THE PHILIPPINE FAMILY PLANNING PROGRAM (1990-1994)

Introduction

The Philippine Family Planning Program (1990-1994) builds on and takes off from the almost two decades old national program. In certain respects, it continues from the previous programs, but on others, it departs from them. Despite the previous and current statements and re-statements of its directions, policies and procedures, the Program has always been, at core, a strategic social development initiative meant to respond to the real needs of individual families which, on the whole, has yielded desirable advances in overall welfare. Over the years, however, policy debates, personality changes, institutional re-alignments and considerable misinformation have obscured the social service character of the Program. This current Program plan covering the five year period from 1990 to 1994 attempts to put together those aspects of the program in the past which need to be continued and modified, and the new directions which need to be taken now and into the end of the 20th century.

This document presents the policy context within which the Program operates, the considerations that play a major role in the shaping of its design, the baseline conditions upon which it shall build, and finally the broad outlines and illustrative details that describe the Program. It is hoped that the transcendent beneficial character of the Program would clearly emerge from this description.

1. Policy Context

The Philippine Family Planning Program (PFPP) is a national program to systematically provide information and services necessary for couples of reproductive age to plan their families according to their own beliefs and circumstances. It is an organized program led by the Department of Health (DOH) and participated in by other government agencies and non-governmental organizations to assist families in carrying out their (the families') choices for planning their future responsibly according to their needs and aspirations. The Program recognizes that forming unions and building families are matters that couples themselves decide and undertake. In the context of widespread poverty and ignorance, however, couples require a level of information and services that can assure them of meaningful options for informed choices regarding family planning. The Program responds to this requirement.

The PFPP is regarded by the government as a program with a crucial contribution to the attainment of development goals both at the national and household levels. Sustainable growth and alleviation of poverty, as well as higher incomes, better education, improved

health and nutritional status at the level of individual households, can be enhanced by the PFPP. By no means, however, should the Program be regarded as sufficient to achieve these goals. In the Medium-Term Philippine Development Plan, 1987-1992, there is considerable articulation of many other important national programs such as agrarian reform, public infrastructure, basic education and primary health care, among others. But considering the dual nature of the population as being comprised of assets capable of creating incomes and wealth, and of liabilities with an appetite for absorbing resources for consumption and investment in human capital, a program that affects the way families contribute to the growth of the population is obviously a key development issue.

1.1 Macro Perspective: Population, Health and Development

Aggregate national development clearly occurs within the context of overall population and health conditions. While the focus of development is traditionally on physical and economic factors (e.g., GNP level, GNP growth, GNP per capita, employment rate, etc.), it is people (defined in the aggregate by demographic and health parameters) that are the proper source and object of this development.

The latest estimates by UPPI place the 1990 Philippine population at 62 million. The 1988 National Demographic Survey (NDS) estimates the annual population growth rate at 2.4 percent which means that about 1.4 million persons are added every year. At this rate, the population will double in 29 years or by year 2019.

The current population is the result of health and demographic developments of the past. Crude birth rate in 1990 is estimated at 29 births per 1,000 population, and this is a significant decline from 46 in the mid-1960's, 39 in 1970, and 36 in 1980. An important source of this decline is the reduction in the total fertility rate (or average number of children a woman expects to have at the end of her reproductive period at present fertility experience) from 6.2 children per woman in 1968 to 5.92 in 1973, 5.2 in 1978, 4.96 in 1983, 4.51 in 1986, and finally to 4.28 in 1988. While there are observed stalls in various periods during the past two decades, crude birth and total fertility rates clearly declined significantly over the whole period.

In two decades, total fertility rate declined by two births per woman (from 6.2 in 1968 to 4.28 in 1988). This decline can be attributed almost entirely to changes in family planning practices. Although the average age at first marriage has increased by one year (from 23.1 to 24 years of age), this factor has a relatively minor impact on overall fertility. Reliable estimates of postpartum behavior (breastfeeding and abstinence) suggest that this has had essentially no contribution to fertility decline. In contrast, the percentage of married women aged 15 to 44 practicing contraception increased from 15 percent in 1968 to 36 percent in 1988. Even more important from the standpoint of fertility impact, the percentage of those using modern effective methods increased from 2 percent to 21 percent. Thus, in this regard, the overall pattern during the past two decades can be summed up as: substantial decline in fertility due almost entirely to increased contraception.

Meanwhile, the overall health status of the nation improved as indicated by significant declines in crude death rates (CDR) and infant mortality rates (IMR) yielding rising trends

mothers and children would yield significant contributions to declines in total mortality and morbidity; that, among the many concerns in maternal and child care, the care before, during and after pregnancy is an important area of concern; that the spacing and limiting of children through family planning would afford mothers with opportunities to reduce health risks to themselves and their children, as well as to gain some measure of control over their own reproductive destiny; that this opportunity is recognized by a large proportion of women at risk, some of whom are already practicing contraception but a large portion remain unprotected. The realization of such opportunities would yield an improvement in health status, as well as a reduction in population growth.

The Philippine Family Planning Program is designed to bring those opportunities into fruition at the core of the national concern for population, health and development.

1.2 Household Perspectives

Macro perspectives provide an important context for the Philippine Family Planning Program. But consideration of aggregates tends to gloss over stark realities, particularly in the poor households of a poor and heavily indebted country like the Philippines. In this section, the Program is considered in terms of how it relates to the conditions of poor households.

Based on 1985 data, 58 percent of Filipino families are below the poverty line. As much as 70 percent of these poor families, most of whom are small farmers, live in rural areas. The poorest include landless agricultural workers, subsistence fishermen, and upland farmers. While there have been some slight improvements due to economic recovery, conditions in 1990 have not significantly changed the situation of the poor: lack of access to income producing assets, mainly land; low level of education; poor health and nutrition; relative lack of participation in self-help community organizations; high fertility; and inadequate knowledge and skills for income generation and efficient utilization of household resources.

Access to income producing assets is clearly an issue which has primary importance to the poor, far ahead of all other factors that contribute to their continuing poverty. Thus, agrarian reform and associated interventions like rural credit, agricultural extension and rural infrastructure in support of agriculture are programs with a central impact on the welfare of poor households.

However, much as these programs may be necessary, they are not sufficient to alleviate poverty and bring about people empowerment in the rural areas. Agrarian reform and the improvement of rural productivity are crucial to rural development. Equally important is the mobilization of mothers for family welfare. The former is well recognized; the latter less so. Health, nutrition, education, and augmentation and utilization of incomes at the household level are generally managed by mothers. Participation in volunteer action in such roles as Barangay Health Workers, Barangay Nutrition Scholars, Barangay Supply Point Officers, and involvement in Parents-Teachers Associations, income generation and livelihood projects are largely accounted for by women of reproductive age. Among the poor, the capability of mothers to expand and manage household resources under the constraints of poverty and given the demands of its members is a decisive factor for survival and for breaking out of the

in life expectancy at birth. The mortality declines were most rapid from the 1940 to 1960 period when CDR dropped from 32 to 14 deaths per 1,000 population and IMR from 136 to 70 per 1,000 live births. The pace of decline, however, slackened over the 1960-70 period, and indications point to a stall at relatively high levels during the 1975-80 interval. By 1990, communicable diseases would still account for a large proportion of mortality and morbidity, pointing to incomplete victory over preventable causes of illness and death. Current estimates of CDR at 7.4 and IMR at 51.5 for a population with a high proportion of young people testify to lagging progress in health status.

An examination of the demographic and health conditions of mothers and children demonstrates the close interrelationships between mortality and morbidity, on the one hand, and fertility, on the other.

A major component of poor overall health status is the relatively high levels of illness and death among mothers, newborns, infants and young children.

There are currently an estimated nine (9) million women of reproductive age. Every year, 1.5 million of them become pregnant. DOH statistics indicate that only 62 percent of deliveries are attended by medically-qualified personnel. Altogether, attended and unattended births are associated directly with about 1,600 maternal and 10,500 fetal deaths and less directly with some 50,800 deaths of children under 1 year of age. An estimated 15,000 fetuses are lost each year in spontaneous or induced abortions and stillbirths. Yet, it is generally conceded that maternal deaths reported are still underestimated as many deaths occurring among pregnant women with concurrent medical complications are reported as deaths from these causes (for example, cardiac death), not as maternal deaths. Perinatal deaths are also underestimated as many newborns who die are buried unreported due to the administrative burdens of death certification.

About half of pregnancy-related deaths of women is due to hemorrhage around the time of delivery; one-third is accounted for by other medical complications, notably hypertension. Much of this risk is associated with increasing numbers of pregnancies per woman. On the other hand, a significant portion of deaths of children is accounted for by low birth weight babies (around 18 percent of babies are born lighter than 2 and 1/2 kilos), as well as by other significantly compromised babies of malnourished and anemic mothers or mothers with concurrent tuberculosis, or malaria or hepatitis or typhoid, which are diseases endemic to the Philippines. Given the risks to mothers and children associated with pregnancy and birth, some 7.7 million women or 63 percent of total women of reproductive age who are under 20 years of age or who are older than 35 years, or who have had four or more births, or had delivered less than 15 months ago, are considered high risk. Only 2.8 million of these are subfecund or practicing contraception. Thus, 2.9 million women are in need of some means of spacing or limiting their pregnancies. In all likelihood, a disproportionate proportion of deaths and illness among mothers and children associated with pregnancy and birth would be generated by this part of the population. Many of these women realize their need since, based on the 1988 NDS, 2 million out of the 2.9 million women at risk may want to practice family planning but are currently not doing so.

The above discussion clearly indicates the following: that improving the health of

bonds of poverty. By and large, mothers are the true managers of the household as a socio-economic enterprise.

Yet, for all that, mothers bear children and care for them. And to the extent that the burden of child bearing and child care bears down on the health, energy, attention and intelligence of mothers, to that same extent would the management of household resources under conditions of poverty deteriorate. Numerous demographic and contraceptive surveys over the years have shown the women of the poor to have been weighed down by undesired fertility much more than the rest of the population. The 1978 and 1983 surveys documented the poor to have higher fertility rates than higher income groups. Fertility is significantly higher in the poorest regions, in the rural areas, among less educated mothers, in agricultural households and among manual occupations. Differentials in total fertility rates ranged from 3.5 per woman in NCR to 6.3 per woman in Bicol; within regions, rural fertility is 40 percent higher than urban fertility; and among women of varying educational level, women with three years or less of schooling average 7 children as against an average of 3.8 children for women with seven or more years of schooling.

These fertility differentials, like the trend in total fertility, are associated with differences in contraceptive use. Women in rural areas, lower income groups, lower occupational status, and lower educational levels also had lower contraceptive prevalence. Yet the proportion of women who were not using contraceptives but did not want more children was higher among poor households, among households in rural areas, among the less educated and in agricultural occupations.

Thus, it is clear that the burden of high fertility is greater among women of poor households because contraceptive use among them is lesser even while demand among them is greater. This inability to reach the poor at the levels appropriate to their expressed desire to space or limit their children is one of the inadequacies which the Program seeks to correct.

Access to family planning services sufficient to meet the demand of poor households would provide mothers with the means to moderate their fertility according to their desires. This has the potential for liberating mothers from the onerous burden of unwanted pregnancies and for freeing up tremendous time, energy, intelligence and capabilities for household management and volunteer social action. Human resources are practically the only readily mobilizable income producing asset of the poor. A moderation of fertility would reduce the allocation of mothers' time and energy for child bearing and child care, thereby freeing up a willing and capable member of the household (the mother) to augment income or to efficiently utilize available income for greater family welfare. In this sense, family planning may be regarded as a wealth-creating program for the poor operating at the household level.

2. Program Design Considerations

The PFPP for 1990-1994 is shaped by the policy context within which it operates. But specific considerations dictated many aspects of its design. This section discusses these considerations and draws out some of the implications in terms of program features.

2.1 Institutional Leadership of DOH

(a) Authority

Executive Order No. 119 reorganizing the Department of Health clearly identifies family planning as a priority health issue. Section 11 (c) points out that the DOH shall "formulate plans, policies, programs, standards and techniques relative to family planning in the context of health and family welfare; provide consultative, training and advisory services to implementing agencies; conduct studies and research related to family planning."

In 1988, the Board of the Population Commission at its meeting on 31 August 1988 designated the Department of Health as the lead agency in family planning services, which are a major component of the National Population Plan.

In 1989, the POPCOM Board via Resolution No. 1, series 1989, specified the role of DOH as lead agency in family planning as being composed of two parts: (a) as an implementing agency delivering family planning services through the DOH hospital and clinic network; and (b) as a coordinating agency for consulting, organizing, guiding, monitoring and leading all other participating government and non-governmental agencies.

The President publicly acknowledged the importance of family planning and the role of DOH in this area when she specifically pointed to family planning as a national priority with the DOH as the lead agency, during her State of the Nation Address before a joint session of Congress on 24 July 1989.

(b) Relationship between POPCOM and DOH

The institutional roles of DOH and POPCOM with respect to family planning have been redefined by recent developments. The POPCOM, headed by its Board, is the agency mandated to be responsible for the national population policy and program. From its inception up to 1989, it performed a direct program management role in family planning in addition to its other population-related tasks like population advocacy, population education, improvement of population-based planning, and other important concerns. Under this old context, the DOH performed merely as one, albeit an important, participating agency with its own family planning program that is part of the larger program managed by POPCOM.

With developments in 1988 and 1989, the direct program management role of POPCOM with respect to family planning has been effectively terminated. The agency is undergoing a reorientation from an excessive and direct preoccupation with family planning as a fertility reduction component of the population program, to a more balanced approach of policy and program coordination, sector monitoring and broad institutional support to all agencies with a contribution to population and development. POPCOM's current concern with nonfamily planning issues related to population as exemplified by its concern for family welfare is an attempt to concretize this reorientation. Only time will tell if the agency will succeed in

translating this strategy into a viable mode of operation in the Philippine social and political environment. As a member agency of the POPCOM Board, the DOH naturally wants POPCOM to succeed in these new directions. It is recognized that the population issue is broader than family planning, and that therefore, there is a role for a Population Commission even as the family planning program is organized, managed and directed by the Department of Health. But the operationalization of POPCOM's new role in population is properly the principal responsibility of its organization and the prime accountability of its operational leadership.

As far as family planning matters are concerned, the DOH now assumes the prime policy and operational management role. POPCOM is committed through the decisions of its Board to extend to DOH whatever assistance it can to assure a smooth turnover of FP program responsibilities while preserving the links between family planning activities and population concerns.

The assumption by DOH of its lead role in family planning unavoidably introduces changes into the program. These changes arise from a re-examination of the issues, a reflection of DOH institutional interests, and a response to the current conditions.

2.2 A Program Responding to Demand

The PFPP is essentially a program to deliver information and services; it is not run as a population control program. While it has an impact on moderating fertility, it is not driven to reduce fertility as a goal. While it can contribute to curbing population growth, it is not focused on slowing down the population growth rate. Instead it is driven to support the chosen paths of couples to manage the risks and outcomes of their reproductive behavior in legally permissible and medically acceptable ways.

While the Program recognizes that the aggregation of individuals' and couples' decisions and actions has an impact on overall fertility and population growth, the Program regards this result as a separate issue altogether distinct from the principal program focus of assisting couples for their own benefit and according to their aspirations. The Program intends to respond to the household demand for information and services relative to family planning on the assumption that the satisfaction of individual couples would also mean the achievement of overall social development goals.

The Program defines the demand for family planning in two ways: (a) in terms of the expressed desire of couples to space or limit their children for a variety of reasons; (b) in terms of the need to reduce the identified risks to the health of mothers and children due to pregnancy and childbirth. In other words, the Program regards demand on the basis of the couple's fertility aspirations and health needs. Thus, it seeks to meet the demand for information and services by those who want to practice family planning because they prefer wider child spacing or smaller families, and also by those who may need to practice because pregnancy and childbirth pose higher health risks than they may be willing to bear.

Based on the 1988 NDS, 31 percent of women of reproductive age want to limit or space their children but are not currently practicing family planning. Using the criteria of high risk

as those pregnancies conceived prior to age 20 or beyond age 35 or beyond a fourth birth or at less than 15 months postpartum, the same survey yields an estimate of 32 percent of women at high risk who should be practicing family planning but not doing so. An overlapping of the two definitions of demand would indicate that 23 percent of women of reproductive age are at high health risk and express a desire to postpone or limit their pregnancy but are not yet practicing family planning. Another 8 percent of women want to limit or space their pregnancy despite being at low risk. Together, these would define the demand by new acceptors. Nine (9) percent more are fecund, not practicing family planning and desire another birth soon yet are in the high health risk group. This would constitute demand for more information as well as maternal and child care for probable high risk pregnancies and childbirth.

Meanwhile, there is a core of 25 percent of women that belong to the high health risk group already practicing contraception. Another 11 percent of women are low risk yet practice family planning. These would define the demand for continuing use.

2.3 Emphasis on Service Quality

The Program relies on voluntary acceptance and compliance among service users. In order to maximize efficiency and effectiveness in supporting couples' choice, the Program has to emphasize service quality as a means to expand initial use by those who want and need these services, and continuing use by those who initiate practice..

Service quality in family planning would include: (a) assurance of safety in methods and supplies utilized in the program; (b) cost-efficient coverage of service outlets in terms of physical reach and financial considerations; (c) reliable links with associated maternal and child care services necessary for women of reproductive age contemplating the prospects of pregnancy and childbirth; (d) accessible availability of a range of choices appropriate for various reasons and circumstances; (e) correctness and completeness of information provided to potential acceptors; (f) adequate support for continuation of practice by those acceptors who wish to do so; (g) regular, predictable, standardized, pleasant and supportive clinic services; (h) adequate area-based coordination between a variety of service providers under a variety of agencies performing a variety of tasks from motivation to clinic services; and (i) priority provision for rural, low education, low income and manual occupation couples.

The revitalization of the FP service delivery network will be largely built on improving service quality along the lines described above. The planning, organizing, budgeting, logistics, monitoring and evaluation functions will be undertaken for the purpose of assuring service quality. The impact of improvements will be measured in terms of utilization of service provisions by new acceptors and continuing users.

2.4 Decentralized Service Delivery

To effectively become demand-driven and quality conscious, the Program will have to be decentralized in terms of service delivery. Central control will have to be exercised through: (a) clear policy articulation after broad consultation; (b) nationally-organized

logistics support system; (c) standard reporting and evaluation; and (d) national planning of IEC, training, clinical standards and other technically determined functions. Actual management of service outlets and implementation of service program through each participating organization need to be decentralized. Thus, the tasks of demand estimation, client identification and prioritization, establishment of outlets, upgrading or expansion of outlets, conduct of training, execution of IEC plans, clinic operations, area coordination, and other service tasks will have to be undertaken at each locality via an appropriate regional, provincial, district, municipal or barangay mechanism following the administrative structure of the DOH.

In addition, as the overall decentralization of government proceeds and as local governments take on roles in the Program, the service delivery would also have to maximize linkage with local governments at the provincial, municipal and barangay levels.

2.5 Primacy of Revitalizing the Service Network

Given the current state of the Program, the first priority is to rebuild and revitalize the network of service outlets and participating organizations. The network of the DOH is the key component that requires prime attention, followed by the NGO network. The other government agencies, notably DOLE, and the agricultural agencies (DA, DAR, and DENR), also need attention. Then comes the network of the provincial and city governments and, finally, the private sector providers.

The tasks necessary to organize, encourage, reorient and mobilize those large groups claim priority demand on the Program's limited managerial and budgetary resources.

2.6 Service Content of the Program

The Program provides information and services. Information consists of factual explanations of health and other benefits of family planning, descriptions of various family planning methods included in the Program, and other materials that couples need to make fully informed choices. It shall also provide motivational materials to get couples to explore reasons and options for responsible parenthood. Further, the Program will provide specific information to allow couples to actually take steps to seek out and obtain services.

The Program shall make available modern contraceptive methods, as well as other ways of managing fertility such as natural family planning and breastfeeding.

The current methods available are low dose combination pills, intrauterine devices, male or female voluntary surgical contraception, condoms, and natural family planning. The Program shall make an adequate range of choices available on an area-wide basis even as each outlet may opt to specialize in one or a few methods. In the provision of services, the choice of the client will be the principal consideration. There shall be no coercion in behalf of family planning or any specific method. And providers shall be required to advise and recommend, and care shall always be taken to avoid misinformation or any action that could compromise the clients' right to free and informed choice in managing their reproductive lives.

All supplies and techniques provided under the Program shall be controlled for safety and quality. No special accommodation or compromise will be adopted that deviates from normal prudent practice for accepting and utilizing contraceptive supplies in the Program. And since all Program procedures are elective, patient safety shall always be preeminent. New methods will be thoroughly considered, studied, evaluated and tested prior to inclusion in the Program.

Method shifting on the part of Program acceptors will be fully supported. Program dropouts shall be given due attention in order to respond to their family planning needs or to support them in their chosen pregnancy and childbirth. While the Program will emphasize client satisfaction in one or some other chosen method, the DOH shall continue to make its other health services equally available to clients who have chosen pregnancy and childbirth.

3. Start-of-Program Conditions

As of 1990, certain conditions characterize the start of the Program. These are described below.

3.1 The State of Demand

The demand for family planning was assessed by integrating health risk consideration and fertility preferences in analyzing the 1988 NDS data. The following description of demand was derived from that analysis:

(a) The top priority group for generating new acceptors is composed mainly of those women of reproductive age who are fecund, high risk, expressed a desire to limit or space their pregnancy and do not currently practice family planning. This can be considered as the "motivated unserved." This comprises 23 percent of women aged 15 to 44.

(b) Also within the top priority group are women of reproductive age who are fecund, expressed a desire to limit or space their pregnancy despite being low risk, and do not currently practice. This comprises 8 percent of women aged 15 to 44. This group is likely to seek out information and services.

(c) The top priority for information and motivation, or alternatively, for maternal and child health services, are women of reproductive age who are fecund, high risk yet want to have a birth soon and are thus not practicing family planning. This could be called the "unmotivated unserved." This constitutes 9 percent of women aged 15 to 44.

(d) Finally, there is the group currently using non-permanent methods which would generate demand for continuing use requiring an adequate response. One part consists of those who are fecund, high risk, want to limit or space their pregnancy and are currently practicing; another part has the same characteristics except that the women are at low health risk.

These basic client groups are distributed in urban and rural areas, various regions,

provinces and municipalities, various income groups, various educational levels, and account for other important additional health risk factors such as malnutrition and the presence of endemic diseases. These parameters would define the various circumstances under which services need to be provided.

While there is almost universal awareness of family planning among the eligible population, no largescale information effort has yet been launched in the last three years. There is the possibility that awareness of and desire for fertility reduction may have slackened somewhat or that misconceptions and superstitions about family planning may have proliferated. But for Program planning purposes, the above demand estimates are useful, considering that, in any case, service capability and Program resources are not adequate to meet total estimated demand.

3.2 The State of Supply

Services are currently provided by a national network of clinics and centers staffed by paid full-time and part-time workers, supported by an associated network of volunteer community workers. There are currently 3,545 static clinics and 42 comprehensive itinerant teams. There are an estimated 1,753 full-time outreach workers, 51,000 barangay service point officers and 350,000 volunteer workers. Some 100 NGOs also participate in the Program, accounting for up to 35 percent of service delivery outputs of the whole Program. The DOH clinics are full service clinics providing many other services besides family planning. The NGO clinics have more substantial focus on family planning but these have also widened the range of their services.

Information is provided by these service outlets in the course of delivering services. At the municipal level, mandatory premarriage counselling is an opportunity to provide information to couples about to be married. There are also 12 adolescent centers that provide adolescent fertility information and counselling. Of course, there is always the mass media which could reach almost the whole population via TV, print or radio, and which have been used as channels for population and family planning messages.

The current service network may be described as follows:

(a) Large public investments in service capabilities over the past two decades have yielded a basically sound clinic infrastructure staffed by trained personnel. At DOH and among NGOs, considerable numbers of well-trained personnel continue to operate service outlets.

(b) Policy uncertainties during the past three years and the lack of any major training or technical upgrading initiatives have exacted their toll on the service network. Many clinics no longer have trained personnel and those who remain there no longer possess up-to-date knowledge and skills.

(c) In addition to the relative neglect during the immediately preceding period, the clinics in the network continue to suffer from chronic breakdowns in management and supervision, producing varying degrees of deficiencies that include running out of contraceptives, lack of IEC materials, trained people with no equipment, equip-

ment without trained people, and untrained people with clients ready and waiting.

(d) Under those conditions, service characteristics are not standardized, predictable or actively controlled. Nonetheless, there are many clean, efficient and well-utilized outlets providing a high level of service quality operating side by side with a number of unreliable providers.

(e) The DOH organization has lately become stronger through consistent implementation of measures such as systems streamlining, technical and policy clarification, decentralization, and greater top management attention given to program management and organizational development. These provide favorable conditions encouraging the overall improvement of clinic outlets. From the Program's standpoint, however, this only has an indirect positive effect as improvements focusing on FP services still need to be undertaken.

Apart from the technical characteristics of the network, old Program habits remain which constrain improvements in service efficiency. These include confused motives on the part of health workers in providing family planning services leading to paralyzation at the local level whenever there is political opposition by anticontraception groups; the lack of client prioritization methods that could segmentize potential acceptor groups; overemphasis on generating new acceptors while neglecting the maintenance of continuing users; over-reliance on the material basis for motivating acceptors and providers; unproductive competition between outlets of various participating groups; the over-riding focus on activities and methods rather than on clients and families; the continued dominance of vertical structures along participating agencies instead of horizontal coordination among outlets of various agencies serving one geographic area.

3.3 State of Program Management

The transfer of direct overall operating responsibility over the Program from POPCOM to DOH created a temporary dislocation in Program management that is rapidly being resolved.

At the DOH, the Office of the Chief of Staff under the Secretary of Health was tasked with organizing the Program, including designing its management structure. A structure composed of a limited number of senior managerial positions has already been created with the support of grant resources from UNFPA and the Japanese government. Staff selection is proceeding. Meanwhile, much of the overall program management responsibility is being borne by the Family Planning Service of the DOH, in addition to its traditional role of supporting the DOH Family Planning activities.

At the POPCOM, its Board has already resolved to make available to the DOH whatever facilities and staff may be necessary for the Program, although the actual details for DOH to absorb these have yet to be worked out.

At the field implementation level, DOH regional offices have been discussing with their POPCOM counterparts the issues related to overall Program management. The actual and

formal delineation of functions and responsibilities has not yet happened, although an understanding exists in many regions.

The provincial, city and municipal Program management is even more unclear and unresolved. The willingness, capability and effectiveness of local governments to serve as the main vehicle for Program management at local levels vary tremendously. And it is likely that many models will have to be developed rather than just one or a few.

Among participating agencies, the national line agencies that have expressed strong support and interest in the Program have also organized or designated responsible units to follow through with their commitments. These agencies are DA, DAR, DENR, DECS and DOLE. Of course, POPCOM and NEDA have also provided strong support to DOH in overall Program management.

The NGOs active in the program continue to have core managerial capabilities. While individual NGOs have largely retained their project development and management resources, there has been considerable erosion due to the resource gaps that went unfilled during the past two years. Efforts to organize the NGOs into a coordinated network have proceeded but the progress has not been as rapid as expected due to overall Program uncertainties.

Management capabilites for functional elements of the Program such as logistics, IEC, training, research, monitoring and evaluation are available in the Program network of agencies. The task of actually putting them together in routinely operating mechanisms of committees, contracts, agreements and formalized arrangements remains largely undone.

3.4 State of Program Planning

This Program document reflects the current state of program planning. A directional plan has been prepared and approved. This Program plan is a further development and specification.

Under the Program, three major projects have been developed and formally approved, namely: the support to family planning through the Dutch Rural Development Assistance Project, the country program of UNFPA, and the Family Planning Assistance Project of USAID. These projects are already being implemented.

Proposed additional projects under the Program have been identified and developed for possible donor review and action. The most notable among these seek resources for activities to be undertaken by NGOs, local governments, and other government organizations aside from DOH.

A technical assistance mission supported by the World Bank, several consultant missions supported by USAID and UNFPA, and a number of local studies commissioned by the DOH have provided up-to-date detailed assessments and recommendations for Program policies and activities. Training and IEC planning is proceeding under the existing projects being implemented. Operations research, logistics inventory and planning, and standards development are all being undertaken or have been concluded.

The current estimation of resource requirements for the Program is shown elsewhere in this document. Some elements of the budget are the result of detailed costing while others are basic ballpark estimates. The budgeting, therefore, relies largely on the level of project preparation.

4. The Program

4.1 General Description

The Philippine Family Planning Program consists of policies, strategies, activities and projects through which government and other cooperating groups can respond to the demand of families for assistance in meeting their health and fertility aspirations through family planning.

At the level of individual households, the Program intends to support whatever might be the choice of the family. Given current information regarding the likely nature of that choice on the aggregate, *if access to quality services were greater*, the Program could expect the number of married couples of reproductive age (MCRA) practicing family planning to increase from 3 million in 1990 to 4.37 million in 1994.

It is the objective of the Program to reduce the level of unmet need for family planning particularly among poor families. This would be achieved on the whole by increasing effective access to information and services for those who want or need to space or limit their pregnancies, and by improving the quality of services towards greater client satisfaction. The Program will be evaluated by families based on whether they consider themselves to have achieved their choices regarding initiation of childbearing, spacing of pregnancies and number of children. On the aggregate, however, the specific objectives of the Program are as follows:

- an increase in the number of family planning acceptors annually from 1.14 million in 1990 to 2.2 million in 1994.
- an increase in the proportion of women of reproductive age practicing family planning from 35.9% in 1989 to 53.4% in 1994.
- an increase in the proportion of women at high risk practicing family planning from 25% in 1988 to 50% in 1994.
- a decrease in the drop-out rate among acceptors of family planning from 50% in 1990 to 37.5% in 1994.
- continuing service to the needs of the 36% of MCRA's currently using family planning.

If the Program succeeds in supporting the choices of client couples, high risk pregnancies could be reduced by as much as 30 percent from 1990 to 1994 and total fertility rate could decline from an average of 3.9 children per woman to 3.38 over the same period.

To achieve the above objectives, the Program has to: (a) mobilize resources to support

service and information delivery; (b) manage projects and activities to insure efficient and effective use of resources for maximum benefit; (c) promote the values of responsible parenthood such as responsible sexuality, delayed marriage, childspacing, small family size norm, counteracting the trend towards preventing birth after conception, safe motherhood and child survival; and (d) strengthen implementation support activities such as field management, logistics, IECM, research, training, monitoring and evaluation.

By the end of the Plan period, the following outputs shall have been realized by the Program:

- the establishment of 2,208 new family planning service outlets established.
- the maintenance of4,622 existing outlets and 46 adolescent/youth centers maintained.
- 21,659 health personnel trained on integrated basic skills, 7,255 on specialized skills, 1,622 on voluntary surgical contraception, 18,383 on ICS, VSC counselling and others.
- 7,974,500 acceptors for five years and up to 4,371,000 continuing users by 1994.

Table 1 shows the projected annual accomplishements of the Program.

4.2 Implementation Strategies

The overall implementation scenario calls for the design of a program framework that assumes resources greater than are currently available so that program planning can proceed on a scale appropriate to national requirements. Meanwhile, with the resources at hand, implementation can be undertaken in distinct projects that relate to specific aspects of the program. The implementation itself will first focus on DOH as the main service delivery network and central institutional pillar of the Program without neglecting the essential requirements of key cooperating agencies like NGOs and other government organizations. Then, as service capability expands, other elements like community outreach, population advocacy and local area integration of family planning with other population concerns can be implemented.

Within this overall scheme, the following strategies have been adopted by the Program:

1. **Revitalize the network for family planning services of the DOH and participating NGO's.**

   Training, IECM, logistics and management development would be principal inputs to strengthen existing service outlets and establish new ones. With the revitalization of the service delivery network, utilization can rise in response to existing demand. Specifically, the approach calls for higher levels of support for four advanced regions (III, VII, X and XI) where program infrastructure and administrative capability are well established. In other regions, emphasis will be on re-installing basic capabilities in preparation for a wider and more vigorous program.

   The current priorities in applying this strategy are: (a) updating and standardiza-

TABLE 1
PROJECTED ANNUAL ACCOMPLISHMENTS

ACCOMPLISHMENTS	1990	1991	1992	1993	1994	TOTAL 1990-94
1. New Service Outlets						
a. DOH Outlets	148	154	167	151	124	744
b. Other GO Outlets	530	251	251	51	51	1,134
c. NGO Outlets	40	146	81	22	18	307
d. NFP Centers		5	7	7	4	23
Total	718	556	506	231	197	2,208
2. Maintenance of Existing Service Outlets						
a. DOH Outlets	2,244	2,392	2,546	2,713	2,864	
b. Other GO Outlets	80	613	864	1,115	1,160	
c. NGO Clinics	284	326	472	553	575	
d. NFP Centers		5	12	19	23	
Total	2,608	3,336	3,894	4,400	4,622	
3. Training						
a. Health workers on basic FP	3,508	5,328	4,946	4,139	3,738	2,1659
b. Health professionals on specialized FP skills	1,139	1,926	2,081	1,197	912	7,255
c. Health professionals on different FP refresher courses	1,862	3,947	3,539	4,543	4,492	18,383
d. MDs/RNs/RMs on VSC	222	473	416	339	172	1,622
4. Acceptors	1,140,000	1,228,600	1,539,700	1,867,200	2,199,000	7,974,500
5. Users	3,004,800	3,062,400	3,283,500	3,841,900	4,371,000	

tion of the technical and medical content of service guidelines; (b) development of new, more appropriate training materials; (c) preparation and dissemination of clinic-based IEC materials; (d) getting contraceptive supplies out to outlets and available to clients by streamlining distribution and dispensing; and (e) re-ordering stocks that are in low supply.

2. **Utilize the nationally extensive presence and decentralized management structure of DOH as the institutional framework for national Program mobilization.**

   DOH has an administratively cohesive organization with on-site presence in all regions, provinces, cities, districts, municipalities and barangays. This would be utilized as the basic institutional pillar around which NGOs, other GOs and local governments can relate to and coordinate with.

   The increasing decentralization of DOH would create favorable conditions for implementing locally responsive Programs in each area. Furthermore, the household targeting approach being developed by DOH for its other health programs can be a vehicle for maximizing family planning support to informed choice of couples.

3. **Establish and operate a system of central policy development committees upon which a consultative and participatory decision-making process can grow to guide the Program.**

   At the central level of DOH, a system of advisory committees would be established. These committees would become fora for policy discussions, conflict resolution, problem raising, problem solving and strategy formulation. The members of these committees would come from participating agencies. The main integrating committee is the Program Steering Committee. Other committees that would be organized are on: clinical standards, training policy, IECM policy, logistics coordination, research policy, area coordination and participating agency accreditation, monitoring review and advocacy coordination.

   These committees will generate recommendations to be adopted and issued by the DOH Secretary as Program guidelines.

4. **Apply a service approach that assures access by clients to full information and an adequate range of medically and legally approved family planning methods.**

   The Program methods currently include pills, IUDs, condoms, voluntary surgical contraception, and natural family planning. The strategy calls for making all these methods available within every municipality or city within the first two years of the Program. An effective referral system shall be developed among service outlets but multi-method outlets will also be encouraged to support the free choice of clients.

   Informed choice shall be used as the framework for developing informational materials to support decisions to be sexually active or not, to have children or not if one is sexually active, and what methods are appropriate if one decides to space or limit pregnancies.

   The Program will consider other methods within the bounds of law and regula-

tions. The existing drugs and devices regulatory system will be the basis for studying, testing, documenting and reviewing new proposed methods for introduction.

5. **Adopt client stratification and prioritization to maximize health and socio-economic benefits of family planning.**

While wider availability is a Program goal, there is also the need to specifically assure service availability to the priority clientele made up of: women in the high risk group who want or need to space or limit their pregnancy, or women with an unmet need for family planning in the lower income groups or less educated groups or in the rural areas or agricultural occupations. Of particular concern from a health standpoint are women of reproductive age suffering from malnutrition, anemia or any of the endemic diseases.

As the identification of these priority clients is normally facilitated by their use of related health services like maternal care, child care, nutrition services, or diagnosis and treatment of endemic diseases (TB, malaria, typhoid, schistosomiasis), the provision of family planning services in tandem with these services is an obvious strategy.

6. **Utilize urban and rural operational approaches to client identification, motivation and servicing.**

Since urban and rural populations have different material conditions, cultural orientations, and ways of accessing family planning services, the Program needs to adopt distinct operational approaches.

The leadership of local governments will be sought by the Program in order to maximize local participation. Integration of family planning with other development interventions like education, livelihood, agriculture, agrarian reform and forest protection will be tested prior to wider implementation.

An outreach network to be operated by local governments will be re-established to support clinic services. The network will organize and maintain community-based workers who will motivate, refer, and re-supply users of pills and condoms.

7. **Improve field level coordination and monitoring.**

At every level of Program operation, several agencies would be serving a common population. In order to maximize benefits and utilize scarce resources properly, field level coordination by DOH would be improved. NGOs and other private sector providers would be encouraged to focus on defined clientele or activities so that DOH can adjust its services accordingly. The key mechanisms for improving coordination are good planning, adequate exchange of information and clear focal points for decision-making affecting all participants. These would be provided through the strengthening of DOH management and coordination capability.

The reporting of family planning information is included in the health informa-

tion system currently being installed by DOH. As soon as new Program activities are established widely enough, the family planning information subsystem would be revised to meet Program needs. In addition to the regular reporting system, regular field supervision will generate qualitative and process-type information for use in Program evaluation. The regular surveys will also be continued to provide a continuing insight on Program problems and progress. A system for tracking financial expenditures and relating these to Program outputs will be developed and installed. Beneficiary feedbacks would be made a regular feature of field monitoring. Quarterly consultative workshops would be held to share field level insights and concerns.

8. **Maximize current project investments as well as prior investments in the Program.**

Considerable resources are currently expended on limited projects whose outputs can be utilized more widely. Many projects supported by various donors are able to generate valuable outputs such as scratch training manuals, IEC materials, technical guidelines, and operations manuals. A lot of these materials are useful not only to the projects but also to the whole Program. The DOH central system of committees will be utilized as the mechanism for maximizing the use of "software" developed elsewhere in the Program.

This approach shall also be applied to resources generated by prior investments including previously trained personnel, built-up facilities, program-related software, and the like. These will also be utilized as far as practicable by the Program.

9. **Develop and test a commercial sector mobilization strategy.**

The current contribution to family planning practice by the private fee-for-service sector is very small. Yet in health, three-quarters of total national expenditures is being absorbed by this sector. Thus, there are possibilities that the commercial sector could be mobilized for an increased share in service provision. Using social marketing methods, a strategy for encouraging private physicians, private midwives and private hospitals to provide family planning services especially to the nonpoor, would be developed, tested and, if feasible, implemented.

10. **Reorient IECM and Training to incorporate health benefits of family planning.**

IECM and training materials previously developed will be reviewed in the light of the new Program directions. In particular, a stronger health orientation will be incorporated in the materials to be developed.

Skills training will be emphasized so that safety and quality of services are assured through well-trained clinic personnel.

Greater availability and higher level of utilization of IECM and training materials at the outlet level will be key monitoring concerns. While production and dissemination will obviously be emphasized, actual availability and use by field workers and clients would be even more important.

The Program will develop and articulate "message policies," i.e., specify what the Program wants to say to service providers and clients. These messages will be consistently reflected in training, service delivery, IEC and motivation activities. A key strategy is to develop a coherent set of messages applicable over the reproductive life of mothers that is embodied in the whole service and information delivery system of the Program.

11. **Promote breastfeeding.**

The Program, in collaboration with the DOH's maternal care and diarrheal disease control programs, will promote breastfeeding as a family planning practice. Although it will not be reported as a program method, exclusive breastfeeding practice of maximum duration will be incorporated in training and IEC materials.

12. **Encourage a research component linked closely to operational management at central and local levels.**

A research component of the Program is the obvious necessity given to the need to base policy decisions on factual grounds. In addition to mechanisms assuring the soundness of research outputs, another key strategy is to closely link research organizations with Program management at the central and local levels. A network of regional research institutes will be organized to provide research support to the Program. Resources for research will be allocated in a decentralized manner so that local issues can be given more importance. But a central research policy will assure national direction to decentralized research activities.

13. **Utilize central DOH support units for Program needs.**

DOH is establishing a Program secretariat at the Office of the Chief of Staff. This will support the national committees and will manage the day-to-day staff concerns of the Program. Each operating component of the Program, however, would have built-in line management provisions. The DOH implemention would be managed by a regional officer, a provincial officer, a district officer and a municipal officer. The NGO implementation would be managed by each participating NGO.

The IEC component of the Program would be supported by the Public Information and Health Education Service of DOH; the logistics component by the Procurement and Logistics Service; the information component by the Management Advisory Service and the Health Intelligence Service; the training component by the Health Manpower Development and Training Service; and the technical matters by the Family Planning Service.

14. **Pursue strategies to maximize coverage and quality.**

As the previously described strategies indicate, the Program is pursuing a range of options to maximize coverage with quality. These options include (a) increasing the number of outlets; (b) increasing the average number of clients served per outlet per month; (c) reducing the dropout rate of continuing users due to service or method

dissatisfaction; (d) responding to client demand for method effectiveness; (e) expanding private sector contribution; (f) expanding participation of organized groups in service delivery, motivation and advocacy; and (g) expanding the range of method choices.

Successful application of these strategies would be monitored via indicators such as: level of unmet need, outlet to MCRA population ratio, contraceptive prevalence rate, dropout rate, and use-effectiveness rate.

4.3 Funding Requirements and Component Projects

The Program consists of elements that can be developed into project in terms of implementing organization, functional contribution, or annual requirements.

In terms of implementing agencies, the DOH accounts for the single largest component in terms of funding requirements (41 percent). NGOs as a group account for 38 percent. Other government organizations will absorb 12 percent with local governments utilizing 8 percent.

In terms of functional contribution, service delivery (51 percent) and logistics (17 percent) together account for 68 percent of Program resources, as is appropriate for a service delivery program. IECM uses 10 percent and outreach would need 9 percent. Training (9 percent) and research (4 percent) complete the functional components.

In terms of annual requirements, the first two years would require 39 percent, the third year 19 percent, the fourth 24 percent and the last 18 percent.

As of 1990, about 63 percent of total Program requirement has already been funded.

Tables 2 to 5 provide more details.

4.4 Program Outcomes

The desired outcomes of the Program at the household level is the satisfaction of the demand for family planning leading to fertility, health and other desirable socio-economic consequences. On an aggregate level, the health and other socioeconomic consequences of wider family planning practice and reduced fertility could not be easily projected. So in this plan, only contraceptive prevalence and fertility outcomes are described quantitatively.

Based on the expected direction of Program thrusts and the past behavior of clients, the following scenarios in terms of program outcomes are expected:

- as the first two years would involve mainly capacity development of participating agencies, there are no changes expected in fertility.
- as the investments in 1990-1991 gain ground, Program clients would adopt more effective methods initially or shift to more effective methods over time as well as adopt any given method longer.

Thus, the utilization of Program services by clients who want or need to space or limit their pregnancies would have the corresponding outcomes as shown in Table 6.

TABLE 2
FUNDING REQUIREMENT OF
THE FAMILY PLANNING PROGRAM
BY IMPLEMENTING AGENCY
1990-1994
(In Million Pesos)

IMPLEMENTING AGENCY	FUNDING REQUIREMENT	FUNDED		UNFUNDED
		EXTERNAL SOURCES	INTERNAL SOURCES	
DOH	2,165 (100.0)	924 (42.7)	1,205 (55.6)	36 (1.7)
Other GOs	640 (100.0)	164 (25.6)	280 (43.8)	196 (30.6)
LGU	436 (100.0)	4 (0.9)	154 (35.3)	278 (63.8)
NGO	2,024 (100.0)	481 (23.8)	105 (5.2)	1,438 (71.0)
TOTAL	5,265 (100.0)	1,573 (29.9)	1,744 (33.1)	1,948 (37.0)

TABLE 3
FUNDING REQUIREMENT OF
THE FAMILY PLANNING PROGRAM
BY FUNCTIONAL COMPONENT
1990-1994
(In Million Pesos)

FUNCTIONAL COMPONENT	PER-CENT	FUNDING REQUIREMENT	FUNDED		UNFUNDED
			EXTERNAL SOURCES	INTERNAL SOURCES	
Service Delivery	51.0	2,684 (100.0)	420 (15.6)	1,120 (41.1)	1,162 (43.3)
IECM	10.1	532 (100.0)	178 (33.5)	32 (6.0)	322 (60.5)
Training	8.6	452 (100.0)	238 (52.7)	119 (26.3)	95 (21.0)
Research	3.9	207 (100.0)	150 (72.5)	6 (2.9)	51 (24.6)
Management/ Logistics	17.3	910 (100.0)	560 (61.5)	320 (35.2)	30 (3.3)
Outreach	9.1	480 (100.0)	27 (5.6)	165 (34.4)	288 (60.0)
TOTAL	100.0	5,265 (100.0)	1,573 (29.9)	1,744 (33.1)	1,948 (37.0)

TABLE 4
ANNUAL FUNDING REQUIREMENT OF
THE FAMILY PLANNING PROGRAM
BY IMPLEMENTING AGENCY
1990-1994
(In Million Pesos)

AGENCY	YEAR					1990-1994
	1990	1991	1992	1993	1994	
DOH	519	321	321	672	331	2,164
Other GOs	112	169	125	116	119	641
LGUs	50	98	92	96	99	435
NGOs	376	406	461	382	400	2,025
TOTAL	1,057 (20.0)	994 (19.0)	999 (19.0)	1,266 (24.0)	949 (18.0)	5,265 (100.0)

TABLE 5
ANNUAL FUNDING REQUIREMENT OF
THE FAMILY PLANNING PROGRAM
BY FUNCTIONAL COMPONENT
1990-1994
(In Million Pesos)

FUNCTIONAL CATEGORY	YEAR					TOTAL
	1990	1991	1992	1993	1994	
I. LOGISTICS						
a) Vehicle	9.8	1.4	0.2	0.2	0.3	11.9
b) Equipment	17.2	23.3	27.6	26.5	23.7	118.3
c) Personnel	7.5	8.1	1.6	2.1	1.9	21.2
d) Building operations and maintenance	4.5	5.2	6.2	7.2	8.5	31.6
e) Distribution	116.0	11.8	14.2	151.3	17.2	310.5
f) Supplies	76.4	11.8	12.6	201.4	1.3	303.4
TOTAL	231.4	61.6	62.4	388.7	52.9	797.0
II. IEC						
a) ICS	17.7	19.3	24.3	24.3	21.2	106.7
b) Prints	5.4	8.1	9.0	8.7	10.6	41.8
c) Posters/Calendars	7.1	1.7	5.7	2.0	0.9	17.4
d) Broadcast	4.6	2.4	2.4	2.6	2.7	14.7
e) AV	12.5	8.9	6.6	7.1	7.9	43.0
f) Support Activities	12.7	11.0	9.4	5.6	6.2	44.9
g) Multi-media/unspecified medium	85.2	40.6	53.5	40.7	42.4	262.4
TOTAL	145.1	92.0	110.9	91.0	91.8	530.9
III. RESEARCH						
a) Contraceptive research	8.3	8.4	5.2	5.3	0.5	27.6
b) Operations research	46.4	9.7	8.1	4.8	3.3	72.3
c) Surveys/Census	1.6	66.8	6.8	4.4	8.6	88.3
d) Management	0.5	0.9	0.6	0.3	0.3	2.6
e) Policy	2.2	3.8	3.7	3.7	3.0	16.4
TOTAL	59.1	89.6	24.3	18.6	15.8	207.4

cont'n (Table 5)

FUNCTIONAL CATEGORY	YEAR					TOTAL
	1990	1991	1992	1993	1994	
IV. TRAINING						
a) Basics	25.2	40.2	34.8	32.8	26.8	159.8
b) Refresher	11.9	16.8	14.1	9.7	8.2	60.7
c) IECM	21.9	21.6	22.4	19.4	22.1	107.4
d) Specialized skills	9.6	12.9	17.1	15.2	12.3	67.0
e) Management	23.7	5.7	5.3	6.0	4.6	45.3
f) Development of training materials	2.6	1.9	3.2	1.6	2.3	11.6
TOTAL	95.0	99.2	96.8	84.6	76.3	451.9
V. MANAGEMENT						
a) Monitoring	6.9	7.7	9.6	8.1	5.5	37.8
b) MIS	1.1	5.6	1.6	3.2	2.8	14.3
c) Evaluation	1.7	3.0	3.8	2.5	5.7	16.7
d) Coordination/Consultation	7.2	8.1	8.4	8.8	3.8	36.3
e) Technical Assistance	3.0	1.9	1.9	1.8	0.1	8.7
TOTAL	19.9	26.4	25.3	24.4	17.8	113.8
VI. SERVICE DELIVERY						
a) Clinic Operations	266.6	336.9	401.8	410.0	454.2	1,869.0
b) Integration of FP SD in other programs	43.7	72.4	58.7	70.4	80.7	325.9
c) Clinic support services	22.4	29.5	36.1	34.6	17.0	139.6
d) Innovative approaches	117.7	81.8	81.6	36.2	32.0	349.3
TOTAL	450.5	520.6	578.2	550.8	583.8	2,683.9
VII. OUTREACH						
a) Personnel	10.0	29.5	26.2	29.8	32.7	128.2
b) Subcontracts	25.7	25.2	25.2	25.2	25.2	126.6
c) Institutionalization	19.9	33.0	33.5	35.3	35.7	157.4
d) Travel	-	16.5	16.8	17.1	17.4	67.8
TOTAL	55.5	104.4	101.7	107.4	111.1	480.1
GRAND TOTAL	1,056.6	993.7	999.5	1,265.6	949.5	5,264.9

TABLE 6
FAMILY PLANNING INDICATORS, 1990-194

INDICATORS	1988*	OUTCOMES 1989	1990	1991	1992	1993	1994
1. TFR	3.95	3.95	3.95	3.95	3.86	3.59	3.38
2. CPR	36.2	35.9	35.6	36.9	42.0	46.2	53.4
3. Number of acceptors by method							
a) Vasectomy	-	5,600	5,900	7,400	11,700	13,300	14,400
b) BTL	-	69,600	71,800	100,000	185,100	236,600	286,200
c) Pills	-	308,700	321,200	351,600	436,400	528,900	609,900
d) IUD	-	69,400	73,400	84,000	112,100	135,200	154,700
e) Rhythm	-	336,500	332,200	343,600	402,500	486,300	579,100
f) NFP	-	47,700	66,200	88,900	126,200	153,700	159,800
g) Condom	-	43,500	46,700	52,000	64,400	78,000	88,500
h) Others (non-program methods)	-	251,700	222,600	201,300	201,300	235,200	306,400
ALL METHODS	-	1,132,700	1,140,000	1,228,600	1,539,700	1,867,200	2,199,000
4. Total No. of Users by Methods							
a) Vasectomy	28,900	32,400	36,100	39,800	46,000	57,600	65,600
b) BTL	882,300	911,000	940,500	970,800	1,054,000	1,248,600	1,420,600
c) Pills	572,800	596,700	621,400	646,800	707,900	845,200	961,600
d) IUD	193,800	206,400	219,300	232,700	259,400	315,000	358,400
e) Rhythm	642,200	635,600	628,600	621,100	644,900	730,200	830,500
f) NFP	-	30,700	62,500	95,500	136,600	199,800	227,300
g) Condom	57,900	62,500	67,300	72,300	81,400	99,900	113,600
h) Others (non-program methods)	514,900	472,900	429,100	353,300	353,300	345,800	393,400
ALL METHODS	2,892,800	2,948,200	3,004,800	3,062,400	3,283,500	3,841,900	4,371,600
5. Women 15-44	13,568,000	13,950,600	14,344,000	14,733,300	15,133,100	15,543,700	15,965,700
6. MWRA 15-44	7,991,600	8,216,900	8,448,600	8,664,900	8,898,100	9,137,400	9,403,700
% Currently Married	58.9	58.9	58.9	58.9	58.9	58.9	58.9

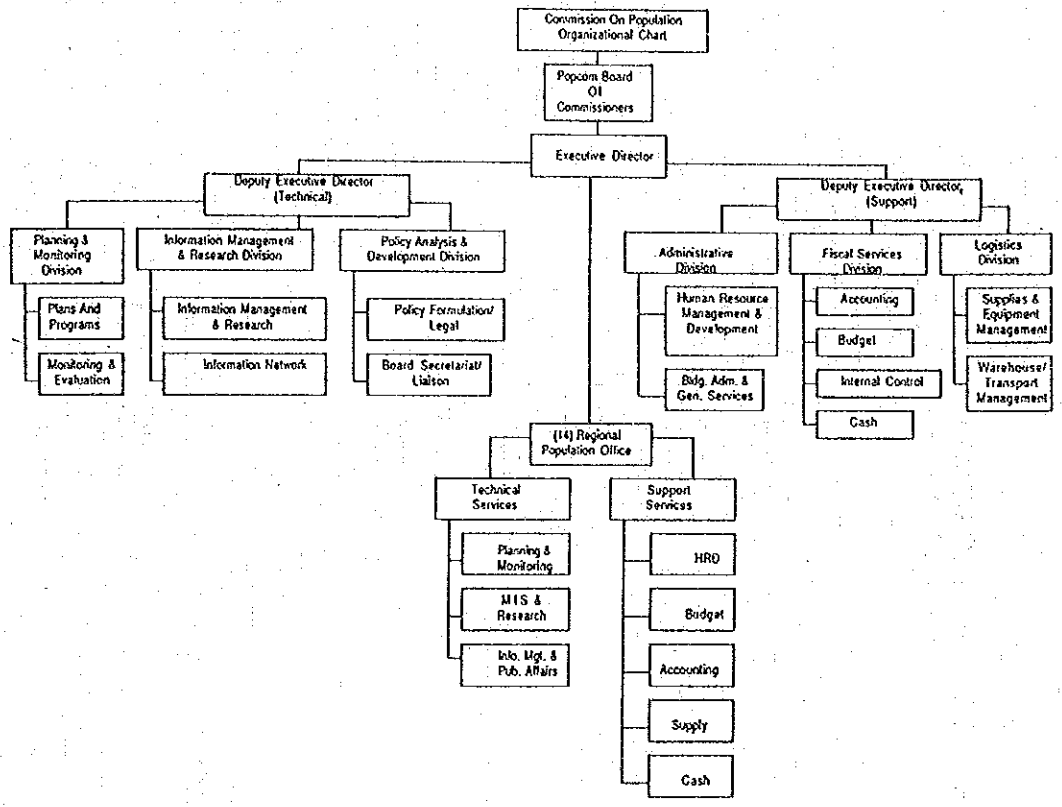
cont'n. (Table 6)

INDICATORS	1988*	OUTCOMES					
		1989	1990	1991	1992	1993	1994
7. Method Mix							
a) Vasectomy	1.0	1.1	1.2	1.3	1.4	1.5	1.5
b) BTL	30.5	30.9	31.3	31.7	32.1	32.5	32.5
c) IUD	6.7	7.0	7.3	7.6	7.9	8.2	8.2
d) Pills	19.8	20.2	20.7	21.1	21.6	22.0	22.0
e) Rhythm	22.2	21.6	20.9	20.3	19.6	19.0	19.0
f) NFP	0.0	1.0	2.1	3.1	4.2	5.2	5.2
g) Condom	2.0	2.1	2.2	2.4	2.5	2.6	2.6
h) Others	17.8	16.0	14.3	12.5	10.8	9.0	9.0
8. Contraceptive Effectiveness							
a) Vasectomy		1.00	1.00	1.00	1.00	1.00	1.00
b) BTL		1.00	1.00	1.00	1.00	1.00	1.00
c) IUD		0.96	0.96	0.96	0.96	0.96	0.96
d) Pills		0.83	0.83	0.83	0.83	0.83	0.83
e) Rhythm		0.63	0.63	0.63	0.63	0.63	0.63
f) NFP		0.70	0.70	0.70	0.70	0.70	0.70
g) Condom		0.42	0.42	0.42	0.42	0.42	0.42
h) Others		0.50	0.50	0.50	0.50	0.50	0.50

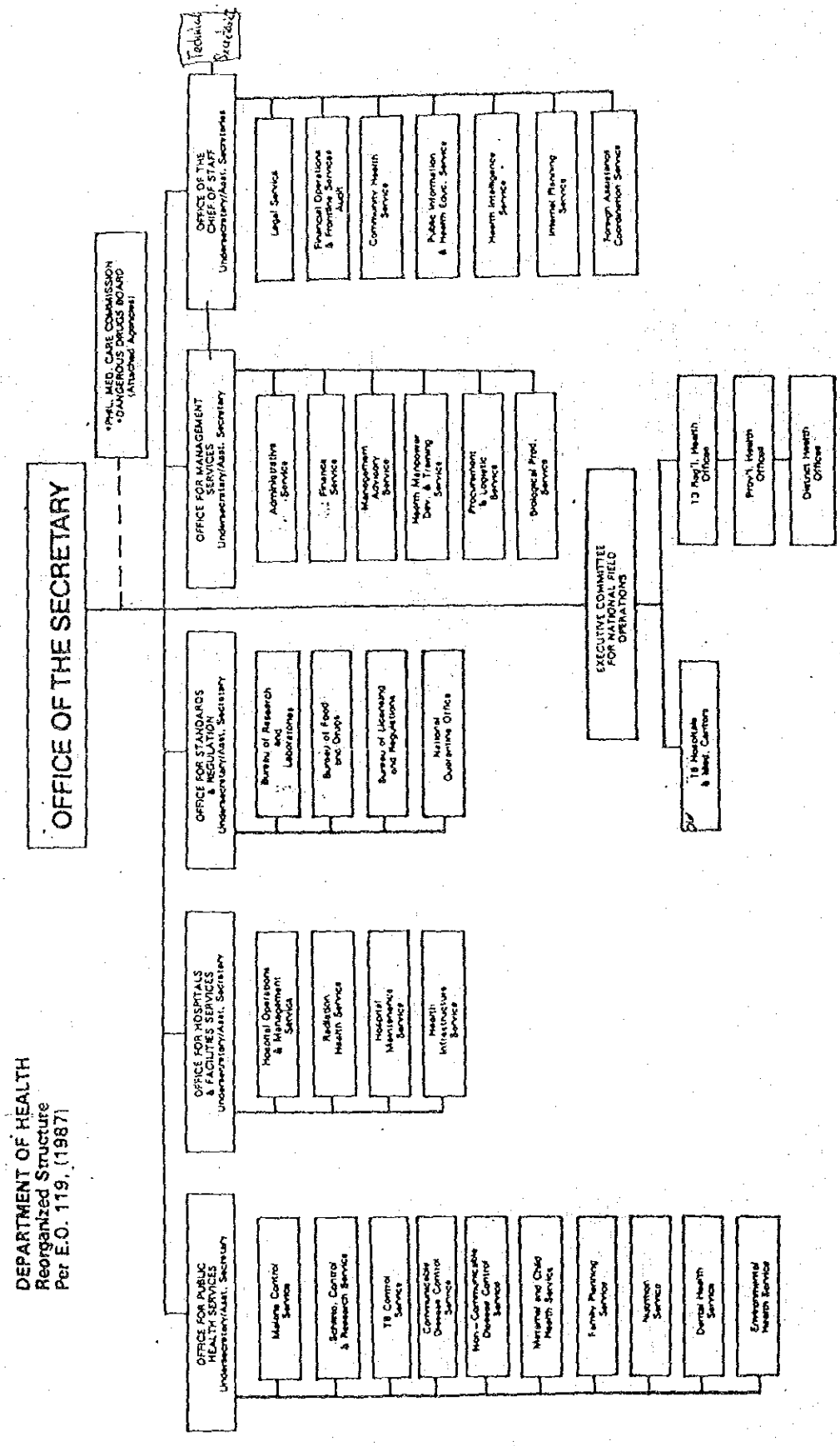
* Estimated based on the 1988 National Demographic Survey.

3）人口委員会の組織図

POPCOM ORGANIZATIONAL CHART



4) 保健省の組織図


DEPARTMENT OF HEALTH
Reorganized Structure
Per E.O. 119, (1987)
OFFICE OF THE SECRETARY
*PHIL. MED. CARE COMMISSION
*DANGEROUS DRUGS BOARD
(Attached Agencies)
OFFICE OF THE CHIEF OF STAFF
Undersecretary/Asst. Secretaries
Legal Service
Financial Operations & Frontline Service Asst.
Community Health Service
Public Information & Health Educ. Service
Health Intelligence Service
Internal Planning Service
Foreign Assistance Coordination Service
OFFICE FOR MANAGEMENT SERVICES
Undersecretary/Asst. Secretary
Administrative Service
Finance Service
Management Advisory Service
Health Manpower Dev. & Training Service
Procurement & Logistic Service
Biological Prod. Service
OFFICE FOR STANDARDS & REGULATION
Undersecretary/Asst. Secretary
Bureau of Research and Laboratories
Bureau of Food and Drugs
Bureau of Licensing and Regulations
National Quarantine Office
OFFICE FOR HOSPITALS & FACILITIES SERVICES
Undersecretary/Asst. Secretary
Hospital Operations & Management Service
Radiation Health Service
Hospital Maintenance Service
Health Infrastructure Service
OFFICE FOR PUBLIC HEALTH SERVICES
Undersecretary/Asst. Secretary
Malaria Control Service
Schisto. Control & Research Service
TB Control Service
Communicable Disease Control Service
Non-Communicable Disease Control Service
Maternal and Child Health Service
Family Planning Service
Nutrition Service
Dental Health Service
Environmental Health Service
EXECUTIVE COMMITTEE FOR NATIONAL FIELD OPERATIONS
13 Reg'l. Health Offices
Prov'l. Health Offices
District Health Offices
18 Hospitals & Med. Centers

5）タラック州の保健医療の概要

HEALTH PROFILE
TARLAC

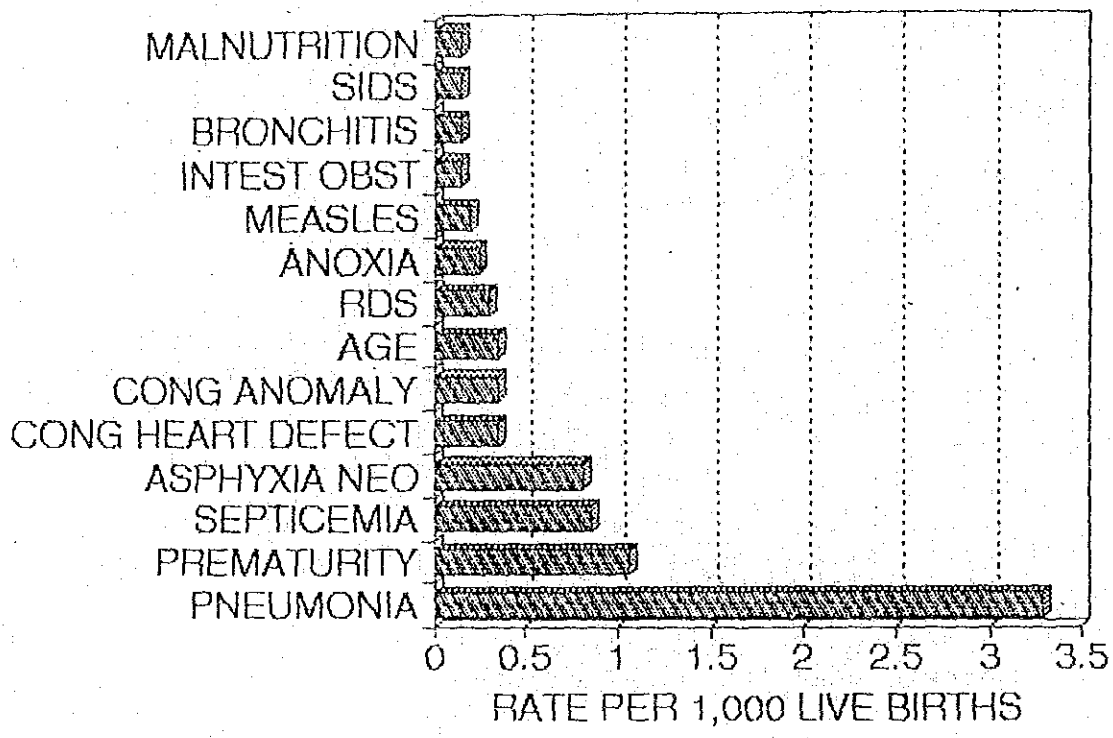
Health and Medical Care in Tarlac is being delivered by a network of hospitals, rural health units, barangay health centers, voluntary units and workers, non-governmental agencies, equitably distributed throughout the province.

Integration of health and medical services and the incorporation of primary health care, attributed mainly the betterment of health care delivery in Tarlac. This system with the active participation of supporting entities have realized the following:

1. Holistic approach in health care delivery.
2. Realistic and comprehensive planning and implementation of health programs /projects.
3. Maximum utilization of available manpower. Rotation of medical and public health personnel in hospitals and community assignments, has considerably improved the capabilities and performance of health workers.
4. Effective utilization and sharing of resources between hospitals and field units.
5. Strengthening and a more functional 2 way referral system and continuity of health care.
6. Improved quality and effectiveness of health care deliv ery.
7. Availability and increased coverage of ehalth services.
8. Increased utilization of health facilities, leading to efficiency and effectiveness.
9. Flexibility in shifting resources.
10. Unity of command, clarification of authority, responsibility and accountability.
11. Supervision by hospital pharmacists on botica sa barangay operations, botica aides and herbal medicines.
12. Involvement and commitment of the hospital in the institution of primary health care.
13. Systematic rescue, relief and rehabilitation procedures in disasters.
14. Integrated services given to people at the permanent resettlement areas.

INFANT MORTALITY

10 LEADING CAUSES (1991)



HEALTH FACILITIES
1991

1. HOSPITALS	NUMBER	BED CAPACITY
A. Government		
Provincial	1	200
District	2	50
Medicare	1	15
Army Station	1	100
B. Private		
Primary	10	112
Secondary	2	45
Tertiary	3	20
2. RURAL HEALTH UNITS	30	
Brgy. Health Stations	146	
3. SOCIAL HYGIENE CLINIC	1	
4. CHEST CENTER	1	
5. MALARIA CONTROL UNIT	1	
6. SENTINEL SURVEILLANCE UNIT	1	

MANPOWER

OFFICE OF THE PROVINCIAL HEALTH OFFICER AND TECHNICAL SERVICE :

CATEGORY :	NUMBER
Physicians	4
Dentist	1
Sanitary Engineer	1
Nurses	5
Nutritionists	4
Health Educator	1
Food & Drug Inspector	1
Midwife Supervisor	1
Statistician	1
Sanitarians	4
Leprosy Nursing Aides	2
Medical Equipment Technician	1
ADMINISTRATIVE STAFF	
Administrative Officer	2
Clerks	5
Drivers	3
SOCIAL HYGIENE CLINIC	
Physician	1
Nurse	1
Medical Technician	1

MALARIA CONTROL SERVICE

Technician	3
Utility Workers (Field Tech.)	4
Drivers	2
Security Guard	1

MARIA CLARA CHEST CENTER

Physicians	2
Nurse	1.
Medical Technologists	2
Radiation Technician	2
Administrative Personnel	8
Driver	1

FIELD HEALTH SERVICES

Physicians	30
Dentists	16
Nurses	46
Medical Technologists	16
Midwives	179
Sanitary Inspectors	50
Dental Aides	17
Driver	1
Others	14

SENTINEL SURVEILLANCE UNIT

Nurse	1
Clerk	1

HOSPITAL SERVICES

	TARLAC PROV. HOSP.	CAMILING DISTRICT HOSP.	CONCEPCIOM DISTRICT HOSP.	LAPAZ MEDIC. HOSP.	TOTAL
Physicians	45	5	5	2	57
Dentist	1		1		2
Nurses	71	7	8	3	89
Dietitians	3	1	1		5
Med. Social Workers	2	1	1		4
Med. Radiation Tech.	3	1	1		5
Pharmacists	3	1	1		5
Med. Tech. & Techn.	3	2	1	1	7
Midwife	1				1
Adm. & Financial personnel	78	25	26	9	138

DEMOGRAPHIC CHARACTERISTICS

POPULATION BY DISTRICT AND RURAL HEALTH UNITS

CAMILING DISTRICT		125,893
Camiling I	34,521	
Camiling 2	29,550	
Mayantoc	21,627	
San Clemente	9,067	
Sta. Ignacia	31,128	
CONCEPCION DISTRICT		204,313
Bamban	36,410	
Capas 1	40,518	
Capas 2	22.009	
Concepcion 1	53,201	
Concepcion 2	24,344	
Concepcion 3	27,831	
TARLAC CATCHMENT		548,018
Anao	8,177	
Gerona I	31,284	
Gerona 2	29,486	
La Paz I	24,934	
La Paz 2	17,917	
Moncada I	25,634	
Moncada 2	16,938	
Paniqui 1	54,280	
Paniqui 2	12,072	
Pura	18,419	
Ramos	13,859	
San Jose	20,925	
San Manuel	17,634	
Tarlac I	56,745	
Tarlac 2	61,063	
Tarlac 3	65,080	
Tarlac 4	30,345	
Victoria 1	56,513	
Victoria 2	16,762	
PROVINCIAL TOTAL		878,221

NUMBER OF BARANGAYS PER MUNICPALITY & LAND AREA

Municpalities	No. of Brgys.	Land Area (sq.km.)
Anao	18	23.9
Bamban	15	133.1
Camiling	61	140.5
Capas	19	440.0
Concepcion	45	245.7
Gerona	44	141.4
La Paz	21	114.3
Mayantoc	24	354.6
Moncada	37	85.7
Paniqui	35	105.2
Pura	16	31.0
Ramos	9	24.4
San Clemente	12	48.6
San Jose	13	324.91
San Manuel	15	42.1
Sta. Ignacia	24	75.4
Tarlac	75	611.19
Victoria	26	111.5
T O T A L	509	3053.4

MORTALITY, LEADING CAUSES, NUMBER & RATE/100,000 POPULATION
TARLAC PROVINCE
1991

CAUSES	NUMBER	RATE
1. Vascular Disease	603	68.6
2. Pneumonia	449	51.1
3. TB, Pulmonary	256	29.1
4. Cancer	189	21.5
5. Other Heart Diseases	175	19.9
6. Hypertensive Diseases	139	15.8
7. Accident	72	8.1
8. Kidney Disease	60	6.8
9. Diarrheal Disease	45	5.1
10. Septicemia	37	4.2
11. General Arteriosclerosis	29	3.3
12. TB, Other Forms	25	2.8
13. Prematurity	21	2.3
14. Bleeding Peptic Ulcer	19	2.1
15. Chronic Obstructive Pulm. Disease	13	1.4

MORBIDITY, LEADING CAUSES,NUMBER & RATE 100,000 POPULATION
TARLAC PROVINCE
1991

C A U S E S	NUMBER	RATE
1. Acute Respiratory Infections	141,339	16,093.7
2. Gastrointestinal Disorders	57,071	6,498.4
3. Nutritional/Vit. Def.	27,578	3,140.2
4. Anemia	25,062	2,853.7
5. Parasitism	22,526	2,564.9
6. Skin Problem	19,109	2,175.8
7. Influenza	16,102	1,833.4
8. Bronchitis	14,883	1,694.6
9. Injuries	6,223	708.5
10. Musculo Intestinal Disorders	5,645	642.7

NATALITY BY PLACE AND ATTENDANCE AT BIRTH

TOTAL BIRTHS :	19,700	
PLACE BY BIRTH :		
Home	15,445	78.4%
Government Hosp.	3,073	15.6%
Private Hosp.	1,044	5.3%
Others	138	.7%
ATTENDANCE AT BIRTH :		
M. D.	4,117	20.9%
Nurse	414	2.1%
Midwife	11,130	56.5%
Trained Hilot	3,605	18.3%
Untrained Hilot	315	1.6%
Others	119	.6%

BIRTHS, TOTAL DEATHS, INFANT DEATHS, PERINATAL DEATHS & MATERNAL DEATHS

	NUMBER	RATE
BIRTHS	19,709	22.43
TOTAL DEATHS	3,055	3.47
INFANT DEATHS	193	9.7
PERINATAL DEATH :		
Early Neonatal Death	91	4.6
Late Fetal Death	102	5.1
MATERNAL DEATHS	6	.3

INFANT MORTALITY, LEADING CAUSES, NUMBER & RATE PER 1000 LIVEBIRTHS
TARLAC PROVINCE
1991

	CAUSES	NUMBER	RATE
1.	Pneumonia	65	3.29
2.	Prematurity	21	1.06
3.	Septicemia	17	.86
4.	Asphyxia Neonatorum	16	.81
5.	Congenital Heart Defect	7	.35
	Congenital Anomaly	7	.35
	Gastroenteritis	7	.35
6.	Respiratory Distress Syndrome	6	.30
7.	Anoxia	5	.25
8.	Measles	4	.20
9.	Intestinal Obstruction	3	.15
	Bronchitis	3	.15
	Malnutrition	3	.15
	Sudden Infant Death Syndrome	3	.15
10.	Infantile beriberi	2	.10
	Meningitis	2	.10
	COPD	2	.10
	Encephalitis	2	.10
		175	8.82

$175 \times \frac{1000}{8.82} = 19841.26$

LEADING CAUSES OF MATERNAL DEATHS, NUMBER & RATE /1000 LIVEBIRTHS
TARLAC PROVINCE
1991

CAUSES	NUMBER	RATE
1. Uterine Atony	2	.10
2. Eclampsia	2	.10
3. Abruptio Placenta	1	.05
4. Postpartum hemorrhage	1	.05

ANNUAL ACCOMPLISHMENT REPORT
1991

EXPANDED PROGRAM ON IMMUNIZATION:

	Target	Accomp.	% Accomp.
a. DPT 3	25,256	24,276	96.12
b. OPV 3	25,256	24,736	97.94
c. Measles	25,256	24,609	97.45
d. B C G :			
- infants	25,256	28,423	112.54
- school entrants	25,256	20,258	80.21
e. Fully Immunized Children	25,256	24,211	95.86
f. Tetanus Toxoid for Pregnant Women	23,568	18,330	77.77

TB CONTROL PROGRAM

Casefinding		21,668	26,817	123.76
Sputum Positive		1,808	1,531	84.68
Sputum Follow-up		5,424	2,355	43.32
Positivity Rate/ Patients Treated			2,339	5.7

MALARIA CONTROL PROGRAM

House Spraying :				
Apr.-June	One Cycle	936	934	99.7
Apr.-June	Two Cycle Ist Cycle	1,595	1,530	95.9
July	Focal	149	160	107.0
Oct.- Nov.	Two Cycle 2nd Cycle	1,595	1,539	96.4
Casefinding		4,563	8.124	178.
Treatment				
Presumtive		4,563	7,825	171.4
Radical		149	149	100
No. of P. Falciparum		43		
No. of P. Vivax		106		

FAMILY PLANNING

New Acceptors	10,345	11,422	112.41
Pills		7,895	
I U D		472	
Condom		1,692	
N F P		309	
Rhythm Calendar		503	
B T L		551	
Vasectomy		0	
Current Users	25,862	24,694	95.48
Pills		15,073	
I U D		931	
Condom		2,469	
N F P		190	
Rhythm /Calendar		387	
B T L		5,643	
Vasectomy		1	

ENVIRONMENTAL HEALTH SERVICE PROGRAM

1. Water Quality Surveillance			
a. Inspection of water supply sources	89,138	38,021	42.65
b. Sampling of water supply sources	10,979	8,272	75.34
- No. found positive		4,398	53.16
- No. found negative		3,874	46.83
c. Disinfection of water supply sources	43,458	17,063	39.26
d. Household container disinfection	14,651	3,924	26.78
e. Construction of water supply sources		577	
2. Toilet Construction			
a. Construction of san. toilets	2,956	2,133	72.15
b. Improvement of unsan. toilets	638	450	70.53
c. Inspection of san. toilets	89,473	30,234	33.79
d. Inspection of unsan. toilets	15,770	11,270	77.80

e. Inspection of household w/o toilet for const,n	16,469	10,811	65.64
3. Food Sanitation			
a. Inspection of food estab.	10,927	9,923	90.81
b. Issuance of san. permits	3,524	2,675	75.90
c. Issuance of san. orders	309	351	113.59
d. Sanitary orders complied	309	151	43.01
e. Issuance of health certificates	5,109	4,441	86.92
f. Training of food operators/food handlers	872	65	7.45
g. Deworming of cooks and helpers	586	269	45.90
CONTROL OF DIARRHEAL DISEASES			
Identification of diarrheal cases	34,176	35,685	104.41
Provision of ORS to diarrheal cases	34,176	35,545	104
MULTI-DRUG THERAPY- LEPROSY CONTROL			
1. Casefinding	169	113	66.86
2. Treatment			
a. DOS Montherapy		0	
b. Modified MDT		1	
c. M D T			
- P B		24	
- M B		79	
NUTRITION PROGRAM			
T F A P			
Pregnant	2,387	2,250	94.5
Lactating	2,273	2,466	108.4
Preschoolers	8,311	8,499	130
Vitamin A Def.			
Preschoolers	29,521	19,135	66
Lactating	12,627	6,637	52.6
Iron Deficiency			
Preschoolers	66,084	22,128	33.5
Pregnant	13,259	6,808	51.3
Lactating	2,272	3,599	158.4

Iodine Deficiency			
School children	2,627	2,193	83.5
Women	2,182	674	31

Operation Timbang			
No. of children Under 7		168,321	
No. of children weighed		158,231	
% Coverage		94 %	
Weight Status of Children Weighed			
Severely Underweight		4,664	- 2.95 %
Moderately Underweight		21,997	- 13.90%
Mildly Underweight		68,241	- 43.12%
Normal		53,961	- 34.10%
Overweight		9,368	- 5.92%

FOOD AND DRUG

Food and Food Products, Processing and Manufacturing Inspection :

No. of Establishment	73
Target	146
No. Inspected	135
% Accomplished	92.47

Drug Establishments Inspection :

No. of Establishment	74
Target	370
No. Inspected	346
% Accomplished	93.5

Samples forwarded to Bureau of Food and Drug and Reg. Lab.

Drug samples collected	73
Drug samples found adulterated	0

HEALTH EDUCATION

No. of Households	140,307
No. of study group organized	696
No. of participants for all	20,880
No. of Brgy. Health Workers trained	1,072
No. of Brgy. Health Workers functional	1,072
No. of family health guide distributed	15,583
Functional Mun. Primary Health Care Committee	10
Non-functional Mun. Primary	

Health CAre Committee	9	
Functional Bargy. Primary Health Care Committee	203	
Non-functional Brgy. Primary Health Care Committee	306	

MATERNAL AND CHILD CARE	TARGET	ACCOMP.	% ACCOMP.
1. Prenatal Registration	29,464	27,740	94.15
2. High Risk Detection & Management		5,297	
3. Deliveries attended	25,256	19,700	78
4. Full postpartum care	25,256	10,165	40.25
5. Under-six registration	104,852	70,194	66.95
6. Breastfeeding Advocacy	26,346	18,789	71.31
7. Treatment of Common Childhood Illnesses	147,076	128,046	87.06
SOCIAL HYGIENE			
Casefinding	2,644	2,477	93.68
Positive:			
Syphilis		2	
Gonorrhea		48	
Others		385	
Treatment	628	435	69.26
DENTAL HEALTH SERVICE			
I. Oral Examination			
Pregnant mothers	16,548	18,074	109
School children	42,123	14,603	34.6
Preschoolers	16,333	4,081	24.9
Other adults	24,643	117,883	480
2. Oral Prophylaxis			
Pregnant mothers	13,540	4,799	35.4
School children		7,500	
Preschoolers		2,614	
3. Sealants		757	
4. Flouride Mouth Rinsing	42,123	8,056	19
Permanent Filling :			
a. Pregnant mothers	5,897	594	10
b. School children	4,002	6,484	162
c. Other adults		1,770	

Gum Treatment :			
a. Pregnant mothers	5,679	1,051	18.5
b. School children		2,132	
c. Preschoolers		851	
Temporary Filling :			
a. Preschoolers	7,840	1,158	14.7
b. Other adults	4,810	3,100	64.4
c. School children		1,118	
Extraction :			
a. Preschoolers		2,579	
b. Other adults	48,104	55,690	115.7
c. School children		6,189	
5. Dental Health Education		4,835	

HEALTH INDICATORS 1991 — 1991 Pop.	SCS BHS	Linggo BHS	Magico BHS	Labuin BHS	Pinngbayanan BHS	PILA, RHU
	7,047	5,793	3,746	6,332	6,794	29,712
Crude Birth Rate (Rate/1000)	14.6	27.10	20.3	29	24	23
Crude Death Rate (Rate/1,000)	5.50	2.58	3.2	1.9	3.8	3.5
Infant Mortality Rate (Rate/1,000)	19.42	0	0	0	18.4	7.32
Maternal Mortality Rate (Rate/1,000)	0	0	0	0	0	0
% 2° & 3° Malnourished	18.6%	17%	17.35%	50.29%	12.7%	24%
Low Birth Weight Rate (Rate/1,000)	0	0	0	0	0	0
DPT Coverage	1,187	918	634	1,030	960	4,729
Pregnant Mother with anemia	95	83	60	99	96	477
Contraceptive Prevalence Rate (Rate/1,000)	47	15	70/5	36	36.2	38.28
PTB Morbidity Rate (Rate/100,000)	354.76	708	400	237	309	394
PTB Mortality Rate (Rate/100,000)	70.95	51.8	53.4	15.8	58.8	53.85
Diarrheal Disease Morbidity Rate (Rate/100,000)	156	397	320	807	603	471
Diarrheal Disease Mortality Rate (Rate/100,000)	14.19	0	0	0	0	3.36
Pneumonia Mortality Rate(Rate/100,000)	70.95	17.26	27	0	44	33.66
% of HH with Sanitary Toilet	51%	58%	79%	48%	54%	49.2%
% of HH with Potable Water Supply	33%	35%	29%	40%	30%	33.4%

HEALTH INDICATORS 1991 — 1991 Pop.	SCS BHS	Lingga BHS	Masloc BHS	Labuin BHS	Pinagbayanan BHS	PILA, RHU
	7,047	5,793	3,746	6,332	6,794	29,712
Total Births	103	157	76	184	163	683
Total Deaths	39	15	12	12	26	104
Total Infant Death	2	0	0	0	3	5
Total Live Births	103	157	76	184	163	683
Total Maternal Death	0	0	0	0	0	0
Total 1°, 2°, 3° Malnourished	713	587	483	521	581	2,885
2° and 3° Malnourished	221	159	110	518	122	1,130
OPT Coverage	1,187	918	634	1,030	960	4,729
No. of Pregnant mother w/ anemia	95	83	60	99	96	433
Total Acceptors FP (N.A. + C.U.)	429	130	386	338	395	1,678
MCRA (Pop. x 15%)	911	869	562	950	1,091	4,383
Effective Users (Pills, IUD, VSC,BTL)	321	34		301		
Total PTB Cases	25	41	15	15	21	117
Total PTB Death	5	3	3	1	4	16
Total No. of Diarrheal Cases	11	23	12	53	41	140
Total Death - Diarrhea	1	0	0	0	0	1
Total Death - Pneumonia	5	1	1	0	3	10

6）前回プロジェクトにて人口委員会に供与した機材の現況及び制作されたＡＶ教材リスト

STATUS OF AV EQUIPMENT

I。 Radio Production System	
1。Turntables	- needs quality evaluation - needs speed regulation test
2。Reel tape recorders	- needs cleaning/ lubrication
3。Reel tape duplicators	- defective
4。Audio connectors	- defective
5。equipment built-in cables	- defective
6。Microphone cables	- defective
II。 Video Editing System	
1。Video cameras	- needs performance check-up
2。Video cassette recorder /players	- roller pins defective
3。Videotizer	- not synchronize with video cassette recorder
4。Cable connections	- defective
III。 Post-Production System (BVE-900)	- installation by Solid Phils。not completed
	- training of AV staff on the operation needed
IV。 AV Briefing Room Audio System	
1。microphone	- defective
2。Audio connectors	- defective
3。Amplifier	- defective
4。Audio patch field	- defective
V。 Photolaboratory facilities	
1。Minolta cameras	- defective
2。Enlarger	- needs performance check-up

VI. For repair

1.	VO-6800 (portable VCR)	1 unit
2.	Sony Stereo Cassette Deck (TC-K444 ES II)	1 unit
3.	Sony video monitro	1 unit
4.	Video 8 MM camera	1 unit

POPCOM PRODUCED AV MATERIALS
(1987 - 1991)

A. VIDEO DOCUMENTATION

: On Population and Development

1. The Philippine Population Program (Five-Year Plan)
   - an orientation on the population plan; its policies, thrusts, projects, goals and objectives.

   (Video, 16min., Enlgish, 1987)

2. Population Program Activity in Camiguin, Region X
   - a presentation of Lanzones festival in Camiguin.

   (Video, 60min., English, 1987)

3. The State of the Phil. Population
   - an orientation on the status of the Philippine population and on ill-effects of growing population if not arrested.

   (Video, 20min., English/Tagalog, 1988)

4. Population Development: The Phil. Perspective
   - discusses the national development goals in consonance with population factors.

   (Video, 18min., English, 1988)

5. Population Development:The Northern Mindanao Perspective
   -features projects and activities of Region X in support of POPDEV thrust.

   (Video, 15min., English, 1989)

6. Population Development: Mindoro Occidental
   - an orientation on the population issues in relation to development in Mindoro Occidental.

   (Video, 26min., English/Tagalog, 1989)

7. Ugnayan Sa Kababaihan
   - an hour presentation of the concluding program of one-week training workshop on women in development.

   (Video, 60min., English, 1987)

8. Population and Development in Laguna
   - a presentation of pppulation issues in relation to development in Laguna.

   (Video, 26min., English/Tagalog, 1990)

9. Metro Manila: Idang Babala o Isang Pangako
   - a presentation of population issues and socio-economic situation of Metro Manila.

(Video, 20min., Tagalog, 1989)

10. Sama-Sama Sa Kaunlaran
   - a presentation of population issues in relation to development in Metro Manila.

(Viddo, 15m., Tagalog, 1989)

11. FISHDEV: A Catalyst of Progress Through Self-Reliance
   - an institutional program on the projects and activities of the Foundation for Integrated Services on Health and Development in relation to health and family planning.

(Video, 18min., English, 1989)

12. Our Population Situation: Our Common Concern
   - an update version of the population situation in the Philippines. Production is in cooperation with PTV Channel 4.

(Video, 18min., English, 1990)

13. Integration of Population Variables in Selected Sectors in Region III
   - a presentation of a Research project on education, health, environment and infrastracture in Region III.

(Video, 15min., English, 1991)

14. Kabalikat: Growing To Serve, Serving To Grow
   - an institutional presentation of the objectives, plans, and thrust of Kabalikat Foundation.

(Video, 15min., English, 1988)

15. PASIG: Our River, Our Future
   - presents the historical background of Pasig river; how it became a dead river. It also tells the government plans on how to rehabilitate it. Production is in cooperation with PTV Channel 4.

(Video, 20min., English, 1989)

: ON MATERNAL AND CHILD HEALTH/FAMILY PLANNING

1. Concepcion Experience
   - a presentation of how JICA's integrated project operates ; its programs, thrust, goals and objectives.

   (Video,15min.,English,1987)

2. Adolescent Fertility: A Growing Concern
   - a presentation of fertility survey and government's action on the young fertility problems.

   (Video,15min.,English,1987)

3. Mother's Milk
   - a demonstration on the proper way to brestfeed a baby; its benefits and importance on the baby.

   (Video,15min.,English,1988)

4. Bathing A Baby:Part I
   - a demonstration on how to bathe a baby with umbilical cord still on.

   (Video,15min.,English,1988)

5. Bathing A Baby:Part II
   - a demonstration on how to give a sponge bath to a one-month old baby.

   (Video,10min.,English,1988)

6. Pre-natal care
   - a presentation on the benefits and advantages derived by undergoing a pre-natal care/check up. It also discusses on the right food for a pregnant woman.

   (Video,15min.,English,1987)

7. Immunization
   - a presentation on the signs, symptoms of communicable diseases and how to prevent them through immunization.

   (Video,8min.,English,1987)

B. TV SPOTS

: On Population and Development

1. Human Survival: Population and Development
(Video,30sec.,Enghlish,1987)

2. World Population day; Theme: Our future is our concern
(Video,20sec.,English,1988)

3. Population Welfare-Theme: Migration
(Video,1min.,Tagalog,1989)

4. Basura (Video,30sec.,Tagalog,1990

5. Edukasyon (Video,30sec.,Tagalog,1990)

6. Hanapbuhay at Kaunlaran (Video,30sec.,Tagalog,1990)

7. Ilaw,Tubigat Populasyon (Video,30sec.,Tagalog,1990)

8. Transportasyon at Populasyon
(Video,30sec.,Tagalog,1991)

9. Population Density and the quality of life
(Video,30sec.,English, 1990)

10. Dependency Burden and area Development
(Video,30sec.,English,1990)

11. Women as partners in development
(Video,30sec.,English,1990)

12. Relationship between family sixe and birth spacing and infant mortality/morbidity
(Video,30sec.,English,1990)

13. Relationship between spaced pregnancies and the total well-being of the mother
(Video,30sec.,English,1990)

14. Relationship between family welfare and family size
(Video,30sec.,English,1990)

15. POPDEV Celebration
(Video,30sec.,English,1991)

: ON HUMAN RIGHTS

1. Karapatang Pantao (human right)
(Video,1min.,Tagalog,1989)

C. RADIO PRODUCTION/SPOTS

1. Human Survival: Population and Development
   (Cassestte tape; English,30sec.,1987)

2. 1988 Christmas presentation of USAID STAFF
   (Cassette tape; English,10min.,1988)

3. Population Welfare:Theme:Migration
   (Reel/Cassette tape;1min.,Tagalog,1989)

4. POPDEV (6 population concern)
   (Cassette tape;30sec.@,Tagalog,1989)

D. EDITED VIDEO COVERAGE ON SPECIAL EVENTS

1. In Memory of Rafael Salas
   - a necrological service for the late Rafael Salas.

   (Video, 60min., English, 1988)

2. 1st and 2nd Rafael Salas Prize Awards
   - awards to individuals/institutions who made an outstanding contributions to population and development activities.

   (Video, 45min., English, 1990, 1991)

3. Development of Effective IEC Strategies for Community Participation in Family Health and Development
   -a presentation of the 7th seminar-workshop conducted by FPOP on the enhancement of welfare of the family.

   (Video, 60min., English, 1989)

4. Lantugi
   - 1st interregional debate on population and development participated in by high school and college students of Visayas and Mindanao regions.

   (Video, 60min., English, 1991)

5. POPQUIZ Show (NCR)
   - a contest on current issues on population conducted in Metro Manila.

   (Video, 35min., English, 1990)

6. POPQUIZ Show
   - a contest on current issues conducted in different regions.

   (Video, 45min., English, 1991)

7）地域中核病院機材整備計画によってタラック州病院に供与された機材リスト

第11表－A　施設別機材リスト

タルラック地域病院

		数量
1．診断用機材		
1-1	診断用レントゲン装置	1
1-2	テレビモニター装置	1
1-3	レントゲン室用空調装置	1
1-4	フィルム自動現像機	0
1-5	手現像装置	1
1-6	レントゲン・アクセサリー・セット	1
1-7	超音波診断装置	1
1-8	心臓蘇生装置	1
1-9	心電計	2
1-10	気管支鏡	0
1-11	内視鏡	0
1-12	直腸・結腸鏡	0
1-13	尿道鏡	0
1-14	内視鏡保管箱	0
1-15	診断セット	2
1-16	血圧計．スタンド型	2
1-17	血圧計．卓上型	7
1-18	聴診器	7
2．手術室用機材		
2-1	無影灯（主手術室用）	1
2-2	無影灯（副手術室用）	0
2-3	架動型手術灯	1
2-4	一般外科用手術台	1
2-5	整形外科用手術台	1
2-6	婦人科用手術台	0
2-7	簡易手術台	1
2-8	主手術室用空調器	1
2-9	婦人科手術室空調器	0
2-10	副手術室用空調器	0

第11表－B　施設別機材リスト

タルラック地域病院

		数量
2-11	麻　酔　器	2
2-12	電気メス	1
2-13	吸引器，架動型	2
2-14	吸引器，ポータブル型	3
2-15	高圧滅菌器	1
2-16	喉頭鏡セット	1
2-17	アンビュバック	2
2-18	一般外科手術セット	1
2-19	簡易手術セット	1
3．集中治療室用機材		
3-1	ＩＣＵ監視モニター	2
3-2	ギャッチ・ベット	2
3-3	心臓監視蘇生装置	1
3-4	人口呼吸器	0
3-5	吸引器，ポータブル型	2
3-6	アンビュバック	2
3-7	ＩＣＵ用空調器	1
4．産婦人科用機材		
4-1	新生児保育器	0
4-2	光線治療器	1
4-3	ジャクソンリース・バッタ	1
4-4	ヘッドボックス	1
4-5	婦人科検診台	1
4-6	分　娩　台	1
5．病棟用機材		
5-1	検　診　灯	5
5-2	吸引器，ポータブル型	2
5-3	整形外科用ベット	2

第11表－C　施設別機材リスト

タルラック地域病院

		数量
5-4	心電計	2
5-5	煮沸消毒器	4
6．検査室用機材		
6-1	分光光度計	0
6-2	オートクレーブ，卓上型	1
6-3	血液貯蔵庫	1
6-4	薬品冷蔵庫	0
6-5	恒温槽	1
6-6	孵卵器	1
6-7	血球カウンター	1
6-8	遠心分離器	1
6-9	双眼顕微鏡	2
6-10	ピペット洗浄器	1
6-11	ミクロトーム	0
6-12	自動固定包埋装置	0
7．その他		
7-1	救急車	0
7-2	発動発電機	1
7-3	高圧蒸気滅菌器	0

8) 地方自治法

THE LOCAL GOVERNMENT CODE OF 1991

HIGHLIGHTS AND WORK PROGRAM

PREPARED AND PRINTED BY
BUREAU OF LOCAL GOVERNMENT DEVELOPMENT

REPRODUCED BY
LOCAL GOVERNMENT ACADEMY

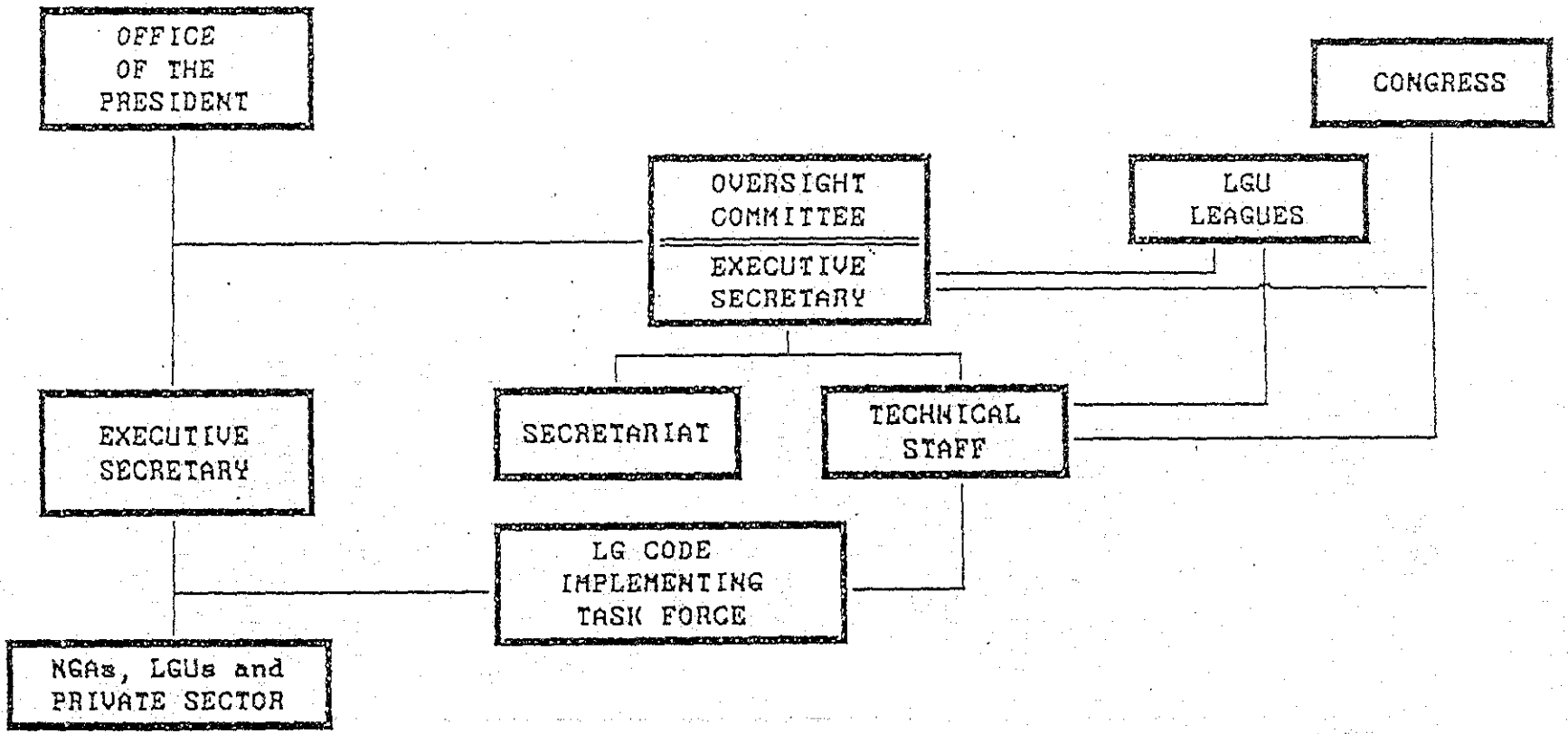
PART III

LGC MILESTONES

LOCAL GOVERNMENT CODE
MILESTONE EVENTS AND DATES

DATE	EVENTS
SEPT 25–30, 1991	TRANSMITTAL OF CODE TO OP
OCT 10, 1991	SIGNING OF LOCAL GOVERNMENT CODE INTO LAW
NOV 8, 1991	CONVENING OF OVERSIGHT COMMITTEE (WITHIN ONE MONTH FROM DATE OF SIGNING OF CODE INTO LAW) PROPOSED AGENDA : - IMPLEMENTATION PROGRAM/CALENDAR - GUIDING PRINCIPLES ON THE TRANSFER OF FUNCTIONS, ASSETS AND PERSONNEL - PROPOSED GUIDELINES ON THE TRANSFER OF PERSONNEL AND ASSETS - PROPOSED BUDGET FOR THE LGC IMPLEMENTATION - PROPOSED GUIDELINES ON THE INFO CAMPAIGN - IRR FRAMEWORK (OUTLINE)
DEC 15, 1991	SECOND OVERSIGHT COMMITTEE MEETING PROPOSED AGENDA : - IMPLEMENTING RULES AND REGULATIONS (1ST DRAFT)
JAN 1, 1992	EFFECTIVITY OF THE LGC START OF DEVOLUTION PROCESS
JAN 8, 1992	SUBMISSION OF OC FINAL REPORT TO PRESIDENT
JUNE 30, 1992	COMPLETION OF DEVOLUTION PROCESS
OCT 10, 1992	COMPLETION OF PHASE-OUT OF REGIONAL OFFICES OF AFFECTED AGENCIES

LGC IMPLEMENTATION ORGANIZATION



Malacañan Jan 27/92

MALACAÑANG
MANILA

EXECUTIVE ORDER NO. 503

PROVIDING FOR THE RULES AND REGULATIONS IMPLEMENTING THE TRANSFER OF PERSONNEL AND ASSETS, LIABILITIES AND RECORDS OF NATIONAL GOVERNMENT AGENCIES WHOSE FUNCTIONS ARE TO BE DEVOLVED TO THE LOCAL GOVERNMENT UNITS AND FOR OTHER RELATED PURPOSES

WHEREAS, Republic Act No. 7160 otherwise known as the Local Government Code of 1991, hereinafter referred to as the Code, transfers the responsibility for the delivery of basic services and facilities from the national government agencies (NGAs) concerned to the local government units (LGUs);

WHEREAS, the Code stipulate that the transfer of basic services and facilities shall be accompanied by the transfer of the national personnel concerned and assets to ensure continuity in the delivery of such services and facilities;

WHEREAS, responsive rules and regulations are needed to effect the required transfer of national personnel concerned and assets to the LGUs;a

NOW, THEREFORE, I, CORAZON C. AQUINO, President of the Philippines, by virtue of the powers vested in me by law and the sovereign will of the Filipino people and upon the recommendation of the Oversight Committee of the Code, do hereby order.

Section 1. Transfer of Assets and Personnel. - The personnel and assets including pertinent records and equipment, corresponding to the devolved service delivery functions enumerated under Section 17 of the Code, shall be transferred to the LGUs.

Sec. 2. Principle and Policies Governing Transfer of Personnel. -

a. Coverage, Tenure, Compensation and Career Development. -

1. Technical and administrative personnel of the NGAs affected by the devolution of powers, functions, and responsibilities shall be transferred to the LGUs.

2. The absorption of the NGA personnel by the LGU shall be mandatory; in which case, the LGUs shall create the equivalent positions of the affected personnel except when it is not administratively viable.

3. Absorption is not administratively viable when there is duplication of functions unless the LGU opts to absorb the personnel concerned.

4. The national personnel who are not absorbed by the LGUs under no. 3 above, shall be retained by the NGA concerned, subject to civil service law, rules and regulations.

5. There shall be no involuntary separation, termination, or lay-off of permanent personnel of the NGAs affected by devolution.

6. Devolved permanent personnel shall enjoy security of tenure.

7. Any reorganization that will be implemented by the LGUs after the devolution of functions shall be governed by the provisions of Republic Act No. 6656.

8. Incumbents of positions, namely, administrator, legal officer, and information officer declared by the Code as coterminous, who hold permanent appointments, shall continue to enjoy their permanent status until they vacate their positions.

9. Casual, emergency, or daily-wage personnel assigned in the field units of the NGAs affected by devolution who are performing duties and responsibilities relative to the delivery of basic services may be absorbed by the LGUs concerned.

10. Contractual personnel of the NGAs concerned directly involved in the implementation of pilot projects in the LGUs need not be devolved.

11. Temporary personnel shall be absorbed by the LGUs, subject to civil service law, rules and regulations.

12. Except as herein otherwise provided, devolved permanent personnel shall be automatically reappointed by the local chief executive concerned immediately upon their transfer which shall not go beyond June 30, 1992.

13. The rank or tenure of devolved permanent personnel shall not be reduced or impaired.

14. There shall be no diminution in pay or benefits of devolved personnel.

(b) Criteria for Deployment. - Subject to the provisions of this Section, devolved personnel shall be deployed to the LGUs in accordance with the following criteria:

1. Personnel performing city or municipality-specific functions shall be absorbed by the city or municipality where they are assigned.

2. Personnel performing inter-municipal functions shall be absorbed by the province wherein the municipalities concerned are located.

3. Regional personnel undertaking LGU-specific functions may be absorbed by LGU concerned.

4. Regional personnel performing primarily regional functions shall be retained by the NGAs concerned to form part of their field units to be established as a result of the phase-out of their regional offices, on or before October 10, 1992, for purposes of monitoring and coordinating the devolved basic services and providing technical assistance to the LGUs.

(c) Retention of Personnel by the NGA. - Regional directors who are Career Executive Service Officers, and other officers of similar rank, shall be retained by the NGA without diminution of rank, salary, or tenure.

(d) Vacant Positions in the NGAs. - Existing vacant positions in the NGAs, whose functions are to be devolved to the LGUs, shall be transferred to the LGUs concerned on January 1, 1992. In the event of duplication of functions, however, the corresponding budget allocated to the salaries of existing vacant positions may be realigned by the LGUs concerned to fund programs, projects and activities in the sector where the fund originated.

(e) Exemptions from Rules on Nepotism, Residency, and Election Ban.

1. The rule on nepotism as provided under the Code shall not apply to devolved personnel.

2. The residency requirement and prior concurrence of the local sanggunian as prescribed under the Code for the appointment of local appointive officials shall not apply to the devolved personnel.

3. Transfer of devolved personnel within the six-month transition period from January 1 to June 30, 1992, shall be exempted from the election ban subject to the approval of the Commission on Elections.

(f) Separation and Retirement Benefits.

1. When the personnel to be devolved opt for voluntary

separation or retirement from the service, they shall be entitled, if qualified under existing laws, to receive the retirement gratuities and other benefits accruing thereunder.

2. When an official or employee is not eligible for retirement, they shall be entitled to separation pay equivalent to one (1) month salary for every year of service, plus a proportionate amount for any fraction thereof over and above the monetary value of their accumulated leave credits pursuant to existing laws.

3. Payment of retirement benefits to the NGA personnel transferred to the LGU shall be proportionately shared by the NGA and the LGU concerned based on the length of service of the personnel concerned in both agencies. The Department of Budget and Management (DBM) shall issue the necessary guidelines for this purpose.

4. The DBM, in the case of NGA officials and employees, and the LGUs, in the case of local government officials and employees, are hereby directed to provide funding priority to personnel retirement and other benefits arising from the devolution of basic services to the LGUs.

(g) Responsibility for Devolved Functions. - The local chief executive shall be responsible for all devolved functions. He may delegate such powers and functions to his duly authorized representative whose position shall preferably not be lower than the rank of local government department head. In all cases of delegated authority, the local chief executive shall at all times observe the principle of command responsibility.

Sec. 3. Principles and Policies Governing the Transfer of Assets, Liabilities, Equipment and Records. - (a) Assets, liabilities, equipment, and records of the NGAs corresponding to the devolved powers, functions and responsibilities shall be transferred to the LGU concerned.

(b) Lands and buildings to be transferred to the LGUs shall, for purposes of disposition, be considered part of the seat of government of the LGUs as defined under Section 11 of the Code.

(c) The LGUs shall provide appropriate funds in their respective budgets for maintenance and other operating expenditures of the transferred assets.

(d) Assets, liabilities, equipment, and records shall be transferred to the LGUs subject to the following conditions:

1. Those which are exclusively used within the territorial jurisdiction of a municipality or city shall be transferred to the municipality or city concerned.

2. Those which are used by two (2) or more municipalities and/or component cities shall be transferred to the province where these municipalities/component cities are situated.

3. Regional assets, liabilities, equipment, and records used for the delivery of devolved services or functions as specified in the Code for a specific LGU shall be transferred to the LGU concerned.

4. Regional assets, liabilities, equipment, and records required by the field units of the NGAs to be established as replacement of the regional offices that will be phased out shall be retained by the NGA concerned.

5. Assets, liabilities, equipment, and records of the NGAs within the Metropolitan Manila Area, which serve more than one (1) LGU, shall be retained by the NGA concerned.

Sec. 4. Closing, Opening, and Maintenance of Accounts. - (a) The books of accounts of the NGAs, whose functions are to be devolved totally to the LGUs shall be closed as of the date of transfer and the balances of all transferred assets, liabilities, and residual equity (surplus) shall be recorded in the books of accounts of the recipient (LGU).

(b) The books of account of the NGAs whose functions are to be devolved partially to the LGUs shall be adjusted as of the date of transfer up to the extent of the balances of actual assets, liabilities, and residual equity (surplus) transferred. These shall be recorded in the books of accounts of the recipient LGU.

(c) All devolved financial transferred of the NGAs shall be recorded in the books of accounts of the recipient LGU after the transfer.

(d) Devolved NGAs maintaining multiple funds shall prepare a consolidated trial balance.

(e) Subsidiary ledgers shall be prepared and maintained by the LGUs for each fund and each NGA to facilitate monitoring and control.

(f) All NGAs affected by devolution shall continue to prepare the usual year end reports and statements as of December 31, 1991. The reports and statement shall be incorporated in the 1991 Annual Financial Report of the National Government.

(g) Additional guidelines and instructions for the closing, opening and maintenance of accounts shall be promulgated by the Commission on Audit.

Sec. 5. Reorganization of the NGAs Affected by Devolution. - (a) The NGAs affected by devolution shall adopt new organizational structure and operating systems responsive to decentralization imperatives.

(b) The NGAs whose functions are not devolved shall effect the deconcentration of requisite authority and power to their regional or field offices on or before June 30, 1992 as provided under Section 528 of the Code.

Sec. 6. Period of Devolution. - (a) Except as herein otherwise provided, the devolution of responsibility for basic services and facilities and the transfer of assets, liabilities, personnel, equipment and records to the LGUs shall be completed not later than June 30, 1992.

(b) All NGAs shall submit not later than March 1, 1992 to the different LGUs a list of the basic services in accordance with Section 17 of the Code that can be devolved by June 30, 1992. Those that cannot be devolved by June 30, 1992, shall be devolved not later than December 31, 1992. For this purpose, the NGAs shall enter into Memoranda of Agreement (MOA) with the different LGUs on the schedule and extent of devolution. The NGAs shall furnish the Department of Interior and Local Government and the DBM with copies of their MOAs.

(c) Except as herein otherwise provided, the corresponding salaries of devolved positions shall be transferred to the LGUs on a quarterly basis by the NGAs concerned not later than July 1, 1992.

(d) The corresponding salaries for the positions devolved pursuant to paragraph B of this Section shall be transferred to the LGU concerned on the actual date of transfer, but in no case to go beyond December 31, 1992.

Sec. 7. Monitoring of Transfer. - All NGAs affected by devolution of functions shall submit to the Oversight Committee the timetable for the transfer of assets, liabilities, personnel, equipment and records of the LGUs within one (1) month after the promulgation of this Executive Order.

Sec. 8. Effectivity. - This Executive Order shall take effect immediately upon its publication in a newspaper of general circulation.

DONE in the City of Manila, this 22nd day of January, in the year of Our Lord, Nineteen Hundred and Ninety- Two.

By the President:

FRANKLIN M. DRILON
Executive Secretary

9) 国連人口活動基金（UNFPA）の活動状況

UNFPA-assisted project

PROJECT PROFILE

1

Project Title:

1990 Census of Population and Housing (PHI/89/P01)

Implementing Agency:

National Statistics Office (NSO)

Executing Agency:

United Nations Department of Technical Cooperation for Development (DTCD)

Project Description:

This project responds to the need for more up-to-date population data to be used for policy formulation and program implementation by the government. It is designed to improve data collection, decentralize processing of census data, and promote wider use of results through various forms of dissemination, analysis and establishment of data base.

Objective:

The project seeks to upgrade the capability of the National Statistics Office in collecting, processing, disseminating and analyzing demographic data from the 1990 Census of Population and Housing.

Location: Nationwide

Components/Activities/Inputs:

1. Planning and preparatory activities, including organization of Advisory/ Technical/Working Committees.
2. Mounting of a publicity campaign.
3. Local training of staff at all levels to be involved in the census.
4. Foreign training of staff on data processing/analysis.
5. Purchase of data-processing equipment.
6. Data collection through direct interviews, mail inquiries, and decentralized data-processing.
7. Publication of results to support the preparatory and post-enumeration activities of the 1990 Census.

Project Duration: Three (3) years starting 1989

Project Cost: US$ 384,775.00 (UNFPA contribution)
P 166,545,900.00 (GOP counterpart)

Project Title:

Strengthening the Institutional Capability for Technical Assistance in Population Planning of the University of the Philippines Population Institute (PHI/89/P06)

Implementing Agency:

University of the Philippines Population Institute (UPPI)

Project Description:

This project seeks to help revitalize the Philippine Population Program by improving the capability of the prime demographic institution in the country. It addresses the remaining gaps identified in UPPI's five-year plan: (1) the need to develop a critical mass of trained population specialists; (2) the need to update the existing UPPI senior staff on new developments in the field and to retool structures; (3) the need to revamp and improve the use and dissemination of research outputs; and (4) the need to upgrade library facilities and services and to strengthen the administrative capability of the Institute.

Objective:

The project aims to strengthen the capability of the UPPI in performing its three-pronged function of research, training and extension service in the light of its critical role in the Philippine Population Program.

Location: Quezon City, Metro Manila

Components/Activities:

1. Grant of 20 local fellowships in MA Demography at UPPI.
2. Sending UPPI staff to foreign short-term training.
3. Recruitment of three middle-level technical research staff, one part-time editor, one full-time editorial assistant, an executive assistant and a driver.
4. Conduct of 15 discussion series, publication of 15 policy papers and dissemination of discussion and policy papers to 500 target recipients within five years.
5. Employment and training of a librarian at East-West Center.
6. Procurement of a vehicle.

Project Duration: Five (5) years starting July 1989

Project Cost: US$ 241,000.00 (UNFPA contribution)
P2,150,844.00 (GOP counterpart)

UNFPA-assisted project

PROJECT PROFILE

3

UNFPA-assisted project

PROJECT PROFILE

4

Project Title:

Integration of Population and Development Planning (IPDP) (PHI/90/P02)

Implementing Agency:

National Economic and Development Authority (NEDA)

Project Description:

This project is a spin-off of the Population/Development Planning and Research Project of the NEDA (PDPR). It adopts the three-pronged approach of institutional support, training and research/research utilization to promote integrated population and development planning. The project addresses the bottlenecks in promoting the more subtantive integration of the population dimension into the development planning process. These bottlenecks include weak institutional support and poor or inadequate technical base. The weak technical base is due to the lack of information and research, the limited use of existing information, and inadequate tools and skills for pursuing integrated population and development planning. In this regard, the project will support the development of frameworks/methodologies, the conduct of research, and of consciousness-raising as well as skills-training conferences/workshops and research utilization activities.

Objective:

The project aims to promote the more substantive and systematic consideration of the two-way relationship between population and development in formulating development plans, policies, programs and projects.

Location:

Nationwide, excluding the four (4) regions covered by PDPR: Ilocos, Western and Central Visayas, and Northern Mindanao

Components/Activities:

1. Setting up of a Project Management Group and expansion of the Project Steering Committee and Technical Working Group.
2. Conduct of POPDEV trainings/workshops for various levels of planners and policymakers.
3. Conduct of research utilization activities targeting policymakers and planners, such as workshops/seminars, and dissemination of print materials in user-oriented form.
4. Conduct of research activities focused on the use of secondary data and the following concerns: (a) updating of population projections; (b) preparation of frameworks for long-term planning, investment programming, local and sectoral development planning; (c) carrying capacity study on population, resources and environment; (d) development of socioeconomic-demographic data bases; and (e) region-based research studies.

Project Duration: Four (4) years starting 1990

Project Cost: US$1,855,058.00 (UNFPA contribution)
P8,466,203.00 (GOP counterpart)

UNFPA-assisted project

PROJECT PROFILE

5

Project Title:

Support to the Philippine Legislators' Committee on Population and Development Foundation, Inc. for Social Development Policies and Programs (PHI/89/P13)

Implementing Agency:

Philippine Legislators' Committee of Population and Development Foundation, Inc. (PLCPD)

Executing Agencies:

- UNDP/Development Training and Communication Planning (DTCP)
- National Task Force for Social Mobilization (NTFSM)

Project Description:

This project addresses legislators' growing interest in, and expressed need to have access to, relevant information on population, child survival, women, environment, natural resources and related issues, and to exchange information, views and experiences on these issues with local officials and the public. Through the conduct of regional conferences with locally elected officials, the project expects to facilitate the achievement of a harmonized nationwide perspective of these issues, including the ways and means of addressing them. It is also expected that participation of legislators in international parliamentarians' conferences would enhance their knowledge of and commitment to address the concerns related to population, child survival, women, and environment.

Objective:

This project seeks to strengthen the institutional capability of the PLCPD in promoting awareness of the interrelationships between population concerns and sustainable development among senators, congressmen, governors, mayors, and other local government officials.

Location: Nationwide

Components/Activities:

1. Setting up of a secretariat to execute PLCPD advocacy role.
2. Organization of regional conferences.
3. Participation of selected legislators in international and global parliamentarians' conferences on these concerns.
4. Compilation and packaging of region-based statistical and research information on these concerns for dissemination to legislators and local government officials.

Project Duration: Two and a half (2.5) years starting July 1989

Project Cost:

US$	115,000.00	(UNFPA contribution)
US$	60,000.00	(UNDP contribution)
US$	114,605.00	(UNICEF contribution)
P	1,544,400.00	(GOP counterpart)

Project Title:

Population Information in Aid of Advocacy for the National Population Program (PHI/89/P17)

Implementing Agency:

Population Commission (POPCOM)

Project Description:

This project is conceived to help achieve a wider awareness of population issues and broader multisectoral consensus and support for the country's population policy and programs. The underlying strategy of the project is simultaneous creation of supply of population informational materials and mobilization of support among the societal ``influentials'' through selective dissemination of information and strategic high-profile public fora. At the same time, project activities will be directed at strengthening staff capabilities and upgrading administrative capacity to respond more effectively to the public need for timely and relevant population information.

Objective:

The project aims to create greater awareness and appreciation of population and development interrelationships, and to promote stronger policy and program support among various influential segments of Philippine society.

Location: Nationwide

Components/Activities:

1. Development and production of advocacy and publicity materials, including: data sheets, the *Philippine Population Journal*, brochure/primer on population, training modules, video programs, and the POPDEV Portfolio.
2. Dissemination of population advocacy materials.
3. Organization of Advocacy Project Advisory Committee.
4. Conduct of media activities, like press releases of project activities in leading newspapers, radio coverage through the Federation of Rural Broadcasters (FRB), TV coverage through Channel 4, and media participation in conferences/fora and award ceremonies.
5. Conduct of Rafael Salas Forum and Prize Award Ceremonies.
6. Capability/capacity-building activities such as: training workshops on information management, provision of foreign study tours, hiring of librarian to backstop various informational activities, contracting consultants, and procurement of equipment.

Project Duration: Forty-two (42) months

Project Cost: US$249,996.00 (UNFPA contribution)
P18,177,432.00 (GOP counterpart)

UNFPA-assisted project

PROJECT PROFILE

7