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# Family planning studies in the Philippines: A review and synthesis

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# FAMILY PLANNING STUDIES IN THE PHILIPPINES: A REVIEW AND SYNTHESIS

## PHILIPPINES

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## Introduction

This report which summarizes the major study findings on population and family planning trends in the Philippines was prepared for the Research Unit of the Family Planning Services (FPS) of the Department of Health (DOH). Specifically, the report was to be used by the FPS in its National Consultative Planning Workshop which was scheduled in early 1994 to discuss and formulate the plans and activities for the Philippine Family Planning Program (PFPP) for 1994-1995. The workshop participants included the DOH Regional Family Planning Coordinators, representatives of local government offices engaged in population and health activities, and local NGOs and women's groups. The report, therefore, was meant to alert participants to population and family planning issues and trends which could assist them formulate their family planning program targets and strategies in their own areas and localities.

In earlier meetings with the FPS-Research Unit, it was agreed that the study findings contained in this report would be organized into two major sections, namely: 1) those that relate to indicators of family planning demand; and 2) those bearing on the supply of family planning services. In view of the changes that have been made on the national family planning program, moreover, it was agreed that the report would incorporate the basic policy changes that ought to guide local plan formulation and program implementation. Additionally, the report was to touch on the 1991 Local Government Code which devolves many of the functions and services earlier provided by the national government to local government units and which affects the delivery of health and family planning services at local levels.

Considering the large number of population and family planning studies that have been made to date, this review limits itself to a presentation of related trends in fertility and family planning awareness, approval and use over time. The chief sources of these findings and which are presented in Section I of this report (Related Indicators of Family Planning Demand), are the Censuses, the National Demographic Surveys (NDS), and some of the FP-KAP (Family Planning Knowledge, Approval and Practice) surveys done since the 1970s. Undertaken every five years since 1968, the NDS is on its sixth series (1968, 1973, 1978, 1983, 1988 and 1993). The NDS provides updated information on fertility, fertility preferences, and family planning awareness, approval and use, as well as related data on breastfeeding and maternal and child health practices. The NDS series has been used largely by government and policy makers to monitor/evaluate the impact of national population program initiatives, and to design strategies for improving the provision of health and family planning services. Complementing the NDS is also the nationwide Contraceptive Prevalence Survey (CPS) undertaken in 1986, which provides more detailed information on contraceptive adoption and use.

In the review, attempts are made to compare trends across the same time periods, i,e, as from 1968-1973 to 1978-1983 and to 1988-1993. But since data from the NDS survey rounds, as well as from other sources and the methods for analyzing these, are not always uniform or comparable, the discussion of some trends may omit certain time periods. In almost all cases, however, the latest available information on a trend or topic is included in the report. The report also focuses more on national trends, but cites marked regional variations where these are found.

In Section II (Factors Affecting the Supply of Family Planning Services), the report draws on a

review of materials and documents on the national population policy and program, particularly after the reformulation of these in the late 1980s into the PFPP Plan for 1990-1994. This section also includes findings from earlier OR (operations research) studies that were commissioned to look into various aspects of the family planning program and its implementation. Among these are some of the OR studies done on the IEC and training components of the program, the number and distribution of family planning service outlets, the accessibility and availability of contraceptives, the referral system obtaining in clinics, clinic preformance and quality of services, and other evaluations conducted on the program. Emphasis is placed on the more recent than on earlier OR study findings since the latter are no longer as relevant or appropriate to the ongoing changes being made on the conduct of the national family planning program.

Finally, in both sections, the report calls attention to some of the policy and program implications of earlier research and study findings, although it should be noted that not all study findings are with direct policy or program implications. In general, by synthesizing information on family planning activities and trends, the report hopes to provide a backdrop for the formulation and implementation of local action plans to advance the national family planning program.

# Related Indicators of Family Planning Demand

## Population Size and Growth

The Philippine population stood at 60.7 million in May 1990, indicating an increase of 12.6 million people since the 1980 Census. The national population in 1990 represents an eight-fold increase over the first national population count of 7.6 million people in the 1903 Census (Table 1).

**Table 1**
**Population in various census years**

| YEAR | POPULATION (IN MILLIONS) |
|---|---|
| 1903 | 7.6 |
| 1939 | 10.3 |
| 1948 | 16.0 |
| 1960 | 19.2 |
| 1970 | 27.1 |
| 1975 | 42.1 |
| 1980 | 48.1 |
| 1990 | 60.7 |

Source: 1990 Census Report

In the last 1980 to 1990 intercensal period, the Philippine population grew at an annual rate of 2.35 percent. This growth rate is the lowest observed in the country since 1948 (Table 2), although it is the highest among major Southeast Asian countries at present.

At this rate, the Philippine population is expected to double in less than 30 years, adding 1.4 million

persons every year or three persons per minute.

**Table 2**
**Population growth rates, 1948 to 1990**

| CENSUS INTERVAL | GROWTH RATE (%) |
|---|---|
| 1948-1960 | 2.89 |
| 1960-1970 | 3.08 |
| 1970-1975 | 2.78 |
| 1975-1980 | 2.71 |
| 1980-1990 | 2.35 |

Source: 1990 Census Report

The country's high rate of population growth became a concern to the Philippine government in 1970, which then instituted a national family planning program to reduce the birth rate and attain a better balance between the country's population, economic and environmental resources. Subsequently, the adverse effects of large family sizes on the health of mothers and children and on the economic well-being of families led a new government administration in 1987 to broaden its population concerns beyond national fertility reduction to include the enhancement of health and family welfare. In 1990, the revised Philippine Family Planning Program puts more emphasis on the latter concerns, while recognizing the beneficial impact that reduced birth rates would have on national development.

## Number of Married Women of Reproductive Age

The demand for family planning has been estimated using various measures including the size and growth of the female population aged 15 to 49 or of women of reproductive age. The measure more

commonly used, however, is the number of married women of reproductive age (MWRAs) who are considered to constitute the group most exposed to the risk of pregnancy.

Estimates derived from the 1968 to 1988 NDS survey rounds show that the population of MWRAs almost doubled during the 20-year period, from 4.1 million in 1968 to 8.0 million in 1988. The latest 1990 Census points to a further increase in the married female population aged 15 to 49 to 9.2 million, or 61 percent of the total 15.0 million Filipino women in these age groups (Table 3).

**Table 3**
**Number of MWRAs, 1968-1988**

| YEAR | NUMBER (IN MILLIONS) |
|---|---|
| 1968 | 4.1 |
| 1973 | 4.8 |
| 1978 | 5.5 |
| 1983 | 6.4 |
| 1986 | 6.8 |
| 1988 | 8.0 |

Source: 1990 Census Report

Available data suggest that current measures of family planning demand based on the number of MWRAs may underestimate the women population at risk. Studies show a considerable risk of pregnancy even among unmarried women. The 1986 Contraceptive Prevalence Survey (CPS) for instance, showed that 22.0 percent of currently married women admit to cohabiting at least a month prior to marriage. The incidence of cohabitation prior to marriage has also been increasing over time: comprising 15.0 percent of the 1986 CPS respondents who first married between 1958 to 1962 and a substantially higher 29.3 percent of those marrying in the latter 1983 to 1985 period (Table 4).

**Table 4**
**Difference between dates of formal marriage and of cohabitation by marriage cohort (in percent)**

| FIRST MARRIAGE COHORT | DIFFERENCE (IN MONTHS) | | | | | TOTAL WOMEN | TOTAL WOMEN WHO COHABITED BEFORE MARRIAGE |
|---|---|---|---|---|---|---|---|
| | 6+ | 2.5 | 1 | 0 | <1 | | |
| 1958-1962 | 6.6 | 4.6 | 3.8 | 83.4 | 1.6 | 100.0 | 15.0 |
| 1963-1967 | 5.9 | 5.2 | 4.3 | 83.4 | 1.2 | 100.0 | 15.4 |
| 1968-1972 | 8.5 | 6.7 | 4.5 | 79.4 | 0.9 | 100.0 | 19.7 |
| 1973-1977 | 10.7 | 8.0 | 5.7 | 74.5 | 1.1 | 100.0 | 24.4 |
| 1978-1982 | 11.6 | 10.2 | 6.1 | 70.8 | 1.2 | 100.0 | 28.0 |
| 1983-1985 | 9.3 | 13.5 | 6.5 | 69.5 | 1.2 | 100.0 | 29.3 |
| TOTAL | 8.8 | 8.0 | 5.2 | 76.8 | 1.2 | 100.0 | 22.0 |

Source: 1986 CPS

The above trend may be related to the long-term rise in the average age at first marriage in the Philippines, and which for women currently stands between 22 to 23 years.

Increasing by over five percentage points since 1970, the proportion of those who never married among women 15 to 19 and 25 to 29 reached 97.5 percent and 27.03 percent respectively in 1990 (Table 5). In turn, the delayed age at marriage increases the chances of premarital sex and cohabitation among younger generations of Filipino women and men.

**Table 5**
**Trends in marriage timing and non-marriage among women by age group**

| AGE | PERCENT NEVER MARRIED | | | |
|---|---|---|---|---|
| | 1970 | 1975 | 1980 | 1990 |
| 15-19 | 89.12 | 87.62 | 87.62 | 97.57 |
| 20-24 | 50.22 | 51.16 | 45.48 | 50.26 |
| 25-29 | 21.46 | 24.30 | 21.04 | 27.03 |
| 30-34 | 11.64 | 12.15 | 11.88 | 11.88 |
| 35-39 | 8.02 | 8.21 | 8.04 | 8.48 |
| 40-44 | 7.34 | 6.81 | 7.01 | 7.72 |
| 45-49 | 6.70 | 6.06 | 6.65 | 7.06 |
| 50-54 | 7.29 | 5.98 | 6.89 | 5.10 |
| 55 and over | 6.14 | 6.38 | 7.60 | 7.51 |
| TOTAL | 36.87 | 37.81 | 34.67 | 33.10 |

Source: 1970, 1975, 1980 and 1990 Census Reports

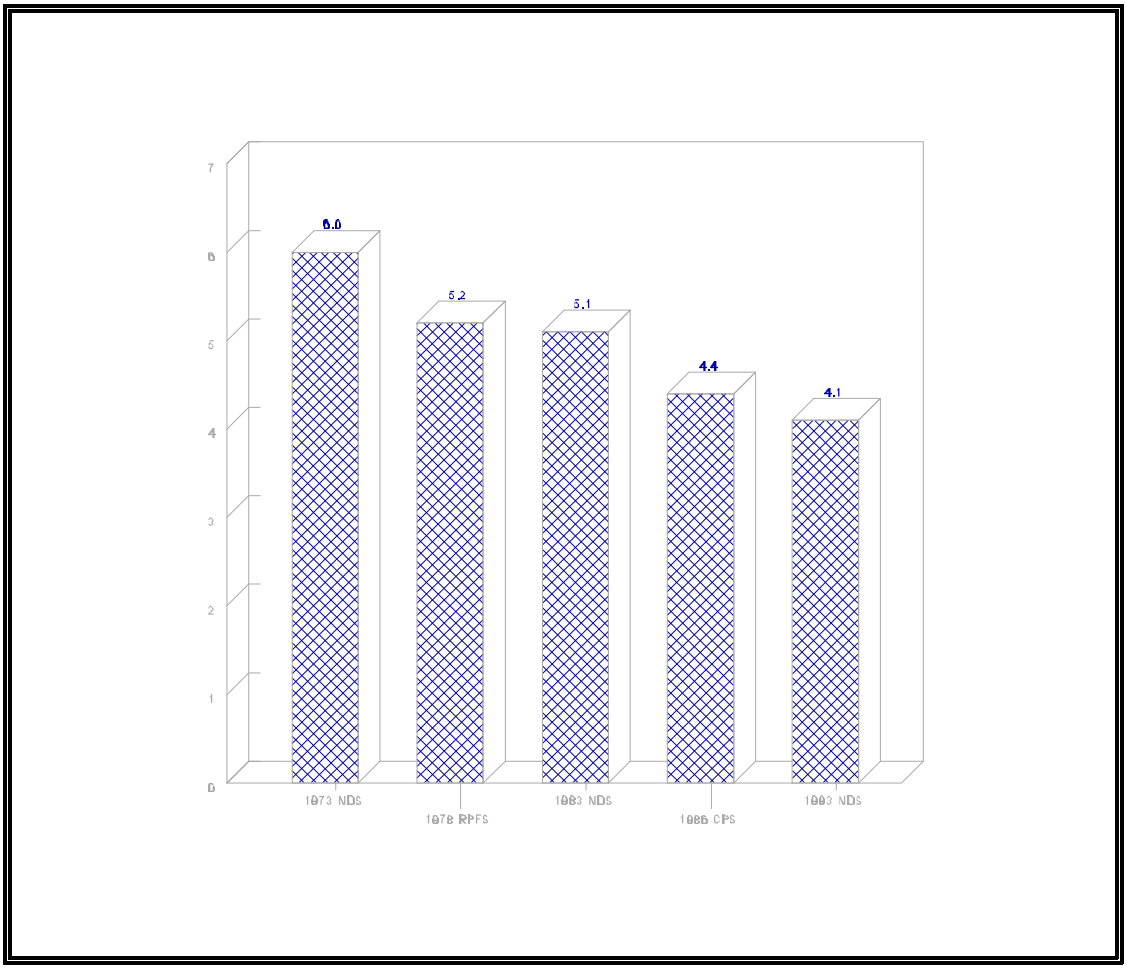
The foregoing data thus point to a need to adjust upwards current estimates of the population at risk and to design strategies to delay sexual activity and/or prevent pregnancies and births among today's unmarried youth.

## Fertility Trends

Partly as a result of the adoption of a national family planning program in 1970, the national birth rate, as indexed by the Total Fertility Rate (TFR), has been declining over time. The TFR is the most widely used and accepted measure of the birth rate and indicates the average number of children a woman is expected to have at the end of her childbearing years.

Comparable TFR estimates derived from the NDS series reveal that this has been declining from around 6.0 children per woman in 1970 to around 4.1 children per woman in 1991, although its rate of decline has been uneven over the 20-year period. Figure I shows that the first substantial decline in the country's fertility occurred between 1970 to 1975 when the TFR began to fall by 2.4 percent per annum. Declining by only 0.6 percent per annum, the pace of decline decelerated in the latter half of the 1970s, although this was again followed by a period of rapid decline in the early 1980s when the TFR fell by 3.2 percent per year. This fall however, has not been sustained in the most recent 1985 to 1991 period, with the TFR declining only by 1.2 percent per annum.

**Figure 1**
**Total fertility rates, 1970-1991**




Source: 1973, 1983 and 1993 NDS reports; 1978 RPFS; and 1986 CPS

Generally reflecting the stages of family formation, age-specific fertility rates show that fertility levels tend to peak at ages 25 to 29, and to decline monotonically at older ages. Consistent with the decline in the TFR, time-series data on age-specific fertility rates from the 1968 to 1993 NDS show that the fertility of women across all age groups has been similarly declining over time (Table 6). The 36 percentage points decline in the fertility of younger women aged 20 to 24 during the period owes in part to delayed marriages, whereas the much larger 73 percentage points reduction in the fertility of women after age 25 indicates an increasing adoption of family planning by Filipino women either for purposes of spacing or stopping their births.

**Table 6**
**Age-specific and total fertility rates from various surveys**

| AGE | FERTILITY RATE BY SURVEY YEAR | | | | |
|---|---|---|---|---|---|
| | 1973 | 1978 | 1983 | 1986 | 1993 |
| 15-19 | 56 | 50 | 55 | 48 | 50 |
| 20-24 | 228 | 212 | 220 | 192 | 190 |
| 25-29 | 302 | 251 | 258 | 229 | 217 |
| 30-34 | 268 | 240 | 221 | 198 | 181 |
| 35-39 | 212 | 179 | 165 | 140 | 120 |
| 40-44 | 100 | 89 | 78 | 62 | 51 |
| 45-49 | 28 | 27 | 20 | 15 | 8 |
| TOTAL FERTILITY RATE | 5.97 | 5.24 | 5.08 | 4.42 | 4.09 |

Source: 1973, 1983 and 1993 NDS reports; 1986 CPS report; and 1978 RPFS report

Regionally, the latest 1993 NDS reveals that current fertility levels are lowest in Metro Manila and in the adjacent and more developed regions of Central Luzon and Southern Tagalog, where TFR levels stand respectively at 2.76, 3.87, and 3.86 (Table 7). TFR levels in all other regions exceed the national average of 4.1, but are particularly high in Bicol (5.87); the Cordillera Administrative Region (5.05); Eastern Visayas (4.86); and in Northern and Central Mindanao (4.81). Expectedly, the TFR is also higher in rural areas (4.82) than in urban areas (3.53).

**Table 7**
**Fertility by background characteristics among women age 15-49**

| BACKGROUND CHARACTERISTICS | TOTAL FERTILITY RATE | MEAN CEB |
|---|---|---|
| Residence | | |
| Urban | 3.53 | 4.34 |
| Rural | 4.82 | 5.65 |
| Region | | |
| National Capital Region | 2.76 | 3.46 |
| Cordillera | 5.05 | 4.44 |
| Ilocos | 4.25 | 5.12 |
| Cagayan Valley | 4.20 | 4.60 |
| Central Luzon | 3.87 | 4.58 |
| Southern Tagalog | 3.86 | 4.81 |
| Bicol | 5.87 | 6.14 |
| Western Visayas | 4.24 | 5.17 |
| Central Visayas | 4.38 | 5.04 |
| Eastern Visayas | 4.86 | 5.70 |
| Western Mindanao | 4.46 | 5.46 |
| Northern Mindanao | 4.81 | 5.79 |
| Southern Mindanao | 4.23 | 5.43 |
| Central Mindanao | 4.81 | 6.09 |

Source: 1993 NDS report

## Fertility Differentials

As elsewhere, fertility among Filipino women is known to differ by their socioeconomic characteristics. Fertility levels are generally lower among women with high education, those residing in urban areas, and those married to men of high occupational status (i.e., professional workers). Employed women also tend to have fewer children than those not in the labor force. Fertility, moreover, varies across ethno-linguistic and religious groups.

The 1988 NDS which presents a more complete analysis of the fertility of women by their background characteristics, reveals that fertility differentials remain substantial across social class groupings (Table 8). On the average, highly educated women (i.e., those with college degrees) have 3.2 less children than those with no more than a primary education. Those married to men in professional occupations have also close to 3 (2.8) children than those married to farmers and agricultural workers. Likewise, women engaged in professional occupations have 2.5 fewer children than housewives and 2.8 less children than women in agricultural jobs.

Fertility differentials across other characteristics are less marked. Data from the same 1988 NDS indicate that women residing in urban areas have 1.5 children less than their rural counterparts. The Tagalog- and Ilokano-speaking provinces manifest lower fertility levels than other regions of different ethno-linguistic backgrounds. Finally, adherents of the Philippine Independent Church (Aglipayan) and Protestantism tend to have fewer children when compared to Catholics and the followers of other religions.

**Table 8**
**Mean number of child ever born to ever married women aged 45-49 years by selected background variables**

| BACKGROUND VARIABLE | MEAN CEB | BACKGROUND VARIABLE | MEAN CEB |
|---|---|---|---|
| Level of Education | | Respondent's Occupation | |
| primary or less | 6.8 | professional | 3.8 |
| intermediate | 6.5 | clerical | 3.9 |
| high school | 5.4 | sales | 6.1 |
| some college | 4.8 | services | 5.4 |
| with college degree | 3.6 | agriculture | 6.6 |
| Place of Residence | | production | 5.9 |
| urban | 5.0 | housekeeper | 6.3 |
| rural | 6.5 | others | 5.5 |
| Husband's Occupation | | Religion | |
| professional | 4.0 | Roman Catholic | 6.1 |
| clerical | 4.8 | Protestant | 5.6 |
| sales | 5.3 | Iglesia ni Kristo | 6.4 |
| services | 5.2 | Aglipayan | 5.0 |
| agriculture | 6.8 | Islam | 5.8 |
| production | 5.4 | others | 6.2 |
| non-gainful | 5.3 | | |
| others | 5.9 | TOTAL | 6.0 |

Source: 1988 NDS

Findings on fertility differentials generally point to the importance of improving the status of women (i.e., through education and the provision of jobs outside of the home) and the economic conditions of families as measures for reducing fertility in the longer term. These also suggest the need to pursue intensive family planning information campaigns and service delivery among lower class and poorly educated women both in the rural and urban areas.

## Reproductive Intentions

Data on reproductive intentions provide another measure of the desire of couples to regulate their births and hence, of the demand for family planning. The 1986 CPS indicates that as many as 55 percent of currently married women then did not want to have anymore children. The desire to stop childbearing became more pronounced (exceeding 60 percent) amomg women reaching 30 to 34 years of age, those who have had three children, and those who have been married for 10 years or more.

There are indications that increasingly more women want to stop childbearing. Results from the latest 1993 NDS reveal that 50.7 percent of currently married women do not want to have another child, while another 12.2 percent say that they have already been sterilized, and 3.1 percent believe themselves infecund. Together, these figure yields a total of 66.3 percent who do not want to, or cannot bear anymore children (Table 9).

**Table 9**
**Desire for more children and age of currently married women**

| DESIRE FOR CHILDREN | CURRENT AGE | | | | | | | TOTAL |
|---|---|---|---|---|---|---|---|---|
| | 15-19 | 20-24 | 25-29 | 30-34 | 35-39 | 40-44 | 45-49 | |
| Want Another | | | | | | | | |
| within 2 years | 19.0 | 9.8 | 10.6 | 10.6 | 8.9 | 6.1 | 4.1 | 9.0 |
| after 2 years | 52.7 | 48.8 | 30.7 | 15.4 | 7.2 | 2.1 | 1.0 | 18.7 |
| not sure when | - | 0.4 | 0.6 | 0.4 | 0.3 | - | 0.1 | 0.3 |
| Undecided* | 7.8 | 8.3 | 8.3 | 7.1 | 4.7 | 2.1 | 1.2 | 5.7 |
| Want No More | 17.8 | 30.6 | 43.4 | 52.6 | 57.5 | 64.6 | 60.6 | 50.6 |
| sterilized | - | 0.8 | 5.4 | 12.6 | 19.2 | 20.8 | 16.9 | 12.2 |
| declared infecund | 1.0 | 0.7 | 0.8 | 1.1 | 1.9 | 4.2 | 15.2 | 3.1 |
| MISSING | 0.6 | 0.6 | 0.1 | 0.2 | 0.4 | 0.2 | 0.8 | 0.3 |
| TOTAL | 100.0 | 100.0 | 100.0 | 100.0 | 100.0 | 100.0 | 100.0 | 100.0 |

*Undecided whether want another child
Source: 1993 NDS

As with the 1986 CPS, the proportion of women who want to stop childbearing in the 1993 NDS increases from 52.6% for women aged 30-34 to 57.5% for women aged 35-39 and to well over 60.0% for those 40 and older. At the same time, married women in their prime reproductive years express a wish for longer years of child spacing. Around half of women 15 to 24 want to have their next birth only after two years. Of those 25 to 29, 30.7% want to have another child after two years, but the plurality, consisting of a higher 43.4% would want to stop childbearing altogether.

## Family Size Desires

The 1986 CPS reveals that the average number of children desired by ever-married women is 3.8. The younger generation of Filipino women, however, want to have smaller families than their older counterparts. Those who are younger than 25, and those who have been married for less than five years want to have no more than three children. In contrast, women who are 35 years old or older and who have been married for 10 or more years want a larger family of at least four children (Table 10).

**Table 10**
**Mean total number of children desired, current age, family size and marital duration of all ever married women**

| ITEM | MEAN | ITEM | MEAN | ITEM | MEAN |
|---|---|---|---|---|---|
| Current Age | | Current Family Size | | Marital Duration (in Years) | |
| 15-19 | 3.0 | 1 | 2.6 | 0-4 | 2.9 |
| 20-24 | 3.0 | 2 | 2.9 | 5-9 | 3.4 |
| 25-29 | 3.4 | 3 | 3.4 | 10-14 | 4.0 |
| 30-34 | 3.8 | 4 | 4.1 | 15-19 | 4.2 |
| 35-39 | 4.1 | 5 | 4.7 | 20-24 | 4.3 |
| 40-44 | 4.3 | 6+ | 5.3 | 25-29 | 4.9 |
| 45-49 | 4.4 | TOTAL | 3.8 | 30+ | 5.9 |

Source: 1986 CPS

Based on the 1986 CPS data on actual and desired family size, the demand for fertility control and regulation appears highest among women aged 25 to 34, and whose achieved fertility and desired family size are almost identical (between three to four children). Women under 25 wish to have one child more than they currently have, whereas older women (35 years and over) already have more births than they say they would have wished to have.

Roughly similar trends are noted from the analysis of the 1993 NDS data on the "ideal number of children" that women say they would like to have. Results from the 1993 NDS shows that the ideal number of children among all women is 3.2 (Table 11). The single largest proportion of women (34.1 percent) would like to have exactly three children, while another 30.5 percent would like to have fewer than this number. Close to two-thirds (64.6 percent) of Filipino women, therefore, would like to have three or less children, as against a lower third who would like to have four or more children. The 1993 NDS likewise shows that younger Filipino women have lower long-term fertility goals than their older counterparts. The mean ideal number of children for women under 35 is closer to three children, while those 35 and older prefer to have around four children.

**Table 11**
**Ideal number of children among currently married women by number of living children**

| IDEAL NUMBER OF CHILDREN | NUMBER OF LIVING CHILDREN | | | | | | | TOTAL |
|---|---|---|---|---|---|---|---|---|
| | None | 1 | 2 | 3 | 4 | 5 | 6+ | |
| 0 | 1.0 | 0.2 | 0.0 | 0.0 | 0.0 | 0.2 | 0.1 | 0.5 |
| 1 | 3.1 | 8.7 | 2.3 | 1.1 | 0.8 | 0.9 | 0.9 | 2.7 |
| 2 | 37.8 | 39.3 | 42.8 | 10.8 | 13.2 | 8.9 | 6.8 | 27.8 |
| 3 | 35.7 | 35.1 | 30.5 | 58.7 | 16.3 | 28.3 | 23.3 | 34.1 |
| 4 | 16.1 | 12.6 | 18.9 | 20.3 | 56.9 | 17.5 | 26.0 | 21.5 |
| 5 | 2.8 | 2.0 | 2.6 | 5.1 | 7.2 | 32.7 | 11.2 | 6.3 |
| 6+ | 1.4 | 1.4 | 2.4 | 3.3 | 4.9 | 10.1 | 28.5 | 5.5 |
| Non-numeric response | 2.0 | 0.5 | 0.4 | 0.7 | 0.8 | 1.5 | 3.2 | 1.5 |

Source: 1993 NDS

When the 1993 NDS data on fertility preferences (ideal number of children) are compared with the TFRs derived from the same data source, one notes that TFR levels across rural and urban areas and the country's regions are always higher than the the ideal number of children expressed by women

from these places. The differences between the TFRs and the ideal number of children provide some indication of the incidence of surplus or unwanted fertility among women. Between rural and urban areas, Table 12 shows surplus fertility to be much higher among rural women who have 1.42 children more than they say they would like to have. Across regions, it is also interesting to note that surplus fertility are highest among regions that currently exhibit the highest TFRs. Women from the Bicol region, for example, who manifest the highest TFR have 2.57 children more than they wish to have, while those in Eastern Visayas and Northern Mindanao have 1.76 and 1.71 children more respectively. These findings underscore the need to improve family planning services in the rural areas and in the less developed regions with the highest birth rates.

**Table 12**
**Total fertility rate and ideal number of children by rural and urban residence and by region**

| BACKGROUND CHARACTERISTICS | TOTAL FERTILITY RATE | MEAN CEB | SUR-PLUS |
|---|---|---|---|
| Residence | | | |
| Urban | 3.53 | 3.10 | 0.20 |
| Rural | 4.82 | 3.40 | 1.42 |
| Region | | | |
| National Capital Region | 2.76 | 2.90 | 0.14 |
| Cordillera | 5.05 | 3.80 | 1.25 |
| Ilocos | 4.25 | 3.40 | 0.85 |
| Cagayan Valley | 4.20 | 3.20 | 1.00 |
| Central Luzon | 3.87 | 3.40 | 0.47 |
| Southern Tagalog | 3.86 | 3.10 | 0.76 |
| Bicol | 5.87 | 3.30 | 2.57 |
| Western Visayas | 4.24 | 3.20 | 1.04 |
| Central Visayas | 4.38 | 3.10 | 1.28 |
| Eastern Visayas | 4.86 | 3.10 | 1.76 |
| Western Mindanao | 4.46 | 3.10 | 0.76 |
| Northern Mindanao | 4.81 | 3.10 | 1.71 |
| Southern Mindanao | 4.23 | 3.10 | 1.13 |
| Central Mindanao | 4.81 | 4.20 | 0.61 |
| TOTAL | 4.09 | 3.20 | 0.89 |

Source: 1993 NDS report

## Family Planning Knowledge

Awareness of family planning and/or contraceptive methods has always been high among Filipino women, reaching close to universal levels (94.2 percent) since the late 1970s and increasing slightly to 95.9 percent in 1993. Between 1978 to 1993, knowledge and awareness levels increased for all family planning methods, but particularly for female sterilization, rhythm or natural family planning (NFP), and withdrawal which registered over 17 percentage point-increases over the 15 year-period (Table 13). As of 1993, the most known methods are the pill, the condom, female sterilization and the IUD (known by over 90 percent). Family planning methods requiring male participation or cooperation like male sterilization, rhythm/NFP and withdrawal are known by a fewer 82 to 89 percent of currently married women. The least known methods are injections (53.5 percent) and diaphragm/jelly (31.07 percent).

**Table 13**
**Percentage of currently married women who know the method**

| METHOD | SURVEY YEAR | |
|---|---|---|
| | 1978 | 1993 |
| Pill | 90.2 | 96.0 |
| IUD | 86.4 | 90.9 |
| Injection | * | 53.5 |
| Diaphragm/Foam Jelly | 21.2 | 31.0 |
| Condom | 87.6 | 93.7 |
| Female Sterilization | 74.7 | 92.2 |
| Male Sterilization | 69.6 | 81.7 |
| Rhythm | 65.9 | 86.4 |
| Withdrawal | 65.3 | 88.7 |
| Others | * | 8.1 |
| ANY METHOD | 94.2 | 97.2 |

* - no data available

Source: 1978 RPFS and 1993 NDS reports

## Trends in Ever-Use of Family Planning Methods

Despite women's high awareness of contraceptive methods and their expressed preference for smaller families, women's use of family planning methods has not consistently risen over time. The NDS survey rounds indicate that after rising in the early 1970s, the proportion of currently married women who had ever used a family planning method declined from 57.5 percent in 1978 to 52.0 percent in 1983 and to 54.6 percent in 1988. The proportion of ever-users appears to be once more on the upswing, however, and reached 61.1 percent in 1993 (Table 14). The troughs in family planning usage in the 1980s have been attributed to the weakened political and financial support accorded the national population program during this decade when the country underwent severe economic and political crises.

**Table 14**
**Percentage of women who ever used a contraceptive method by method**

| METHOD | SURVEY YEAR | |
|---|---|---|
| | 1978 | 1993 |
| Pill | 24.7 | 29.9 |
| IUD | 7.0 | 7.8 |
| Injection | * | 1.2 |
| Diaphragm/Foam Jelly | 2.2 | 0.5 |
| Condom | 20.1 | 9.6 |
| Female Sterilization | 4.5 | 11.9 |
| Male Sterilization | 0.6 | 0.5 |
| Rhythm | 23.1 | 19.4 |
| Withdrawal | 31.0 | 23.3 |
| Others | * | 2.1 |
| ANY METHOD | 57.5 | 61.1 |

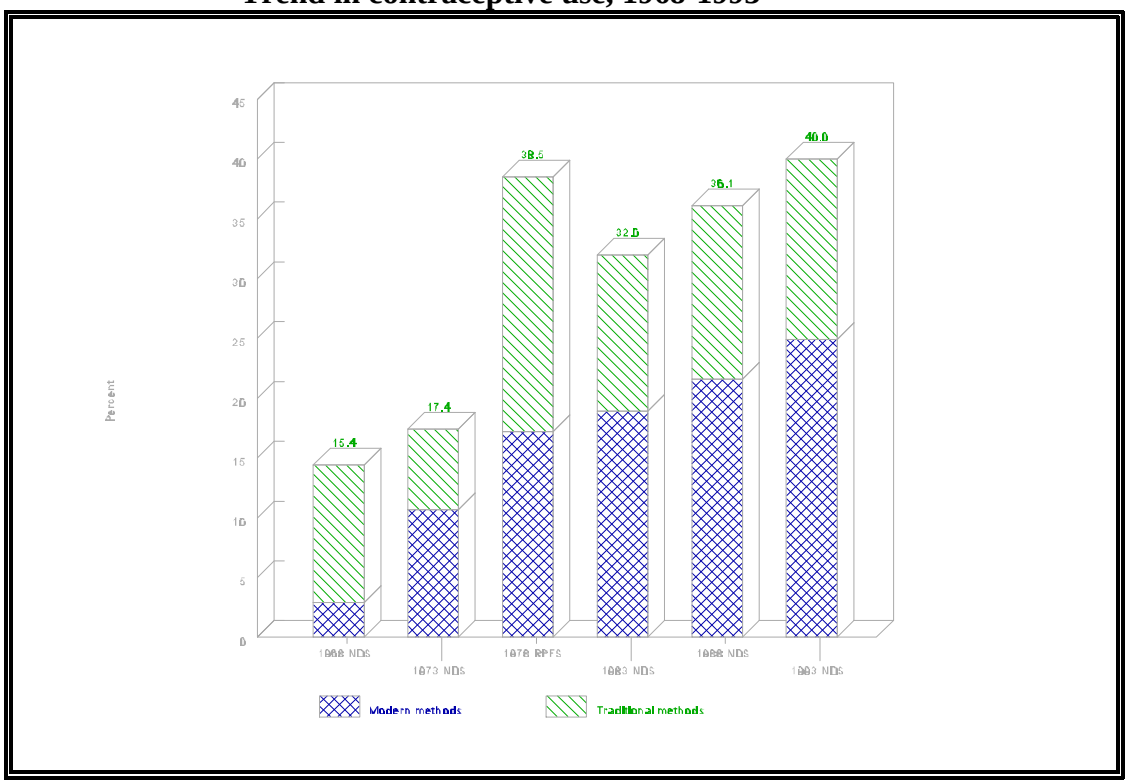
* - no data available
Source: 1978 RPFS and 1993 NDS reports

A comparison of the proportion of ever-users in 1978 and 1993 shows that the 3.6 percent percentage point-increase in ever-users during the period owes primarily to an increase in the number of women who have opted for sterilization and which rose from 4.55 percent in 1978 to a more substantial 11.9 percent in 1993. Pill ever-users also increased from 24.7 to 29.9 percent, while IUD ever-users remained somewhat stationary at 7.0 to 7.8 percent. Ever-use of other methods declined, however, with rhythm/NFP ever-users dropping by a large 19.7 percentage points, condom-users by 10.5 percentage points, and those practicing withdrawal by 7.7 percentage points.

## Trends in Contraceptive Prevalence

The trends in contraceptive prevalence rates (CPR) or in the proportions of married women currently using a form of family planning display similar patterns as those noted for ever-users. Time-series data from the 1968 to 1993 NDS reveal a much more rapid rate of family planning adoption in the 1970s, with the CPR rising from 15 percent in 1968 to 39 percent in 1978, or by over a 160 percent during the 10 year-period. In contrast, the CPR rose by a mere two percent in the subsequent 15-year period: from 39 percent in 1978 to 40 percent in 1993 (see Figure 2). Again, one notes that the slower increase in CPRs in the latter period is due to declines in family planning usage in the 1980s when CPR levels were lower than the 39 percent noted in 1978. The slower rate of family adoption in the 1980s also partly explains why the country's birth rate which began to decline in the 1970s did not decline as fast as in other Southeast Asian countries.

**Figure 2**
**Trend in contraceptive use, 1968-1993**




Source: 1968, 1973, 1983, 1988 and 1993 NDS reports;
and 1978 RPFS report

Of the 40 percent current users in 1993, 25 percent were using modern methods, while 15 percent were using traditional methods (Table 15). Of the modern methods, the most popular is female sterilization (12%), followed by the pill (9%), and the IUD (3%). Reflecting the female bias of modern contraceptive technologies and of family planning programs, male contraceptive forms as male sterilization and the condom are employed by a minimal 1.4 percent of married couples. Of the traditional methods on the other hand, roughly equal proportions of around 7 percent each rely on rhythm /NFP methods and on withdrawal. NFP and withdrawal are the third ranking family planning method currently in use, next to female sterilization and the pill.

**Table 15**
**Contraceptive method currently used by currently married women, by selected background variables**

| BACKGROUND CHARACTERISTICS | ANY METHOD | MODERN METHODS | | | | | | | | TRADITIONAL METHODS | | | | NOT USING ANY METHOD | TOTAL |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | Any Modern Method | Pill | IUD | Injec-tion | Foam/ Jelly | Con-dom | F. Steri-lization | M. Steri-lization | Any trad. method | Nat. FP Method | With-drawal | Other Methods | | |
| Age | | | | | | | | | | | | | | | |
| 15-19 | 17.2 | 9.6 | 7.0 | 2.7 | - | - | - | - | - | 7.6 | 2.0 | 4.9 | 0.7 | 82.8 | 100.0 |
| 20-24 | 31.9 | 18.9 | 13.3 | 4.1 | 0.1 | - | 0.6 | 0.8 | - | 12.9 | 4.9 | 7.5 | 0.5 | 68.1 | 100.0 |
| 25-29 | 39.1 | 23.5 | 13.3 | 3.3 | - | 0.1 | 1.4 | 5.4 | - | 15.6 | 7.1 | 7.9 | 0.6 | 60.9 | 100.0 |
| 30-34 | 45.8 | 29.0 | 10.9 | 3.8 | 0.1 | - | 1.6 | 12.0 | 0.6 | 16.7 | 9.0 | 7.5 | 0.2 | 54.2 | 100.0 |
| 40-44 | 43.1 | 27.0 | 3.5 | 1.9 | - | - | 0.7 | 20.5 | 0.4 | 16.2 | 8.8 | 7.1 | 0.3 | 56.9 | 100.0 |
| 45-49 | 27.2 | 19.4 | 0.7 | 1.5 | - | - | 0.4 | 16.1 | 0.8 | 7.9 | 3.7 | 3.9 | 0.3 | 72.8 | 100.0 |
| Residence | | | | | | | | | | | | | | | |
| urban | 43.0 | 27.6 | 9.0 | 2.9 | 0.1 | - | 1.3 | 13.9 | 0.4 | 15.4 | 7.8 | 7.3 | 0.2 | 57.0 | 100.0 |
| rural | 36.8 | 21.9 | 8.0 | 3.2 | 0.1 | - | 0.6 | 9.6 | 0.3 | 14.9 | 6.8 | 7.5 | 0.5 | 63.2 | 100.0 |
| Educational Attainment | | | | | | | | | | | | | | | |
| no education | 10.8 | 7.2 | 1.6 | 1.4 | - | - | - | 3.8 | 0.4 | 3.6 | 2.1 | 1.1 | 0.3 | 89.2 | 100.0 |
| primary | 34.5 | 21.5 | 7.0 | 2.6 | - | - | 0.4 | 11.1 | 0.4 | 13.0 | 5.2 | 7.3 | 0.4 | 65.5 | 100.0 |
| secondary | 43.8 | 27.6 | 10.1 | 3.5 | 0.1 | - | 1.2 | 12.3 | 0.4 | 16.1 | 7.6 | 8.1 | 0.5 | 56.2 | 100.0 |
| higher | 47.1 | 28.5 | 9.4 | 3.3 | 0.1 | - | 1.9 | 13.5 | 0.2 | 18.6 | 11.1 | 7.4 | 0.1 | 52.9 | 100.0 |
| Number of Children | | | | | | | | | | | | | | | |
| 0 | 1.9 | 0.6 | 0.6 | - | - | - | - | - | - | 1.3 | 0.7 | 0.6 | - | 98.1 | 100.0 |
| 1 | 26.7 | 13.9 | 9.7 | 2.5 | - | - | 1 | 0.7 | 0.1 | 12.7 | 5.9 | 6.5 | 0.4 | 73.3 | 100.0 |
| 2 | 44.0 | 25.4 | 13.1 | 4.3 | 0.1 | 0.1 | 1.4 | 6.3 | 0.2 | 18.5 | 9.9 | 8.0 | 0.6 | 56.0 | 100.0 |
| 3 | 51.5 | 35.5 | 10.1 | 4.0 | - | 0.1 | 1.2 | 19.5 | 0.6 | 16.1 | 7.7 | 8.0 | 0.4 | 48.5 | 100.0 |

**Table 15 continued...**

| BACKGROUND CHARACTERISTICS | ANY METHOD | MODERN METHODS | | | | | | | | TRADITIONAL METHODS | | | | NOT USING ANY METHOD | TOTAL |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | Any Modern Method | Pill | IUD | Injec-tion | Foam/ Jelly | Con-dom | F. Steri-lization | M. Steri-lization | Any trad. method | Nat. FP Method | With-drawal | Other Methods | | |
| Region | | | | | | | | | | | | | | | |
| Cordillera | 38.6 | 23.1 | 3.4 | 2.1 | - | - | 1.7 | 15.9 | - | 15.5 | 7.6 | 7.9 | - | 61.4 | 100.0 |
| National Capital | 41.9 | 27.3 | 9.4 | 1.6 | 0.1 | - | 1.1 | 14.8 | 0.2 | 14.6 | 7.1 | 7.5 | - | 58.1 | 100.0 |
| Ilocos | 38.8 | 21.9 | 6.8 | 0.9 | - | 0.2 | 1.2 | 12.8 | - | 16.9 | 5.5 | 10.9 | 0.5 | 61.2 | 100.0 |
| Cagayan Valley | 41.1 | 32.2 | 14.9 | 2.9 | - | - | 0.8 | 13.3 | 0.2 | 8.9 | 2.9 | 6.0 | - | 58.9 | 100.0 |
| Central Luzon | 43.8 | 30.9 | 9.4 | 1.1 | 0.1 | - | 1.3 | 19.1 | - | 12.8 | 3.2 | 9.6 | - | 56.2 | 100.0 |
| Southern Tagalog | 35.2 | 22.6 | 5.8 | 3.4 | - | - | 0.9 | 12.5 | - | 12.6 | 4.5 | 7.9 | 0.2 | 64.8 | 100.0 |
| Bicol | 36.4 | 16.1 | 6.5 | 1.0 | 0.3 | - | 0.9 | 6.9 | 0.5 | 20.2 | 7.5 | 12.3 | 0.3 | 63.5 | 100.0 |
| Western Visayas | 39.7 | 23.4 | 9.7 | 1.6 | - | - | 1.0 | 9.9 | 1.3 | 16.3 | 10.1 | 6.0 | 0.1 | 60.3 | 100.0 |
| Central Visayas | 46.1 | 28.8 | 9.6 | 4.7 | - | 0.1 | 1.6 | 11.5 | 1.2 | 17.3 | 8.8 | 8.4 | 0.1 | 53.9 | 100.0 |
| Eastern Visayas | 35.9 | 18.2 | 6.0 | 1.8 | - | - | 0.2 | 10.2 | - | 17.8 | 9.8 | 6.6 | 1.4 | 64.1 | 100.0 |
| Western Mindanao | 28.5 | 16.7 | 8.7 | 1.7 | - | - | 0.2 | 5.9 | 0.2 | 11.8 | 7.3 | 3.3 | 1.1 | 71.5 | 100.0 |
| Northern Mindanao | 49.3 | 31.3 | 12.3 | 9.1 | 0.2 | - | 1.4 | 8.2 | 0.2 | 18.0 | 13.2 | 4.3 | 0.5 | 50.7 | 100.0 |
| Southern Mindanao | 45.9 | 27.1 | 8.5 | 5.5 | - | - | 1.2 | 11.0 | 0.9 | 18.8 | 11.3 | 6.6 | 0.9 | 54.2 | 100.0 |
| Central Mindanao | 32.5 | 20.4 | 6.7 | 7.3 | - | - | - | 6.2 | 0.2 | 12.1 | 8.4 | 2.9 | 0.8 | 67.5 | 100.0 |
| Religion | | | | | | | | | | | | | | | |
| Roman Catholic | 40.8 | 25.3 | 8.9 | 3.1 | 0.1 | - | 1.0 | 11.9 | 0.3 | 15.5 | 7.3 | 7.9 | 0.3 | 59.2 | 100.0 |
| Protestant/Other | 36.0 | 22.8 | 6.7 | 2.7 | 0.1 | 0.1 | 1.2 | 11.6 | 0.5 | 13.2 | 7.3 | 5.3 | 0.7 | 64.0 | 100.0 |
| TOTAL | 40.0 | 24.9 | 8.5 | 3.0 | 0.1 | - | 1.0 | 11.9 | 0.4 | 15.1 | 7.3 | 7.4 | 0.4 | 60.0 | 100.0 |

Source: 1993 NDS

The 1993 NDS further shows that current family planning use increases with age, with CPR levels rising from under 40 percent among women aged 20 to 29 to over 40 percent among those 30 to 39. As expected, non-permanent methods as the pill and withdrawal are preferred by younger women (20-29) who are in their early stage of family formation. Female sterilization is more popular among older women (35 and over) who have completed their families and want to stop childbearing. NFP users, on the other hand, are found mostly among women aged 30 to 39.

Based on the prevailing CPR levels in 1993, around 60 percent of currently married women are not shown to be employing any form of family planning, and in no region does the CPR reach 50 percent (Table 16). The regions with CPR levels higher than the national average of 40 percent are Metro Manila, Cagayan Valley, Central Luzon, Central Visayas, and Western and and Northern Mindanao, while all other regions exhibit CPR levels below the national average.

**Table 16**
**Contraceptive prevalence rates by region, 1983-1993**

| REGION | CONTRACEPTIVE PREVALENCE | | |
|---|---|---|---|
| | 1983 | 1988 | 1993 |
| Cordillera | * | 32.4 | 38.6 |
| National Capital | 45.9 | 42.1 | 41.9 |
| Ilocos | 30.0 | 31.6 | 38.8 |
| Cagayan Valley | 24.3 | 36.1 | 41.1 |
| Central Luzon | 43.0 | 38.0 | 43.8 |
| Southern Tagalog | 28.2 | 34.6 | 35.2 |
| Bicol | 18.7 | 28.2 | 36.4 |
| Western Visayas | 27.1 | 33.6 | 39.7 |
| Central Visayas | 28.5 | 37.4 | 46.1 |
| Eastern Visayas | 25.2 | 33.7 | 35.9 |
| Western Mindanao | 30.4 | 32.7 | 28.5 |
| Northern Mindanao | 34.3 | 41.9 | 49.3 |
| Southern Mindanao | 41.7 | 44.3 | 45.9 |
| Central Mindanao | 19.7 | 26.1 | 32.5 |
| TOTAL | 32.1 | 36.1 | 40.0 |

* - no data available
Source: 1983, 1988 and 1993 NDS

## Other Measures of Family Planning Demand

More recently, the World Bank has proposed two other measures of family planning demand in keeping with the changed emphasis of the national family planning program after 1987. These measures which are articulated in the PFPP 1990-1994 Plan include a measure for a family planning health-based demand, and another for a fertility preference-based demand.

Women in need of family planning on health grounds are identified by their age, parity (or number of children) and birth spacing. Accordingly, a pregnancy is assumed to present women with an elevated health risk if women:

- are less than age 20 or are 35 years or older;
- have already had at least 4 live births; and
- are less than 15 months post-partum and not amenorrheic (implying a birth interval of less than 24 months).

Using results from the 1986 CPS, the World Bank estimates that 60.9 percent of currently married Filipino women aged 15 to 44 fall into one or more of the above categories. Taking those women with a need to space births (women less than 15 months post-partum and
women under age 20), and those with a need to limit births (women with four or more births and aged 35 and older), 28.4 percent are assessed to be in need of family planning but are not currently using any method. When added to the 45.8 percent shown in the 1986 CPS to be using some form of family planning, the estimate yields a 74.2 percent potential health-based demand for family planning (Table 17).

**Table 17**
**Total potential demand according to health-based criteria**

| RISK | DEMAND | | TOTAL POTENTIAL DEMAND |
|---|---|---|---|
| | Unmet demand | Current use | |
| Spacing | 8.5 | 5.7 | 14.2 |
| Limiting | 19.9 | 26.7 | 46.6 |
| Not at risk | - | 13.4 | 13.4 |
| TOTAL | 28.4 | 45.8 | 74.2 |

Source: World Bank (1991)

Preference-based demand for family planning is derived from women's responses to questions on whether or not they intend or want to have another birth. Using the 1986 CPS again, the World Bank estimates that 26.1 percent of currently married women aged 15 to 44 express a desire to either space or limit their births but are not currently using any form of contraception. In terms of preference, total potential demand amounts to 71.9 percent if the 26.1 percent expressing an unmet need is combined with the 45.8 percent of women currently practicing a method to space or limit their births (Table 18).

**Table 18**
**Total potential demand according to preference-based criteria**

| RISK | DEMAND | | TOTAL POTENTIAL DEMAND |
|---|---|---|---|
| | Unmet demand | Current use | |
| Spacing | 6.2 | 13.2 | 19.4 |
| Limiting | 19.9 | 32.6 | 52.5 |
| TOTAL | 26.1 | 45.8 | 71.9 |

Source: World Bank (1991)

## Need for Other Indices

To date, the available indices of family planning demand are based exclusively on data collected on and from women. There has been little attempt to collect data on men's own fertility desires or intentions, their patterns of contraceptive use, and their family planning method preferences. Because family size results from the joint decisions of husbands and wives, it is important that demographic and fertility surveys include men as respondents. In fact, studies and researches focusing on male fertility preferences and contraceptive behavior are needed at this time to refine existing measures of family planning demand.

# Factors Affecting the Supply of Family Planning Services

## Changes in Government Policy with Regard to Population and Family Planning

Following the change in government in 1986, and the ratification of a new Constitution in 1987, the government of the Philippines embarked on reassessing and redirecting the 20-year old national family planning program adopted in 1970. This brought about certain changes in state policy which were meant to address some of the criticisms of the old program and guide the implementation of the new program. The more important of these changes are as follows:

- The new population policy delineates the national family program from broader population and development issues. In turn, this has resulted in a shift in stated program goals from the reduction of national fertility levels to improving family welfare by providing accurate and timely information and services to support the fertility decisions of individual couples.
- While the new program recognizes the contributions that family planning makes to fertility reduction and slowed population growth, it places emphasis on the family welfare and health rationales for family planning. Hence, the new program aims to be responsive to couples who express a desire to plan their families, and to be active in promoting the health benefits of family planning particularly for mothers and children.
- In line with the new Constitution, the new program is guided by the principle of respecting the rights of individual couples to determine the size of their families and to choose voluntarily, the means of family planning which conform with their moral conviction and religious beliefs.

## Change in Implementing Agency

The new population policy has also shifted responsibility over the national family program from the Population Commission (POPCOM) to the Department of Health (DOH) while POPCOM continues to address broader population and developmental issues. The assignment of the primary responsibility for defining national family planning policies and for delivering family planning services to the DOH recognizes that family planning is basically a health concern with a matching demographic impact.

By assuming the primary responsibility for family planning program implementation, the DOH will need to:

- execute and manage the different components of the family planning program, including service delivery, IEC, training, management information system (MIS), and logistics; and

- coordinate the family planning activities of local government units (LGUs), other government agencies (Gos), non-government organizations (NGOs), and private practitioners, including specifying the roles of DOH and other public and private agencies with regard accreditation, flow of funds, contraceptive supply and resupply, and training and IEC support for family planning.

## The 1990-1994 Philippines Family Planning Program (PFPP) Goals and Objectives

The overall goal of the new PFPP is to support couples in managing the risks and outcomes of their reproductive behavior in legally permissible and medically acceptable ways. It defines couples' demand for family planning in terms of:

- their fertility aspirations as their expressed desire to space or limit the number of their children; and

- the health needs of families, and hence the identified risks posed by pregnancy and childbirth to mothers and children.

The general objective of the PFPP is thus to respond to the demand of families for assistance in meeting their fertility and health aspirations by providing family planning services in government health facilities and through other cooperating agencies.

Based on data and information available in 1989, the 1990-1994 Program Plan sets the following objectives and targets for the period:

- an increase in the number of family planning acceptors annually from 1.4 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 percent in 1989 to 53.4 percent in 1994;

- an increase in the proportion of women at risk practicing family planning from 25 percent in 1988 to 50 percent in 1994;

- a decrease in the drop-out rate among acceptors of family planning from 50 percent in 1990 to 37.4 percent in 1994; and

- continuing services to the needs of the 36 percent of MCRA's currently using family planning.

The foregoing targets however, need to be modified in light of new information and data that have become available since 1989. The modification and updating of targets should also take into account the measures which the DOH has adapted so far to organize and upgrade its service outlets and resources for implementing the PFPP.

## Program Thrusts

Consistent with the changes in state policy, the current 1990-1994 National Family Planning Program Plan identifies the following program thrusts for the new program:

- an integrated approach to the delivery of health, nutrition and family planning services, a subset of which is the integration of family planning as a vital component of maternal and child health;

- the conduct of information, education and motivational activities in the promotion of family planning services in tandem with other development programs, taking personal beliefs and cultural values in consideration;

- the provision of full and sustained information on medically-approved and legally-acceptable family planning services as the couple's basis for free choice;

- the assurance of accessibility to and availability of family planning services;

- the support to programs enhancing the status and role of women;

- the advocacy of policies and measures which can reduce the imbalance in population distribution as this relates to inequities in the social structure.

**Program Strategy**

The 1990-1994 Program Plan has also developed a seven-point strategy for implementing the new program. This seven-point strategy aims to:

- put in place during the first two years the facilities, manpower, and mechanisms in areas with high unmet needs to strengthen service delivery, IEC, organization, mobilization, logistics, program monitoring and evaluation, while implementing in advance a more appropriate set of activities in regions with better service track record;

- ensure the availability and accessibility of full information and services of all medically and legally-approved methods of contraception in all areas;

- implement innovative approaches along the integration of family planning with other development concerns through community participation and the mobilization of motivational networks;

- develop and strengthen coordinating and monitoring mechanisms among participating agencies at various levels

- widen and strengthen IEC and motivation efforts towards the promotion of responsible parenthood among MCRAs and non-MCRAs;

- provide professional and technical training for program professionals and volunteers; and

- develop and implement a more relevant research program and information base for the formulation, monitoring and evaluation of policies and program activities.

## Information, Education and Communication

Changes in policy and implementing guidelines call for other changes in the conduct of family planning activities, including the provision of IEC services. An assessment of previous IEC program activities therefore, can provide some insights on how to improve future IEC efforts.

An inventory and analysis of the family planning IEC materials produced by major government agencies (POPCOM, DECS, DOH and DOLE) and non-government organizations (FPOP, PCF, IMCH and the Center for Family Affairs) showed a total of 654 family planning program IEC materials produced between 1975 to 1990. Most of these were produced in 1975 to 1980 when an average 48 new materials were issued annually.

Following the much lower levels of political and economic support given the family planning program in the 1980s, the production of IEC materials declined to an average of 41 yearly during the period 1981 to 1986, and dropped even further to 22 per year from 1987 to 1990 (Table 19). The PFPP thus requires the production of new materials that will also reflect the changed objectives and thrusts of the new program.

**Table 19**
**Period IEC materials were produced**

| YEAR | % | N | YEARLY AVERAGE |
|---|---|---|---|
| 1975-1980 | 44 | 286 | 47.7 |
| 1981-1986 | 37 | 245 | 40.8 |
| 1987-1990 | 13 | 87 | 21.6 |
| Not Indicated | 6 | 36 | * |
| TOTAL | 100 | 624 | 44.6 |

* - not applicable
Source: An inventory and analysis of FP IEC, FP AKAPS studies and FP training programs. Quezon City: University of the Philippines-College of Mass Communication, 1990.

The University of the Philippines-College of Mass Communications (UP-CMC) which undertook the inventory and analysis of FP-IEC materials in 1990 also found an over-reliance on print media in earlier IEC materials. Audiovisual (12 percent) and film and broadcast media (11 percent) have not been tapped as widely. Considering that family planning practice is inversely correlated with educational attainment and other socioeconomic indicators, the report recommends that the present trend be reversed since print media requires a higher literacy level among the target audience when compared with other media forms (Table 20).

**Table 20**
**Media form used**

| MEDIUM | % | N |
|---|---|---|
| Print | 65 | 425 |
| Audiovisual | 12 | 77 |
| Film/Broadcast | 11 | 74 |
| Souvenirs | 6 | 37 |
| Performance | 4 | 29 |
| Outdoor | 1 | 6 |
| Others | 1 | 6 |
| TOTAL | 100 | 654 |

Source: An inventory and analysis of FP IEC, FP AKAPS studies and FP training programs. Quezon City: University of the Philippines-College of Mass Communication, 1990.

The 1993 NDS provides some indication of the reach of audiovisual (radio and television) family planning campaign messages. Its results show that only about half of the survey's women respondents have heard of a family planning message over the radio, or seen a similar one on TV during the month prior to the survey interview.

Expectedly, the proportions of women who have never heard of family planning over the radio or on television are higher among rural women (55.9 percent) and among those with no or little education (59.5 to 85.9 percent), than among urban women and those with higher education (Table 21).

**Table 21**
**Family planning messages on radio or on television**

| BACKGROUND CHARACTERISTICS | Neither | Radio Only | Television Only | Both |
|---|---|---|---|---|
| Residence | | | | |
| Urban | 44.6 | 12.5 | 11.7 | 31.0 |
| Rural | 55.9 | 21.4 | 3.1 | 19.2 |
| Region | | | | |
| National Capital Region | 38.8 | 6.2 | 22.3 | 32.7 |
| Cordillera | 15.2 | 43.6 | 1.1 | 40.2 |
| Ilocos | 46.6 | 7.0 | 4.9 | 41.5 |
| Cagayan Valley | 51.1 | 36.1 | 1.5 | 11.0 |
| Central Luzon | 28.9 | 20.1 | 7.8 | 43.2 |
| Southern Tagalog | 50.1 | 15.0 | 9.3 | 25.5 |
| Bicol | 61.0 | 23.2 | 4.2 | 11.3 |
| Western Visayas | 64.0 | 15.5 | 1.4 | 19.1 |
| Central Visayas | 58.5 | 17.3 | 5.1 | 18.7 |
| Eastern Visayas | 57.6 | 20.9 | 2.1 | 18.6 |
| Western Mindanao | 59.0 | 22.8 | 2.1 | 15.6 |
| Northern Mindanao | 61.1 | 16.4 | 2.2 | 20.1 |
| Southern Mindanao | 56.7 | 15.1 | 4.7 | 22.5 |
| Central Mindanao | 56.8 | 23.4 | 2.4 | 17.1 |
| Education | | | | |
| No education | 85.9 | 6.6 | 1.7 | 5.3 |
| Elementary | 59.5 | 20.4 | 4.0 | 15.8 |
| High school | 48.9 | 16.8 | 8.5 | 25.6 |
| College or higher | 36.0 | 11.9 | 12.2 | 39.6 |
| TOTAL | 49.5 | 16.4 | 8.0 | 25.9 |

Source: 1993 NDS report

Across regions, those least reached by radio and TV family planning messages are the Bicol region, Western, Central and Eastern Visayas, and Western and Northern Mindanao, where the proportions who have never heard of family planning over broadcast media are closer to 60 percent.

In terms of content, most of the earlier family planning IEC materials contain messages on population and development, general contraceptive use, small family size, general family planning concepts and responsible parenthood. The change in the national population policy calls for a realignment of IEC materials along the new goals and thrusts of the PFPP. Following are some of the suggestions that have emerged to improve the production and content of IEC materials:

- MCRAs are a much too diverse group to reach with the same IEC materials. There is a need to further "segmentalize" the FP-IEC audience, with some priority given to rural residents and the urban poor.

- Consistent with the new emphasis on the health rationale of the PFPP, IEC materials must highlight the linkages between family planning practice and improved maternal and child health. IEC materials must point to the high incidence of maternal and infant/child mortality and morbidity associated with high-risk pregnancies (those occurring under age 20, less than 15 months post-partum, after four children and by age 35 and onwards), and to the health benefits that come with family planning practice.

- IEC materials must likewise impart full and technically correct information about program methods and their use, and engender positive attitudes towards the practice of family planning.

- Additionally, IEC materials must address clients' fear of side effects and highlight the clients' satisfaction with their chosen methods. In this connection, IEC materials should correct misinformation and other rumors about the effects of the pill and other contraceptives.

- In line with the new policy of placing the responsibility on the family and not just on women, IEC materials must be developed for men. These should aim to raise the currently low levels of vasectomies and condom use, and highlight men's responsibility as fathers and contraceptive partners.

- Finally, IEC materials should also include not only thematic messages but also tactical ones, e.g., where to go for family planning information and for specific forms of contraceptives or family planning methods.

## Training

As with the development and production of IEC materials, the DOH needs to step up its family planning training activities in order to meet the targets of the PFPP. Based on the Program's projected training accomplishments, the DOH should have trained 48,919 health workers and professionals in basic and specialized family planning skills and in various refresher courses by the end of 1994.

The UP-IMC inventory and analysis of family planning training activities from 1975 to 1990 show that majority of the participants in earlier training programs belong to middle management and supervisory positions (65 percent), and that fewer came from the rank and file (34 percent). A Knowledge, Attitude, Skills and Practice (KASP) study done by the Asia Research Organization (ARO) among midwives also showed that about a fourth of midwives had no training on family planning. Of those who have been trained, the majority were trained on basic family planning services, while only 35 percent were trained on IEC activities and 15 percent on counselling. Method specific training and training on particular service delivery skills also remain insufficient. Only a third of midwives have been trained to dispense pills, and only a tenth on IUD insertion.

Subsequent training of midwives should therefore take into account the foregoing findings and the training needs that midwives have identified for themselves. The ARO study indicates that midwives desire specialized forms of training which will raise their knowledge and skills in a particular aspect of family planning service delivery. Midwives would like to be trained on IUD insertion, the use of audiovisual aids, counselling, interpersonal communication and campaign planning. The majority also wish to be informed more on the side effects of different family planning methods and on the effectiveness of each family planning method.

Another recently completed study on the performance of volunteer family planning workers -- the Barangay Service Point Officers (BSPOs) and Barangay Health Workers (BHWs) -- carried out in Iloilo by the Social Science Research Institute of Central Philippine University (CPU-SSRI) notes that

BSPOs and BHWs lack confidence in their skills as family planning counsellors, which they cite as a major drawback in the performance of their functions. Accordingly, the study recommends the conduct of family planning training for BSPOs and BHWs suited to local needs and which will respond to the BSPOs' and BHWs' desire for improving their counselling and referral skills in family planning.

With assistance from the United Nations Fund for Population Activities (UNFPA), the Basic/Comprehensive Course in Family Planning for nurses and midwives has been revised for the PFPP. The new material which have been developed for the course was introduced to the regions in late 1991. An evaluation of the training course undertaken in September 1993 indicates a number of findings which should also be taken into account in developing future training materials for health personnel.

The course raised the overall knowledge of trainees on family planning although major gaps in knowledge exist with regard the health benefits of family planning and the side effects or complications arising from the use of different contraceptive methods. More specifically:

- 34 percent of trainees could not name four advantages of oral contraceptives;
- 59 percent could not list five early pill danger signs;
- 38 percent could not name three modern methods of natural family planning; and
- 47 percent could not describe how to identify when ovulation has occurred using banal body temperature.

With regard maintaining client records, deficiencies were noted in the following areas:

- 50 percent did not maintain complete medical histories of clients
- 42 percent did not obtain and record the complete obstetric history of clients.

Other studies done by the University of the Philippines-Population Institute (UPPI) and DOH have also noted that health workers themselves have little appreciation of the health benefits of family planning, with some expressing negative attitudes about the practice. Since these impede their effectiveness as family planning counselors and service providers, it has also been suggested that training contents and materials include more information on the health benefits of family planning, promote positive and supportive attitudes about the health benefits of family planning and contraceptive use, and raise the skills of health workers in motivating MCRAs for family planning and in the provision of family planning services.

## Number and Distribution of Service Outlets

As of 1992, the inventory of family planning service outlets done by DOH shows that the Department had accredited a total of 2,244 service outlets nationwide. These outlets are mostly rural health centers or RHUs (1,856), and include some hospitals (321) and a few social hygiene clinics (18) and other facilities (10). Based on DOH projections, the number of accredited service outlets should have reached 4,400 in 1992. However, the figure shown above corresponds only to the projected number for 1990, suggesting a two-year backlog in the number of DOH accredited family planning service outlets. Other than DOH, there are a few other government outlets consisting mostly of local government units (LGUs) and NGOs offering family planning services.

Metro Manila, and Central and Southern Luzon account for a greater number of DOH service outlets (over 200 each) owing also to the larger populations of these regions. Most of the 301 hospital outlets offer both sterilization and reversible contraceptive methods, while a third provide sterilization only and six hospitals provide only reversible contraceptive methods. For the most part, rural health centers also offer only reversible contraceptive methods.

At the national level, there are approximately 3.71 family planning service outlets for every 100,000 Filipinos. Only six regions surpassed this national average. These include some of the less developed

regions like the Cordillera, Eastern Visayas and Cagayan Valley. The other regions are the Ilocos, Northern Mindanao and Southern Mindanao. Even in these regions, however, the service outlet to population ratio is not very favorable. The Cordillera which exhibits the highest ratio has 7.07 service outlets per 100,000 population.

Based on the 1990-1994 PFPP Plan, the program should have doubled the number of service outlets to over 4,000 by the end of 1994 for the programs to meet its targets. The foregoing available figures indicate the need to establish new family planning service outlets and improve the ratio between these and the population.

## Accessibility and Availability of Contraceptives

In terms of distance to service facilities or outlets, the 1990 Survey of Accessibility to Contraceptives (SAC) reveals that a high 94 percent of the rural women live within some 30 kilometers (km) of an RHU which could be reached by the most common form of transportation within 10 to 30 minutes during the dry season and within 10 to 45 minutes in the rainy season. As many as 74 percent of rural women likewise had access to the Barangay Health Station (BHS). These RHUs and BHUs usually offer pills and condoms, and sometimes IUDs.

A substantial 45 percent of the population also live within a 30-km distance to a public hospital, although fewer (42 percent) have access to a private NGO facility or NGO offering family planning services. Hospitals generally offer tubal ligation, in addition to the pill, condoms and IUD. NGOs carry the pill, condoms and IUD.

Measuring accessibility in terms of the availability of contraceptive supplies in at least one facility that is within a 30-km distance from clients, the SAC further shows that the pill is available to virtually all rural women in each of the country's regions (90 to 100 percent); followed by the condom shown available to anywhere between 40 to 100 percent; and tubal ligation, 33 to 100 percent. The IUD is available to 30 to 86 percent, while vasectomy is the least available form, reaching fewer regions and only between three to 31 percent of the population. There are also substantial regional variations in the availability of specific contraceptive methods. In general, Northern Mindanao and Western Visayas which exhibit contraceptive prevalence rates higher than the 40% national average, also

exhibit higher figures of contraceptive availability for all forms of contraceptives. The 1990 SAC provides some evidence that increasing the accessibility of contraceptives in localities also increases local contraceptive prevalence rates.

In line with the client-centered focus of the PFPP and to operationalize its thrust of providing couples a basis for free choice, it is also essential that measures be taken to ensure the availability of all forms of family planning methods in clinics, to include surgical and modern contraceptives and information on breastfeeding and natural family planning methods.

## Clinic Performance and Quality of Services

Although the majority of married couples are reached by an RHU or by other family planning service outlets, studies indicate that much needs to be done to improve the performance of clinics and the quality of their services.

An operations research on clinic performance done in 1991 shows that clinic management employ different methods for determining their family planning acceptor targets. Moreover, whatever targets are set, clinic personnel consider as satisfactory a 52 percent attainment of target even as they now attain 64 percent of their targets on the average. The study further shows that clinic managers and staff are happy if they can service family planning acceptors at 10 to 15 percent below their clinics' servicing capacity, although again on the average, actual servicing amounted to about 25 percent of capacity.

The UPPI study traces the satisfaction of clinic managers/staff with the target accomplishments and with low servicing capacity to the inadequacy of resources and to the limited number of personnel in many clinics. In particular, the study notes the heavy workloads of BHWs who are expected to perform some 28 daily and weekly responsibilities, of which only four are related to family planning and maternal and child health. To improve clinic performance in family planning service delivery, these findings indicate a need to review the resources and staff available in clinics. Measures should be taken to ensure that clinics meet the minimum standards set by the DOH with regard to clinic equipment, supplies and resources, and the ratio of clinic staff (doctors, nurses, midwives and BHWs) to the population that they serve.

The UPPI study further shows that most clinic managers and support staff do not know how many eligible but unserved family planning practitioners they have in their respective areas. In turn, this owes to the lower priority that the DOH places on such things as contraceptive coverage, incidence or prevalence. Planned as facility-based rather than as a population- or community-based program, the DOH family planning program is concerned more with making available the services that it has to clients who come to the clinics, rather than with proactively promoting its health in communities.

There are as yet no common standards or definitions for high quality family planning service performance. Clinic managers and staff tend to associate this with the clinics' ability to keep continuing users, attract new acceptors and reduce local fertility rates and maternal mortality rates. The DOH and the PFPP on the other hand, define quality service in terms of other standards such as the assurance of safety in methods and supplies, cost-efficient coverage of service outlets, availability of a range of choices, correctness and completeness of information provided to potential acceptors, among others. Still other studies mention other elements of quality of care including the choice and number of methods given by clinics on a reliable basis, the technical competence of service providers, the information given to clients, and the personal dimensions of service. The UPPI study suggests further research on quality service factors as perceived by clinic management and by clients.

At present, the UPPI study reveals that the strongest determinants of acceptors'overall satisfaction with clinics are the clinics' location, the processing for their contraceptive supply and resupply, and the processing of the client's first visit. Acceptors generally like clinics that are near, convenient, not crowded and with clean surroundings. They also like clinics that thoroughly check on their needs on first visit, and promptly and efficiently process the provision of their contraceptive supplies.

## Client Satisfaction with Family Planning Methods

The 1993 NDS provides some data on the satisfaction of women with family planning methods. The data on method satisfaction, however, were elicited only from women current users, and not from women who were dissatisfied with their methods that they stopped or discontinued their use.

The large majority (90 percent or more) of the current pill, IUD, condom, female sterilization, NFP and withdrawal users in the 1993 NDS reported they have no problems with their methods (Table 22). The remaining few who had problems were more likely to complain of side effects particularly from using the pill. Condom users, on the other hand, complained more of inconvenience.

**Table 22**
**Problems with current method of contraception**

| Main Problem | Pill | IUD | Condom | F. Sterili-zation | M. Sterili-zation | NFP | With-drawal | Others |
|---|---|---|---|---|---|---|---|---|
| No problem | 89.4 | 93.6 | 87.5 | 91.2 | (83.6) | 97.0 | 89.4 | (97.7) |
| Husband disapproves | 0.2 | 0.2 | 0.0 | 0.1 | (0.0) | 0.4 | 0.4 | (0.0) |
| Side effects | 5.9 | 4.1 | 1.0 | 5.9 | (5.3) | 0.8 | 3.7 | (2.3) |
| Health concerns | 2.7 | 1.6 | 1.0 | 2.6 | (0.0) | 0.4 | 3.4 | (0.0) |
| Access/availability | 0.1 | 0.0 | 0.0 | 0.0 | (0.0) | 0.0 | 0.0 | (0.0) |
| Cost | 0.2 | 0.0 | 0.0 | 0.0 | (0.0) | 0.0 | 0.1 | (0.0) |
| Inconvenient to use | 0.6 | 0.5 | 9.4 | 0.0 | (0.0) | 0.6 | 1.7 | (0.0) |
| Sterilized/want children | 0.0 | 0.0 | 0.0 | 0.1 | (2.8) | 0.0 | 0.0 | (0.0) |
| Other | 0.1 | 0.0 | 0.0 | 0.1 | (5.6) | 0.3 | 0.5 | (0.0) |

Source: 1993 NDS report

Method-specific discontinuation rates that were similarly calculated from the 1993 NDS may also be indicative of the satisfaction of clients with family planning methods. Table 23 shows that discontinuation rates (within 12 months after the start of use) are highest for the condom (59 percent), followed by withdrawal (41 percent) and the pill (40 percent). Discontinuation rates are lower among NFP users (31 percent) and the lowest for IUD (22 percent). Overall, one in three users is likely to discontinue with the method during the first year of use.

**Table 23**
**First-year discontinuation rates for contraception**

| METHOD | REASONS | | | | |
|---|---|---|---|---|---|
| | Method failure | Desire to become pregnant | Side effects/ health concerns | Others | All reasons |
| Pill | 5.1 | 6.6 | 13.9 | 14.4 | 40.1 |
| IUD | 2.5 | 2.1 | 7.6 | 10.2 | 22.4 |
| Condom | 15.1 | 5.7 | 3.9 | 34.5 | 59.2 |
| NFP | 15.6 | 4.8 | 1.0 | 9.8 | 31.3 |
| Withdrawal | 20.6 | 3.7 | 2.5 | 12.9 | 35.4 |
| All methods | 11.6 | 4.6 | 6.4 | 12.8 | 35.4 |

Source: 1993 NDS report

The major reasons for discontinuation are side effects/health concerns for the pill, and method failure for the condom, NFP and withdrawal. Those citing "other reasons," however, also constitute a substantial 34 percent of those who had used the condom, and a considerable 10 to 14 percent of those who had used the pill, IUD, and withdrawal. It is possible that "other reasons" may have something to do with the lack of quality in service provision, or in the motivation and support given to clients by family planning workers.

## Referral System

A recent study on the referral system of family planning service outlets also done by UPPI indicates this to be poorly functioning. The family planning directories used are outdated and referral forms are either not used or not standardized. The procedures of referring clients, too, are not uniform, and recording and reporting processes are therefore divergent.

The number of referrals made and received by family planning outlets are few, comprising 22 per clinic on the average. Of these, a number are referrals for maternal and child health services suggesting a potential for positive interaction between health and family planning service delivery. The demand for maternal and child health services may augment the delivery of family planning services and vice versa.

The tendency of workers in one agency to refer family planning clients to another clinic of the same agency owes to the fact that family planning clinics carry a limited range of contraceptives. But because clinics in the same areas also provide the same methods, referrals work against the best interests of the clients for more accessible and convenient sources of family planning services.

The study suggests that an area analysis of the availability of contraceptives be undertaken to improve the complementarity of methods provided by family planning outlets, since family planning clinics do not carry all forms of contraceptives. In addition, the fact that outlets refer clients to other outlets for methods which are already available in their clinics (more commonly, the pill, condoms and IUD) indicates a need to equip or supply clinics with a variety of brands for each form of contraceptives.

Most referred clients report obtaining their information and services from the midwife rather than from family planning workers. The majority (60 percent) of the referred clients also have a method in mind when they come to the family planning outlets, while the remaining 40 percent are open to suggestions regarding what method they should use. The study findings show, however, that the information provided by clinics to clients are almost entirely confined to program methods or to methods available at the clinics.

Finally, 82 percent of referred clients actually pay (in cash or in kind) or make a voluntary contribution for the family planning services they receive. This indicates that clients are beginning to value family planning and are willing to pay for their contraceptive supply and related services.

## Family Planning Activities of Other Government Agencies

As the lead agency for family planning policy formulation and program implementation with purview over the family planning activities of other organizations, the DOH is expected to forge new relationships with other government agencies, local government units (LGUs) and NGOs with family planning-related programs. This will require imparting the new health-thrust of the PFPP to these groups and agencies, as well as avoiding the interagency conflicts that characterized the interagency bodies set up to coordinate the national population program in the past.

The government agencies which have been earlier mobilized to support the national population program are the DECS, DOLE, BAEX, DENR, the National Nutrition Center and LGUs. For the most part, the family planning IEC and service activities of DECS, DOLE, BAEX and DENR are focused on population-development or population-resources concern, so that there is a need to infuse these with the health-thrust of the mew program. Since the DECS' population education courses currently reach the school population in the elementary, secondary and tertiary levels, it is also important that health-based family planning materials be introduced in the adult extension, basic literacy and out-of-school youth programs of the DECS' Bureau of Non-Formal Education. The same should be done with the factory-based population and family welfare programs of Dole, with the extension programs of BAEX and DENR. The above programs currently serve the poorer and less educated sectors of the rural and urban population, who have less access to family planning information and services.

## LGUs

In the past, LGU involvement in the Family Planning Outreach Program has taken the form of financing, political backing and the provision of human resources. In the cities, LGUs provide budgetary support for all health personnel except for the City Health Officer for whom the DOH provides. In the provinces, the DOH provides for most staff who are then assisted by volunteer workers consisting of LGU-supported BHWs, BSPOs and nutrition scholars. In terms of financing, the LGUs' share of outreach costs had reached 85 percent of total costs in 1987, or around 42 percent of the government's outlays for family planning.

With the passage of the Local Government Code, LGUs are now expected to assume the major role in the provision and delivery of social services to households, including those of health and family planning. To date, however, no systematic effort has been made to note the level of support for family planning and the number of LGUs interested in making this one of their priority programs. Given differences in the nature of local problems, it is expected that LGU support for family planning will vary greatly across cities and provinces.

It is suggested that LGUs who express an interest or a commitment in expanding family planning services in their areas be prioritized for family planning program assistance. The assistance should include outreach and IE campaigns, training, clinic and equipment upgrading, and operations research for management and the monitoring and evaluation of their local programs. Since LGU support is needed to ensure the success of the program, it is further suggested that some demonstration cities and provinces be adopted to show the beneficial effects of family planning on households and localities.

With the devolution of health functions and services to LGUs, a clearer delineation of roles and responsibilities is needed between the DOH on the one hand, and the Health Offices and Population Offices of LGUs on the other. Points to be considered in the division of tasks are the complementation of outreach and service-delivery activities, and which office will assume primary responsibility over specific activities. Finally, all concerned offices should aim for improved cooperation and coordination, since previous experience indicates that disharmonious relationships adversely affect the performance of frontline service providers and volunteer workers coming from different units or offices.

## NGO Family Planning Activities

NGOs have always been active participants in the country's family planning program and the new PFPP calls for stronger linkages between DOH and NGOs, and envisions the expansion of NGO involvement in family planning. Nearly 600 NGO service outlets are estimated to account for between 15 to 23 percent of all family planning clinics and clients, and for a similarly substantial proportion of new acceptors. The three largest family planning NGOs that operate nationally are the Institute of Maternal and Child Health (IMCH), the Family Planning Organization of the Philippines (FPOP) and the Institute of Maternal and Child Health-SDI. In addition, there are many other regional and local NGOs engaged in family planning service delivery.

To improve the coordination and complementation of family planning services, it is essential to update the existing directory and inventory of NGOs engaged in family planning work at local and national levels. Among others, this directory must include the location of NGO facilities, the type of family planning or contraceptive methods promoted by their programs, the other forms of health and family planning services that they provide, and the basic socioeconomic characteristics of their respective clients.

To expand NGO participation in the PFPP, the program should increasingly tap the women- and youth-NGOs working on reproductive health. Other than direct service provision, the program should also build on the advocacy strengths of NGOs to generate popular and political support for promoting the health benefits of family planning practice.

## Monitoring, Evaluation and Research Activities

Most evaluations of the family planning program in the past were carried out nationally and by external donors who tended to focus on program outcomes rather than on the services and effectiveness of the program. The change in program policies and strategies again requires changes in the program's information and monitoring systems. The following recommendations have emerged in these areas:

- The PFPP's base population data for planning and monitoring need to be updated, to reflect the results of the latest 1990 Census and adjusted for internal migration movements and changing marriage or nuptiality patterns.

- Given variation across provinces and the time required to await and aggregate data from the field, it is desirable to begin setting up a system for monitoring family planning objectives and performance at the level of LGUs (i.e., at the province- or city-level). This process should be started particularly for LGUs who express an interest in prioritizing family planning activities in their localities.

- The PFPP's reporting and monitoring system should give more balanced attention to continuing users and not only to new acceptors. Service statistics, therefore, should include ways of monitoring the incidence of continuing use and of family planning drop-outs in localities.

- The program's information system must likewise introduce health parameters to monitor services provided to high risk groups. This requires a closer coordination of the statistics collected by the program and those collected by other units engaged in maternal and child health.

- Finally, program objectives should be expressed in ways that are meaningful to health workers, and which focus attention on the clients that they serve, rather than on percentage of target accomplishments or indicators.

In addition to the NDS which have been used to monitor program outcomes in the past, following

are the suggestions for new research directions and activities:

- Demographic surveys which exclusively focus on MWRAs must be expanded to include young unmarried adults as well as men, to gain a better understanding of young adult fertility behavior and of men's fertility preferences and contraceptive practices.

- Surveys and studies must likewise be devised to provide more information on the infant/child/maternal health aspects of family planning. Such surveys should be designed to provide estimates of the prevalence of pregnancies to women of various health risk categories, the incidence of infant/child mortality by maternal characteristics, and other estimates of child feeding practices, post-partum duration, maternal and child morbidity incidences, and the use of health services by the population.

- Also considered a priority are smaller-scale and localized surveys on the underlying reasons or motivations for contraceptive behavior to raise current understanding of the continuing gap between the expressed family size desires of Filipinos and their contraceptive practice.

- Operations research should be increasingly done at local levels (i.e., for provinces or cities), in view of the wide variations in local level interest, capacity and resources for family planning. Provincial or city-based operations research also ensures the rapid utilization of results by local program managers and service-providers.