putting serious pressure on the coastal resource base.
  - i. Mangrove vegetation has been reduced from 500,000 hectares in the 1920s to 139,725 hectares in 1988.
  - ii. 30% of coral reefs are in excellent (5%) or good (25%) condition, meaning that 70% have been damaged or destroyed by destructive fishing methods or other incursions.
- e. Average farm size has shrunk from 3.5 hectares in 1960 to 2.8 hectares in 1980. Arable land per rural inhabitant has declined to 0.38 hectare.

### **13. Poverty and inequality**

55.2% of households (5.82 million families) remain below the poverty line. The top 20% of households account for 50% of total income, while the bottom 20% accounts for only 5%.

### **14. Sluggish economic growth**

Real per capita GNP (base year, 1985) has declined from 12,595 pesos in 1980 to 11,619 pesos ( around \$500) in 1990.

### **15. Lack of jobs**

About 800,000 persons enter the job market each year. In 1991 unemployment was estimated at 10.6%, and underemployment was estimated at 31.6%.

### **16. Lagging food production**

While population grows at around 2.4% per year, increase in food production lags at around 1% per year. Crop production actually declined from 64.2 million metric tons in 1989 to 61.5 million metric tons in 1990. Conversion of farm lands also affects food security.

## **17. Infant and child health**

- a. The infant mortality rate has hovered around 50 per 1,000 live births (DOH and USAID estimates) for over a decade. A UNFPA document says the NSCB Task Force on Infant Mortality Rates reports IMR of 61.0 for the past decade 1980-1990.
- b. 18% of children are born with low birthweight.
- c. 14% of all children below 6 are moderately or severely underweight. 70% of children age 1-6 suffer from anemia.
- d. UNICEF estimates that 3.5 million children are working, 20,000 are prostituted, and 85,000 in 17 cities are homeless streetchildren.

## **18. Maternal health**

- a. Maternal mortality has remained at around 100 per 100,000 live births for a decade.
- b. 45% of pregnant women and 50% of lactating mothers suffer from anemia.
- c. There are an estimated 1.5 million pregnancies per year, but only 62% of deliveries are attended by medically qualified personnel. This fact is especially disturbing in view of the surplus of doctors.
- d. 1,600 women die each year from pregnancy related causes. Unpublished statistics from the Philippines OBGYN Society show that 24% of all maternal deaths reported by 78 participating hospitals can be attributed to induced abortion.
- e. "Illegitimate" births have increased from 3% in 1970 to 9% in 1990.

## **19. Social attitudes**

The Social Weather Stations' 1991 nationwide survey indicated:

- 78% of the voting public favor candidates who would promote free choice of FP methods, while 18% favor candidates who would restrict such choice;

- Filipinos do NOT feel strongly restricted from using family planning methods, either by the rules of their religion, by the teaching they received in school, or by the advice given by their physician.

## **20. DOH Family Planning Program Status**

In a briefing for the newly appointed Secretary of Health in July 1992, the PFPP program manager presented the following data. The data are based on a 1990 assessment of 4,897 Barangay Health Stations (BHS), 1,312 Rural Health Units (RHUs), and 192 hospitals of the DOH. (Note: the reader should note that the USAID Family Planning Assistance Project with DOH began in 1990 and hopefully has improved these figures from 1990-1993; however updated data are not available).

- a. Only 1.9% of BHS had both trained personnel and adequate supplies of contraceptives.
- b. Only 0.5% of RHUs were similarly equipped.
- c. No hospital had both trained staff and adequate supplies for family planning services.
- d. Only 82% of public health nurses had training in basic FP courses, and 62.3% of midwives were similarly trained.
- e. Only 10.3% of RHU physicians had training in basic FP and IUD insertion, and 3.1% of hospital physicians had the required training in basic FP, IUD, and VSC courses.

#### **IV. BACKGROUND**

##### **A. FAMILY PLANNING PROGRAM DEVELOPMENT: 1968-1992**

The history of the Philippine family planning program can be divided into three major periods; i.e., the POPCOM years (1968-86), the Aquino years (1986-92) and the Ramos years (1992-1998). There are marked differences among the three periods, but perhaps none more so than the stated goals of each period. Under POPCOM, the major goal was openly expressed in terms of fertility reduction; even DOH health staff were often unaware of the relationship between family planning and maternal/child health. The Aquino era, on the other hand, justified the family planning program almost entirely in health terms. More realistically, the Ramos administration recognizes the health benefits of family planning as well as the development implications of a less rapid population growth rate.

Although the three had differing goals, they have all been constrained by the same two major problems i.e., high (perhaps as high as 50 percent) discontinuation rates and low modern use (Contraceptive Prevalence Rate - CPR). There is reason to believe that modern CPR has increased in the past 18 months\* with the fielding of more than 3,000 DOH providers, but as recently as 1988 (National Demographic Survey), the modern CPR was 22 as compared to 62 for Thailand and 32 for Bangladesh, in spite of the latter's largely illiterate population. Somehow, in spite of fielding the third largest outreach staff for family planning led by world recognized physicians during the POPCOM years, most Filipino couples did not internalize the need for using modern contraceptives as a basic element in their life planning.

Some observers have posited that the Catholic Church has been a major factor in the relatively poor showing of the Philippine program. This hypothesis was carefully studied by the CDIE Impact Evaluation Team for the period 1968-88 with the conclusion that Church teachings on contraception carried little weight with more than 95 percent of couples. The Impact Report noted, however, that Church opposition had weakened the will of politicians and bureaucrats to the point that family planning services, including the supply of contraceptives, were seriously disrupted.

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\* One recent survey, however, estimates modern CPR to be as low as 20.6 in 1990 while a more recent study places it at 29 in 1993. In the absence of a full DHS or NDS, this paper uses the 1988 NDS survey data.

Indeed, one major study found that contraceptive stock-outs were the single most frequently cited reason for acceptor discontinuation. By 1988, because of the political fears, there was no real family planning program in the public sector and very little in the NGO sector because the NGO providers were largely the agents for POPCOM and donors, who could no longer rationalize supporting such a faltering effort.

It should be stated for the record, however, that when President Aquino was shown the rising maternal mortality rates after the withdrawal of family planning services under her administration, she overrode her powerful Secretary of Finance and allowed the Secretary of Health to re-institute family planning services as a health measure. It should be further noted that three years prior to the Aquino administration, POPCOM, with declining support from President Marcos and frequent leadership changes in the POPCOM Board, had largely lost its capacity to lead and implement a national program as evidenced by its failure to develop a follow-on proposal for USAID funding prior to the conclusion of Population Planning III in 1986.

When the Aquino government transferred family planning services from POPCOM to DOH in 1988, it was necessary for that Department to begin almost from scratch to build the necessary infrastructure. Progress has been slow, but by the end of the Aquino years, nation-wide training, logistics and services for DOH service points were largely in place. Work-based programs in the private sector were progressing nicely. IECM materials were nearly ready for distribution. MIS was as unresolved as ever, but operations research was beginning to take form as was the key social marketing sector. Unfortunately, the once powerful NGOs were mostly mere shadows of their former selves, a condition that can be laid on the failure the DOH's Technical Secretariat to facilitate and coordinate NGO programs and progress.

Thus, when President Aquino's hand-picked successor, General Ramos was elected president in June 1992, the new Administration inherited a DOH with capacity stronger than anytime in the past to deliver a wide range of contraceptives, a fledgling social marketing (commercial) sector, an NGO sector on the verge of collapse plus POPCOM whose leaders at the national level were still unreconciled to the loss of responsibility for family planning services. Even the apparent strength of DOH masked a completely bi-furcated leadership which was depriving the Department of the capacity to utilize its national systems (IECM, etc.) developed during the past three years. How the Ramos administration handled this complex and sensitive situation plus the challenge of the new Local Government Code are detailed in part C of this section.

## B. DEMOGRAPHIC TRENDS

The Philippines is blessed with a wealth of high quality demographic information. There have been 9 censuses in this century (see Country Overview Section of this report), and 6 demographic surveys from 1968 to 1988. A contraceptive prevalence survey planned for 1990 was not conducted for unknown reasons. A Demographic and Health Survey is scheduled for April, 1993, and it is hoped that preliminary results will be available by September, 1993. There are no reliable family planning service statistics. The former POPCOM MIS has fallen into disarray, and the DOH FHSIS which was implemented in 1988 has not functioned. So, in essence, we have a wealth of current population and housing data from the 1990 census, but no reliable information on contraceptive prevalence or fertility since 1988.

The history of high fertility in the Philippines has created an age structure conducive to rapid growth. The average, annual, intercensal growth rates exceeded 3.0% from 1948 to 1970 and exceeded 2.7% from 1970 to 1980. Most of the women born since 1948 are still in their reproductive years. Those women born in 1980 are now 13 and will soon enter the age 15-44 reproductive cohorts. For this reason, it is highly likely that the population of the Philippines will double to 120 million sometime between the year 2020 and 2075. If the current growth rate remains unchanged, the population will reach 120 million in 2020, but if the family planning program significantly reduces the growth rate, the population will not reach 120 million until around 2075. It is hard to imagine the Philippines with 120 million people, but this is probably inevitable. It is essential that family planning succeed to buy some time for socio-economic development. The progress of the family planning program over the next ten years will be a critical factor necessary to improve the quality of life.

The evidence indicates that rapid population growth is inhibiting improvements in the quality of the human resource base. Progress in maternal and infant health and nutritional status have plateaued. For education, enrollment has improved in the face of an increasing number of school entrants, but this has been achieved at the expense of quality. Unless these human resource quality indicators can be reversed, the quality of the labor force will have stabilized or deteriorated as the Philippines enters the 21st century, precisely at the time when higher per capita productivity will be needed to support a much larger population.

The 1990 Census of Population and Housing enumerated 60.7 million population. However, the 1990 Census Evaluation Survey estimated around a 3%

average undercount, putting the 1990 population at 62.5 million and the estimated 1993 population at 67.1 million. 39.5% of the population is 0-14 years of age, 57.1% is 15-64, and 3.4% is 65 and over. From 1990 to 2000, rough projections call for the 0-14 age group to increase by around 3.0 million, the 15-64 group to increase by 12.5 million, and the 65 and over group to increase by 1.2 million. The large increase in the working age population is both a challenge for job creation and an opportunity for economic growth. The 15-24 age cohort which has the highest unemployment will grow by round 3.5 million.

It is important to understand the difficulty of increasing contraceptive prevalence (the percentage of MWRA or married women of reproductive ages 15-44 presently using contraception). The denominator in this indicator (MWRA) has more than doubled from 4.1 million in 1968 to around 8.9 million in 1993. During this 25 year period, the family planning program would have had to double the number of current users just to maintain the contraceptive prevalence rate. This phenomenon will continue for the foreseeable future and until the number of couples entering the young side of the reproductive age span (age 15-19) is smaller than the number of older couples departing the reproductive age span (age 40-44). The current median age is 20 years for women and 19 for men.

Table 1 presents the principal demographic trends of the Philippines from 1968 to 1988 (based on survey data), as well as 1990 and 1993 population, MWRA, and TFR estimates based on the 1990 census.

During the 20 years from 1968 to 1988 the Total Fertility Rate (TFR or total number of children expected to be born per woman) fell from 6.3 to 4.2, the contraceptive prevalence rate rose from 16% to 36%, while the mean age at marriage rose slightly from 22.9 to 23.5 years, and breastfeeding duration declined slightly from 14.5 months to 12.1 months. According to analysis done by John Casterline and the University of the Philippines Population Institute (May, 1988, "Trends in Fertility in the Philippines: An Integrated Analysis of Four National Surveys," by Casterline, Domingo and Zablan), the family planning program was responsible for roughly two thirds of the fertility decline and the increase in age of marriage was responsible for most of the remaining one third.

Until the results of the 1993 National Demographic Survey are available, we will not know what has happened to contraceptive prevalence since 1988. Any increase in CPR would have probably taken place after 1990 when additional family planning program inputs materialized. TFR is estimated to have declined from 4.2 to

**TABLE I**  
**Demographic Trends**

Indicator	1968	1973	1978	1983	1986	1988	1990	1993 (Estimated)
Population Size (in millions)	35.8	40.1	46.0	52.4	56.0	58.40	62.5	67.1
Married couples of reproductive age (in millions)	4.1	4.8	5.5	6.4	6.8	7.99	8.1	8.9
Crude Birth Rate per 1,000	40.5	37.4	34.0	34.7	33.7	31	—	—
Contraceptive Prevalence Rate (in percent)	16.0	24.0	37.5	32.1	45.3	36.2	—	—
Desired Family Size	5.0	4.4	4.4	4.1	—	3.96	—	—
Singulate mean age at marriage for women (years)	—	—	24.4	23.3	—	24.02	—	—
Total Fertility Rate (children per woman)	6.3	5.9	5.2	5.0	4.5	4.28	—	4.01

Sources: 1968, 1973, 1983, 1988 National Demographic Surveys  
 1978 Republic of the Philippines Fertility Survey  
 1986 Contraceptive Prevalence Survey  
 1990 Census of Population and Housing (adjusted)

Z.C. Zablan "Knowledge and Attitudes of Grassroots Family Planning  
 Workers about Contraceptive Methods," Asian Population Studies, Series  
 No. 86-F ESCAP, 1988

(—) indicates data not available.

4.0 from 1988-93, but it is not clear what is causing this decline. First, the singulate mean age of marriage (SMAM) for women has stayed roughly the same at 24.02 in 1988 and 23.8 in 1990. An increase in SMAM for women would have had an effect in lowering fertility, but there was actually a slight decrease. Second, the 1990 census indicates that rate of decline in CEB or Children Ever Born (average number of children ever born - a figure lower than TFR unless the woman is over 45) slowed 1980 to 1990. From a CEB of 4.02 in 1970, average CEB decreased to 3.50 in 1980 and 3.27 in 1990. This indicates a decrease in CEB of 0.52 in the 1970s and 0.23 in the 1980s. The most likely explanations for the decrease in TFR would be an increase in the CPR or an increase in induced abortion. However, we should wait until the results of the 1993 DHS are available rather than speculate.

Table 2 presents the contraceptive prevalence and fertility data available from the six national demographic surveys conducted between 1968 and 1988 (National Demographic Surveys in 1968, 1973, 1983, and 1988; The Republic of Philippines Fertility Survey in 1978, which was part of the World Fertility Survey, and the Contraceptive Prevalence Survey of 01986). These data indicate that total contraceptive prevalence increased from 16% in 1968 to 36.2% in 1988. During the same time span, modern program methods increased from 2% prevalence to 20.6% prevalence (21.3% if one includes condom use). The most impressive gains were in female sterilization, which at 11.0% prevalence in 1988 was the most popular method. The second most popular modern method was the oral contraceptive at 6.9% prevalence. There was also substantial growth in other program and non-program methods, including rhythm and withdrawal, but it is believed these figures fluctuated from 1986 to 1988 partly due to measurement biases. With the significant inputs in training and supplies since 1990, one hopes to see an increase in modern method prevalence in the 1993 DHS.

The injectable contraceptive Depo-provera was removed from the program in 1989, as it had been only approved for distribution for research purposes and was not FDA approved in 1989. Applications are currently pending with the Bureau of Food and Drugs for approval of both Depo-provera and Norplant. Based on the initial reception to Depo-provera, this method would seem to have very significant appeal; and it could be introduced with minimal donor assistance through the private sector doctors, nurses, and midwives. There is less interest in introducing Norplant at this time, given the high cost and training requirements and the fact that other methods are not yet fully available. We believe the highest priority should be given to approval of Depo-provera. The DOH indicated a decision on the application for BFD approval of Depo-provera should be available by May, 1993.

TABLE 2

TRENDS IN CONTRACEPTIVE PREVALENCE (CPR)  
AND TOTAL FERTILITY RATE (TFR)

SOURCE	NDS 1968	NDS 1973	RPFS 1978	NDS 1983	CPS 1986	NDS 1988
<p>CPR: Percentage of Currently Married Women Aged 15–44 Practicing Contraception by Method</p>						
ALL METHODS	16	24	37	32	45.3	36.2
PROGRAMME METHODS	8	9	25	27	33.3	29.8
Modern Programme Methods	2	11	12	18	20.4	20.6
Pill	1	7	5	6	6.4	6.9
IUD	1	3	2	2	2.4	2.4
F. Sterilization	0	1	5	10	10.9	11.0
M. Sterilization	0	0	0	0	0.5	0.4
Injectible	–	–	–	–	0.2	0.2
Other Programme Methods	6	8	13	9	12.9	8.8
Rhythm, Rhy, comb.	6	7	9	7	12.2	8.1
Condom	0	1	4	2	0.7	0.7
NON-PROGRAMME METHODS	8	5	12	5	12.0	6.4
Withdrawal, Wid. comb.*	6	4	10	4	9.4	5.6
Others*	2	1	2	1	2.6	0.8
<p>TFR: Cross-sectional estimate, based on current age-specific fertility rates, of the total number of children expected per woman.</p>						
TOTAL FERTILITY RATE	6.30 (1965)	5.92 (1970)	5.20 (1975)	4.96 (1980)	4.51 (1983)	4.28 (1985)

Note: Hyphen (–) in the cells means that injectables were not available at that time. Zero (0) in the cells means that prevalence is below 1 per cent.

\* Includes other programme methods requiring re-supply (e.g. foam, jellies, suppositories).

Table 3 summarizes the available information on current demographic indicators. The 1993 population of 67.1 million is estimated to be growing at around 2.4%. At this rate of growth, the population will double in 30 years. As previously mentioned, the contraceptive prevalence of 36%, based on the 1988 NDS, is the most current estimate available. Based on the 1990 census, the number of married women of reproductive age in 1993 is 8.9 million, and the estimated TFR is 4.0.

### C. CURRENT STATUS OF THE FAMILY PLANNING PROGRAM

Compared to most sub-Saharan countries, the Philippine program is advanced in terms of services provided and acceptor levels, but compared to most countries in Asia, Latin America and even the four large NE countries, the program here has not kept pace. For example, all available data, albeit outdated, indicate that the Philippine program has achieved a modern contraceptive prevalence rate of 22 compared to rates in the thirties in the Near East and parts of Asia, the forties for much of Latin America and fifty for Indonesia and the sixties for the outstanding Thai program which began at the same levels of acceptance as the Philippines in the late 1960s. Thus, it is clear that this program has a long way to go before reaching the level of a critical mass where the need for effective family planning has been internalized to the point that the program is genuinely sustainable. The picture here is not entirely bleak, however, as surveys here have shown that at least one third of these couples who are using family planning purchase their contraceptives from the private sector. This number should increase quite rapidly now that social marketing for pills has been launched.

An additional unknown number of acceptors secure services via the NGO sector. Traditionally, NGOs have provided these services at no or little cost to the acceptor, but now with USAID policy for NGOs to achieve at least partial sustainability, acceptors will be charged enough to cover costs. On average, tubal ligations will be offered for the equivalent of \$40 and IUDs for \$8. With the new A.I.D. provided IUD (CUT 280-A) valid for eight years of use, this is extremely reasonable, (one dollar a year), for almost any economic sub-group. If the NGO sector can be revitalized to the point of providing a third or more of the services as they did during the POPCOM years, and this is added to the one third or more being provided via commercial/social marketing sector, the Philippines will be close to having the right portion of acceptors ready to secure their own contraceptives.

This still leaves the poorest one third of the populace requiring DOH free services. Indeed, with increased quality services being offered by the DOH and the former DOH staff now in LGU clinics and with the poverty levels in the Philippines now at 55 percent, there may be an actual increase in DOH's share of the contraceptive market. This certainly has occurred over the past couple of years as access to NGO services declined.

#### **D. RECENT DEVELOPMENTS**

As noted earlier, the Ramos government inherited a family planning/population development program with some real strengths and major weaknesses. For the most part, the new Administration has dealt with the aforementioned weaknesses in a forthright, resolute manner, thus freeing the DOH bureaucracy to utilize the national systems at its disposal in a manner to complement LGU family planning activities. Outlined below are the actions taken by the Ramos administration to strengthen the program.

##### **By President Ramos:**

- Appointed a strong proponent of family planning as Secretary of Health.
- Named new Secretary of Health as co-chair of the POPCOM Board.
- Appointed another proponent of population planning as head of NEDA, and co-chair of POPCOM Board.
- Has spoken out firmly on numerous occasions of the importance of a more moderate population growth rate.
- Has provided moral support to his cabinet in their efforts to factor population into the development process.

##### **By the Secretary of Health:**

- Merged the formerly schismatic staffs and functions of the family planning under one DOH physician who reports directly to the Secretary.

- Initiated steps to secure a line-item in the Public Investment Budget of the DOH budget for family planning totalling one billion pesos per year.
- Worked with the co-chair of the POPCOM Board to bring about new national level leadership at POPCOM.
- Waived the cumbersome re-accreditation requirements for previously accredited NGOs so that they resume their key role in family planning service provision.
- Sanctioned five joint DOH/LGU pilot programs to assess the most appropriate manner of taking advantage of devolution by increasing access to and local resources for family planning services.
- Authorized a national training needs assessment to determine the required levels of different staff to provide IECM and service skills for an expanded family planning program.
- Has made the mid-wife's role central to the functioning of the program so that the number of midwives will be increased from the current 3,364 to 8,156 by 1988 while reducing other categories of health personnel.
- Initiated steps to provide a wider choice of medically approved and legally acceptable family planning methods to acceptors.
- Has met with Church leaders to secure their cooperation in areas, e.g., NPF where agreement can be reached.
- Canceled the unofficial ban on wide promotion of contraceptives.
- Has encouraged the full participation of the commercial and NGO sectors.
- Has worked tirelessly to promote the benefits of family planning for couples, communities and the nation.

The accomplishments of the Ramos administration are very impressive. All of them plus others, such as fully staffing the new unified family planning section at the national and at the regional field offices of DOH, will be necessary to attack the long-term and mutually related issues of unmet need for family planning services and programmatic sustainability as discussed in the next two sections.

## **V. USAID MANILA POPULATION ASSISTANCE STRATEGY 1993-1998**

The strategy contained in this document will guide USAID central and bilateral assistance to the population sector for the period 1993-1998. Although this strategy is proposed for five years, it is important to recognize that programmatic support to the population sector will be required for at least ten years in order to achieve contraceptive prevalence levels that would make the program sustainable in the long term. The Philippines has a history of setting unrealistically high targets for the family planning program. This mistake should not be repeated. The most efficient and effective family planning programs in the world have increased contraceptive prevalence by around 2% per year. If the Philippines is able to increase contraceptive prevalence by 1.5% to 2.0% per year for the next ten years, the prevalence would be 51% to 56% in the year 2003, assuming a 1993 baseline prevalence of 36%. Only at this level of contraceptive prevalence will programmatic sustainability become a reality. The programmatic strategies and priority activities proposed in this strategy document will require sustained support through 2003 to achieve the desired health, demographic, and programmatic outcomes.

### **A. PLANNING ASSUMPTIONS**

The following assumptions were used as the basis for formulating this strategy:

- (1) The contraceptive prevalence rate in the Philippines in 1993 is 36.2%; and the prevalence of modern contraceptive methods is 20.6%.
- (2) 5.6 million women of reproductive age in the Philippines are at high risk for bearing children (defined as pregnancies to women who are under 20 years of age, older than 35, have had four or more births, or have delivered within 24 months of a previous birth). These women at risk comprise 63% of the 8.9 million women of reproductive age in

the Philippines in 1992 (estimate from 1992 UNFPA Country Profile).

- (3) Of the 5.6 million WRA at high risk for bearing children, 3.2 million are using some form of contraception, and only 1.8 million are using modern contraceptive methods.
- (4) To provide contraception to women currently at high risk for childbearing, the family planning program would need to provide services to an additional 2.4 million to 3.8 million women in 1993. This number will increase over time as the number of MWRA expand.
- (5) If we assume for the moment that the number of MWRA will remain constant over time at 8.9 million (an erroneous assumption but useful for planning purposes); and that contraceptive prevalence will increase by 2% per annum, it would take 13-21 years to provide the additional contraceptive services required to fulfill current unmet need due to high risk. If we assume that contraceptive prevalence will increase by 1.5% per annum, it will require 18-28 years to fulfill current unmet need due to high risk.
- (6) 75% of MWRA, or 6.675 million women, expressed a desire to regulate their fertility for reasons of spacing their next birth or limiting family size (estimate from 1992 UNFPA Country Profile). Using 1993 estimates for contraceptive prevalence and modern method prevalence, there is an unmet need for family planning services for 3.5 million to 4.9 million MWRA based upon expressed desire.
- (7) The DOH estimates that 2.7 million women have an unmet need for family planning on health grounds, and an additional 1.8 million women have unmet needs for family planning based upon desired preference. This estimate places total unmet need for family planning services in the Philippines at 4.5 million MWRA in 1993.
- (8) If a 2% per annum increase in contraceptive prevalence is assumed, it will require 25 years to fulfill current unmet need for family planning services in the Philippines.

## **B. OBJECTIVES**

Based upon the historical analysis of the strengths and weaknesses of the Philippine National Family Planning, prevailing demographic trends, the very favorable recent developments which have ascribed a higher priority and profile for the family planning program, and the planning assumptions stated above, the following objectives will constitute the foundation of USAID's Population Assistance Strategy to the Philippines:

**(1) To reduce the national unmet need for family planning due to high risk births or expressed desire.**

Even the most conservative should agree that based upon a combination of health risk and desired fertility preference, there is an unmet need for family planning among at least 3 to 4 million women. The advantages of directing family planning program efforts towards this group are significant. Demand among this group is high, and the ancillary health benefits that will accrue secondary to reducing high risk births, in the form of reduced infant, child, and maternal mortality, are substantial.

If the family planning program makes steady progress and increases contraceptive prevalence by 1.5% to 2% per year, it will take around 17 to 22 years to fulfill this unmet need. Unfortunately, by putting family planning on the "back burner" for the last 15 years, the Philippines had inherited a large unmet need liability.

**(2) To increase programmatic sustainability**

Genuine programmatic sustainability is only attained when a critical mass (often said to be 50 percent or more) of fertile aged couples come to believe that it is in their best interest to take active steps to plan their families. Once this internalization of the need to plan one's family has occurred, fluctuations in donor support or that of national politicians will be relatively unimportant, because couples will pro-actively seek the services they want from different sources.

Thus the definition of sustainability as being the willingness of the host country to replace the role of donors is misleading, because it assumes that the host country will have the recurrent resources to provide free services to all their citizens.

In almost every country there is a significant portion of the population which is willing and able to pay for these services.

Although a promising proportion of commercial and NGO acceptors have already laid the basis for a sustainable program, the major problem remains that with modern prevalence at 22, the Philippine program is still almost 30 points short of reaching the critical mass needed for true sustainability. To reach true sustainability, USAID, through DOH, will support the expansion and improvement of information and services across the board. First, support will be given to increasing quality private sector services, e.g., training for pharmacy assistants to provide counselling to clients. Second, support will increase the capacity of NGO staff to provide quality services and to manage their clinics in a cost-effective manner. Third, USAID will provide support directly to DOH and indirectly through DOH to LGUs to expand coverage and to increase quality in the newly devolved service points.

In addition to the commercial/NGO sectors support for sustainability, additional resources for the program should accrue via LGU generated funds. The experience from decentralized efforts in other countries has shown that decentralizing family planning programs contribute significantly to their sustainability.

### C. PERFORMANCE INDICATORS

Although the health-based family planning program of the Philippines does not wish to espouse demographic targets, the performance of the program in achieving its goal must be monitored using indicators based on contraceptive prevalence and high risk births. Once the results of the 1993 DHS are available, these data would provide contraceptive prevalence and high risk birth baseline information for the next project. The Mission should reach agreement with the DOH on baseline data and realistic, annual, purpose-level indicators of progress for the life of the project.

To make significant inroads in reducing the unmet need, the program should strive to increase contraceptive prevalence by an additional 937,000 (roughly 1.0 million) users over the life of the program as follows (in thousands): 180 in year 1, 184 in year 2, 187 in year 3, 191 in year 4, and 195 in year 5. Progress at this pace would reduce the number of women currently at high risk for childbearing by around 25% to 39%, and the unmet need based upon expressed fertility preference by 19% to 27% (the actual reduction would be less than this, because the number of MWRA will grow during the life of the program). Achieving these progress indicators

would be roughly equivalent to a 2% increase in contraceptive prevalence per year. If this rate of increase could be sustained over a 10 year period, contraceptive prevalence rates in the vicinity of 50% are realistic, and a critical prerequisite to programmatic sustainability would have been realized.

#### D. PROGRAMMATIC GUIDELINES

To achieve the performance targets for contraceptive prevalence and additional contraceptive use which are enshrined in this strategy, the Philippine National Family Planning will have to mobilize the considerable resources that are available through the LGUs, NGOs, and the private sector. The complementary USAID support provided in consonance with this strategy will follow three guiding principles:

- (1) Nothing in USAID's program of support and technical assistance should in any way threaten the contribution of the private sector in achieving lower fertility rates; in fact to the extent feasible, the proportionate share of TFR attributed to private sector services should be increased as a major component in reaching programmatic sustainability.
- (2) USAID will not abruptly close out support to any program element, e.g. IECM, essential to the attainment of programmatic sustainability so long as USAID resources are being used in a productive way.
- (3) USAID will base decisions based on the knowledge that quality programs in terms of information and services are far more important factors in achieving genuine programmatic sustainability than a government's willingness to put up counterpart funds to replace a donor's input into program.

#### E. PRIORITY PROGRAM ACTIVITIES

##### **(1) National Services**

As national family planning programs mature, governments often turn to decentralization as a means of reducing central bottlenecks and improving the

quality of planning and increasing local resource for and local commitment to the program. Thai leaders, for example, have found that they were able to expand coverage at the same time as they were able to reduce cost per acceptor. The Thais also learned that certain services are more efficient when directed from the central level e.g., programs would be poorly served by having different information about the safety of contraceptives coming from various levels of government.

Since the GOP is in the process of devolving many government activities including health services, no separate decision was required to determine the optimal time to decentralize the DOH family planning program. Basically, USAID will continue to support the DOH in carrying out its responsibilities for providing on a national scale technical assistance and commodities in the following areas:

- (a) Training: through grants and contracts with non-government organizations in the Philippines and through AID/W Cooperating Agencies (CAs) for specialized training, e.g., surgical contraception.
- (b) IECM: support to this sector will be expanded through the use of an AID/W CA specialized in motivational skills transfer.
- (c) Logistics: through Mission and AID/W funded CAs and registered PVOs in the Philippines. This does not include the cost of contraceptives, but does include in-country transportation, training, equipment and medical kits.
- (d) Contraceptives: through AID/W-funded contracts for the purchase of contraceptives and international transportation.
- (e) Research: operations research inputs will be obtained via the AID/W centrally funded operations research contract. Demographic research will supported for a mid-term DHS survey in 1996 via the AID/W contract for this purpose.
- (f) Policy Analysis: will be provided via AID/W CAs for this purpose.
- (g) MIS: to the extent feasible, technical assistance for provincial MIS will be provided through an AID/W CA.

(h) Post\partum Support: in order to have a major impact on maternal/child mortality as well as to lower fertility, a new initiative will be tested first at the DOH hospitals and medical centers. Synergistic care will be provided to the new born infant and the mother on DAY 40 after delivery. The program will be part of the Secretary of Health's priority program for making hospitals into centers for wellness. Inputs necessary for the success of the program are:

- \* strong motivational support from the IECM sector to inform patients of the importance of the DAY 40 appointment for the health of the baby as well as the mother.
- \* Support from the policy advocacy section to alert local decision makers so that they will want to incorporate the DAY 40 program into their community programs.
- \* Technical assistance from the Research CA in order to monitor, adjust and document this innovative program component.

Over the next five years, the cost of providing these national services will be assumed in part by the GOP.

## (2) NGOs and Private Sector

Family planning in the Philippines was originally a strictly NGO effort. In fact, USAID's first support for family planning here was to a local NGO. With the establishment of POPCOM, USAID support was concentrated there, but the success of POPCOM can be attributed to their continued use of the NGOs to provide training, services and advocacy. As noted earlier in this paper, the NGOs were neglected by DOH until the Ramos Administration, recognizing their importance, re-instated their accreditation to provide services.

USAID support to the NGO sector will be expanded through this strategy. National and Regional NGOs will receive direct support through a US contractor to enable these NGOs to continue FP service delivery and sustainability efforts begun under FPAP.

Additionally, USAID support will be provided to the private sector as follows:

- (a) Social Marketing support will be expanded through the AID/W CA for this purpose.
- (b) Work-based Family Planning will be expanded under a Mission grant to a local PVO

While not exactly a new initiative, there will be a greatly strengthened effort to include private physicians, and private-practice midwives through a variety of mechanisms.

### **(3) Local Government Units**

With the passage of the LGU Code and its implementation, the family planning program will face one of its greatest challenges and most important windows of opportunity. Fortunately, this challenge/opportunity coincides with the pro-family planning Ramos years. USAID will provide technical assistance, support and evaluation through several mission funded contracts and grants. The major part of the LGU channel of support will be effected through a mechanism similar to the Mission's innovative performance-based child survival project.

## **F. PLAN FOR USAID PROJECT ASSISTANCE**

The population assistance strategy which has been outlined in this document will guide the development of USAID bilateral and central assistance to the GOP over the next five years. A bilateral project to succeed the Family Planning Assistance Project, which will conclude in 1994, will commence development in Fall 1993. AID/W support through buy-ins to centrally funded projects will be programmed simultaneously. This combined package will comprise USAID's principal project assistance to the Population sector over the next five years. The components of that project assistance are:

- (1) private sector & NGOs
- (2) national services
- (3) support to local governments

The Mission strategy for supporting the first two components above, which was initiated under the Family Planning Assistance Project, will be continued through a variety of cooperative agreement, contracts, buy-ins, and A.I.D. (R&D/POP) central project arrangements. This section will provide a brief description of the plan for project assistance to these three components, but will focus primarily upon the strategy proposed for support to local governments. As this will be the first project developed after the implementation of the Local Government Code.

### **(1) Private Sector and NGOs**

Support to national and provincial NGOs is currently provided through a Mission cooperative agreement. It is expected that a new cooperative agreement will be executed to build on this experience.

Support to social marketing has been implemented through the central Contraceptive Social Marketing project. The program has launched the "Sensation" condom and in March 1993 launched the "Couples Choice" program which at present includes only oral contraceptives. It is envisioned that during this strategy period, other-contraceptives may be made available through the "Couples Choice" program. The program works with local manufacturers and distributors so there is no product subsidy.

It is recommended that project development propose a joint DOH/USAID plan for sustainability of NGO activities. It is also recommended that the Philippine Board of Food and Drugs approve Depo-provera, and that plans be made now for a Depo-provera launch in the public and private sector via doctors, nurses and midwives. Since there is a need for more effective spacing methods, and Depo-provera proved extremely popular when it was available, Depo-provera should prove to be very sustainable and significant in reducing unmet need.

### **(2) Support to National Services**

This program component will continue to be implemented through existing arrangements. It assists program elements that are centrally managed, essential enabling factors to provide the LGUs, NGOs and private providers with the means to lower unmet need. The national services to be supported are as follows:

- \* Information, Education & Communication
- \* contraceptive support

- \* logistics
- \* training
- \* voluntary surgical contraception
- \* provincial MIS
- \* operations research
- \* policy planning

In the project development process, the Mission plans to jointly address two issues with DOH: (1) a plan to phase-in DOH funding for these activities over a ten year period; (2) a plan to phase over responsibility from external to local contractors over a ten year period.

### **(3) Support to Local Governments**

The proposed support to local government would consist of three components: FP Challenge Grants to Local Government Units; Technical Assistance; and Performance Monitoring.

(a) Challenge Grants: The DOH and TA group would, in essence, administer a managed grants competition. It is envisioned that the grants would focus on the 79 provinces and 16 cities, or a total of 95 LGUs. The process would work within DOH similar to the matching grant process AID uses for NGOs. Within AID the process would work as performance-based, program (non-project) assistance. Benchmarks for progress would be mutually agreed upon by USAID and the DOH.

Once the benchmark review has been held and USAID concurs that the benchmarks have been met, A.I.D. would release the first tranche of funds to pay offshore, dollar-denominated debt designated by the Central Bank. The Central Bank will then augment the DOH budget by an equivalent amount of pesos for LGU family planning programs.

The process would be repeated each year, with performance to date being an important factor added to the selection criteria for provinces which have previously participated.

(b) Technical Assistance Contract: A technical assistance contract will be awarded for five years to assist the DOH to provide TA to provinces and administer the managed grants competition. At the end of five years, the DOH should

be managing this process with its own personnel or locally contracted TA. One output of the TA contract would be to prepare DOH for this outcome (to manage the second five years of the program). The contract will fund a central TA team to assist the DOG and LGUs as well as set up a local consultant roster of national, regional, and provincial level consultants that can be called upon by the LGUs for assistance in planning or implementation. This will enable the LGUs to call on whomever they feel best able to help them, including former officials of the regional DOH, POPCOM, and NEDA offices, universities and private sector.

During the course of project development, the Mission will reach agreement with the DOH concerning measures for immediate and significant strengthening of the staff devoted full-time to family planning in the DOH Office of Special Concerns. Without a major strengthening of DOH staff, it will not be feasible for the DOH to participate operationally in this process. At the end of the five years, the DOH should either be managing this TA process with its own personnel or funding the locally contracted TA.

(c) Performance Monitoring: The planned program support is based on national performance toward the objective of reducing unmet need for FP. The 1993 DHS will provide the baseline information. The DHS survey should be repeated in 1996. The 1993 and 1996 DHS surveys will have a sufficiently large sample size to provide some provincial level data on contraceptive prevalence, fertility, and unmet need. In the "off years" of 1994, 1995, 1997, and 1998, the NSO will conduct less ambitious surveys, using shorter questionnaires and cluster sampling or other less costly survey techniques to confirm progress toward the objective of reducing unmet need for FP. In addition to survey costs, this may include TA from BUCEN, some hardware and software expenses. Each year the tranche would be released based upon a DOH summary report of progress in the targeted provinces and the evidence of progress toward reducing unmet need.

In addition to unmet need, there are two additional performance indicators. First, as previously mentioned, by the end of the five-year period, the DOH should be managing or contracting for local TA to manage the continuing grants program to LGUs. At this point, minimal external assistance for DOH management of this process should be required. Second, the total proportion of the provincial proposals financed with locally generated funds (from LGU budget, revenue generation, cost sharing, community contributions, etc.) should increase from a minimum of 25% in year one to 30% in year 3, 35% in year 5, 40% in year 7, and 50% by year 10.

For the strategy to succeed, it is essential that the DOH address the following issues:

1. The need to substantially increase the number of DOH staff dedicated full-time to family planning.
2. The DOH must have a line item budget for family planning which grows to around 40% to 50% of program costs during the life of the project.
3. A plan must be developed for how to sustain the NGO support and national services activities that are funded with outside contracts and cooperative agreements. The suggested solution is that DOH begin to co-finance these contracts.
4. The DOH should approve Depo-provera for immediate launch via social marketing in the private sector.
5. The DOH should take steps to ensure that all accredited VSC facilities budget re-current cost requirement for VSC.

(d) Evaluation and Audit: Around \$750,000 has been set aside for evaluation and audit which would be conducted through local contracts.

(e) Budget: A proposed budget for the project is presented in

Annex I.

#### G. AID CENTRAL SUPPORT VIA R&D/POP

The Mission and R&D/POP need to develop a medium-term plan for desired central support that will improve accountability, efficiency and impact while reducing the Mission workload associated with buy-ins. Around 17 CAs are currently involved in the Philippines. While the door will always be open to the opportunity to use any CA, we should consider how we can: better focus on a smaller number of core organizations; improve joint planning for financing these activities; and get Mission/DOH suggestions for improving their management.

While the Mission is supportive of family planning and includes it among its top priorities, due to political sensitivities and other development needs, it cannot permit family planning alone to consume two-thirds of its annual OYB. Given these legitimate concerns, a joint Mission-R&D/POP financing plan for a program that is designed for successful impact, rather than designed to program available funds should be developed. Central funds can be sought to provide core support, reduce Mission buy-in workload, and improve CA portfolio management.

Although funding is always contingent upon availability of funds from R&D/POP annual authorization, a memorandum of understanding should be developed outlining CA support to be funded by R&D/POP and Mission over next several years. Although not formally binding, such documents are serving a useful purpose in a number of countries. It is believed R&D/POP would deliver support for a well documented package that delivers performance, especially beginning in FY 94. Continued investment of R&D/POP could be contingent upon continued successful performance of the program toward the national objective of reducing unmet need.

For strategy development purposes, an agreement on the objective and the mechanisms that are needed to program for success, should be able to overcome the administrative or bureaucratic obstacles. After all, global impact is a Congressional priority and a State concern, population is an Agency priority, the Philippines is a priority country, family planning is a Mission priority and a priority of President Ramos and Secretary Flavier.

ANNEX I  
1994-1998 BUDGET  
INTEGRATED FAMILY PLANNING AND  
MATERNAL/CHILD HEALTH PROJECT

<u>Program Component</u>	<u>\$ Millions</u>
A. Private Sector and NGOs	
1. NGOs	13.75
2. Social Marketing	8.0
B. National Services	
1. IE&C	10.0
2. Contraceptives	15.0
3. Logistics	8.0
4. Training	6.0
5. Voluntary Surgical Contraception	7.5
6. Provincial MIS	1.5
7. Operations Research	1.5
8. Policy Planning (LGU planning, TA, PLCPD)	2.0
C. Support to Local Government	
1. Challenge Grants (79 provinces and 16 chartered cities eligible to compete)	25.0
2. Technical Assistance	8.0
3. Performance Monitoring	3.0
D. Evaluation and Audit	
1. Evaluation	0.5
2. Audit	0.25

NOTE: THE CHALLENGE GRANTS TO LOCAL GOVERNMENT UNITS (\$25 MILLION UNDER C.1 ABOVE) WOULD BE PERFORMANCE BASED, NON-PROJECT ASSISTANCE; THE BALANCE PROPOSED WOULD BE PROJECT ASSISTANCE.

ANNEX II  
POTENTIAL PROGRAMMING AND  
COST SHARING ARRANGEMENTS

<u>Program Component</u>	<u>Mechanism</u>	<u>SM-Funding Source</u>
A. Bilateral		
1. NGOs	Cooperative Agreement	13.75 Mission
2. Training	Contract	6.00 Mission
3. Challenge Grants	NPA	25.00 Mission
4. LGU TA	Contract	8.0 Mission
5. Performance Monitoring	DHS/Census Buy-Ins	3.0 Mission
6. IE&C Partial	PCS Buy-In	3.50 Mission
7. Evaluation	Contract	0.50 Mission
8. Audit	Contract	0.25 Mission
TOTAL		60.00 Mission
B. Central		
1. IE&C Partial	PCS	6.50 R&D/POP
2. Contraceptives	Central Procurement	15.00 R&D/POP
3. Social Marketing	CSM III	8.00 R&D/POP
4. Logistics	CARE & FPLM	8.00 R&D/POP
5. VSC	JHPIEGO & AVSC	7.50 R&D/POP
6. OR	Pop Council	1.50 R&D/POP
7. MIS	FPMD	1.50 R&D/POP
8. Policy Dev.	TFG/Rapid/Options	2.00 R&D/POP
TOTAL		50.00 R&D/POP

NOTE: THE ABOVE COST SHARING ARRANGEMENTS WOULD BE NEGOTIATED IN A MEMORANDUM OF UNDERSTANDING TO BE CO-SIGNED BY MISSION DIRECTOR AND DIRECTOR, OFFICE OF POPULATION.