

## I. Background

**In 2005, the United Nations Population Fund (UNFPA), United Nations Children's Fund (UNICEF) and United Nations Development Programme (UNDP) will be harmonizing program cycles in the Philippines in response to UN Secretary General Kofi Annan's call for reforms within the UN System. The Reform Agenda proposes a coherent vision and strategy for the United Nations through a unified approach towards common developmental goals. The country programme formulation for the three UN agencies will be preceded by an analysis of the national development situation called the Common Country Assessment (CCA), and the strategic planning for operational activities known as the United Nations Development Assistance Framework (UNDAF).**

The CCA is the common Instrument of the UN System to analyze the national development situation and identify key development issues. Both a process and product, the CCA takes into account national priorities. It focuses on the Millennium Development Goals (MDGs) and other commitments, goals and

targets of the Millennium Declaration and international conferences. These include, among others, the International Conference on Population and Development (ICPD) and the World Summit on Social Development (WSSD), Beijing.

The UNDAF, on the other hand, is the common strategic framework for the operational activities of the UN System at the country level. It provides a collective, coherent and integrated UN response to national priorities and needs within the framework of the MDGs and the other commitments, goals and targets. It emerges from the analytical and collaborative effort of the CCA and is the foundation for the UN System's programmes of cooperation.

UNFPA is committed to supporting the UN Reform Agenda. Hence, UNFPA's programming guidelines were substantially revised in 2003 to integrate UNFPA's participation in the CCA and UNDAF processes, and to incorporate the MDG along with the ICPD goals as the platform for UNFPA's programme focus.

In the conduct of the CCA, UNFPA is expected to take the lead, in consultation with the Government, in identifying and analyzing the root causes of population and reproductive health (RH) issues, identifying stakeholders, selecting priority areas, and recommending interventions. UNFPA's main contribution to the CCA is the analysis of the population and reproductive health situation.



## II. Process

In preparation for the CCA and the 6<sup>th</sup> Country Programme of Assistance to the Government of the Philippines, the UNFPA Philippines Country Office commissioned the Situational Analysis of the Philippine Population (SAPP) to a group of local experts in February 2003. The SAPP consisted of two major parts: (1) an in-depth analysis of the population, reproductive health and gender situation, including policies, programs and institutional arrangements, identifying critical needs and opportunities; and (2) general recommendations for strategic action by key stakeholders, and specific proposals for UNFPA intervention in order to address these needs and take advantage of emerging opportunities.

To promote country ownership of the document, the SAPP was conducted under the overall guidance and oversight responsibility of a National Committee chaired by the Secretary of Socioeconomic Planning and co-chaired by the UNFPA Representative. The National Committee was multisectoral and multidisciplinary, with participation from government, civil society, women and youth groups, media, academic institutions, the private sector, UN agencies and the donor community.

Among the core members of the National Committee were: the National Economic and Development Authority (NEDA), Department of Health (DOH), Commission on Population (POPCOM), Department of Education (DepEd),

Department of Social Welfare and Development (DSWD), National Commission on the Role of Filipino Women (NCRFW), University of the Philippines Population Institute (UPPI), National Anti-Poverty Commission (NAPC), and Philippine NGO Council on Population, Health and Welfare (PNGOC). The National Committee was convened three times to review the document. Valuable comments and suggestions for improvement were provided by the National Committee. The final draft of the SAPP was submitted to UNFPA on June 11, 2003.

The SAPP was conducted from February to June 2003. The revised programming guidelines were received by the Field Office in April 2003. The guidelines provided specific steps to be followed in the population and reproductive health analysis. The SAPP, however, did not exactly follow the stages provided for in preparing the population and RH analysis document. While the SAPP identified and extensively analyzed a whole range of issues and problems in population and reproductive health, the core problems were not singled out. Moreover, no systematic causality analysis of the core problems was done. Also, while current institutional arrangements were described, there was no assessment of the capacity of UNFPA and its key partners to address the identified core problems in population and RH.

## III. Population and Reproductive Health Analysis

To address these gaps, UNFPA organized a workshop among its national, regional and provincial partners from June 2-4, 2003 in Tagaytay City. The Population and Reproductive Health Analysis is the output of this workshop.

### A. Identifying Core Problems in Population and RH

From a cluster of concerns and issues in population and reproductive health, three major problems emerged:

1. Poor access to quality, culturally and gender-sensitive, and rights-based RH information and services, especially among the marginalized and disadvantaged;
2. Imbalance between rapid population growth and socioeconomic development; and
3. Weak policy environment and poor institutional capacities to address population and reproductive health problems.

### B. Causality Tree Analysis

In conducting the causality tree analysis, three workshop groups were formed, one per problem. The workshop groups identified the manifestations of each problem, and the intermediate, underlying and root causes of each manifestation. A common definition of terms was agreed upon. The manifestation of the problem was defined as something observable and measurable, a condition that can be changed, and a common public concern. The immediate cause pertains to

the primary cause or reason directly leading to, or resulting in, the manifestation of the problem. The underlying cause, on the other hand, was defined as contributing to the primary or immediate cause. It bridges the root and immediate causes. The root cause is the source of the underlying cause, that is, the original cause. Data were supplied by the SAPP and other secondary sources. At the end of the analysis, the interlinkages among the major problems were identified.

#### ***Problem No. 1: Poor Access to RH Information and Services***

##### **Manifestations of the Problem**

Seven manifestations of the problem were identified:

##### ***a. Increasing number of teenage pregnancies***

Data from the 1998 National Demographic and Health Survey (NDHS) showed that 1 out of every 5 females were married by age 19. By age 24, nearly 60% were married. National data show that more than one-third of young women conceived before marriage. Young mothers (15 to 24 years old) account for 30% of all births, 17% of induced abortion cases, 12% of normal deliveries, 6% of spontaneous abortions, 3 out of 4 maternal deaths, and 74% of all illegitimate births. (State of the Philippine Population Report 2001)



**b. Unmanaged family size**

There is a difference of one child between the actual total fertility rate (TFR) of 3.7 and the desired TFR of 2.7, based on data from the 1998 NDHS. Rural couples' unintended fertility is higher at 1.4 births compared to 0.7 among their urban counterparts. (SAPP 2003)

**c. Pregnancy-related complications**

Estimates based on the 1998 NDHS revealed that 2.4 million Filipino women become pregnant every year, resulting in 2 million full-term births. About 300,000 of these women will experience a major obstetrical complication requiring hospitalization. Forty percent (960,000) will develop some other pregnancy and delivery-related disease/condition. Of the 10.43 million married Filipino women of reproductive age (WRA) in year 2000, about 7.2 million were regarded as high risk. (SAPP 2003)

**d. High incidence of cancer in men and women**

Malignant neoplasms currently rank as the third and fifth leading causes of mortality in the Philippines for females and males, respectively. Among the neoplasms in women, breast cancer remains the number one cause of mortality, followed by cervical cancer. In 1998, the Philippine Cancer Society reported an estimated 9,325 new breast cancer cases and 3,057 expected deaths. For cervical cancer, 4,536 new cases were estimated and 2,204 deaths were expected in the same year. For males, prostatic carcinoma

remains the most common form of reproductive tract cancer, with an estimated 2,226 new cases and 588 deaths in 1998. (SAPP 2003)

**e. High incidence of induced abortion**

The DOH reported that 12% of all maternal deaths were due to abortion. This makes induced abortion the fourth leading cause of maternal deaths. It is estimated that unwanted pregnancies end up in around 400,000 abortions each year. Of these women, 80,000 or 20% were hospitalized for complications. A UPPI-AGI clandestine abortion study estimates the incidence at 25 per 1,000 WRA or 16 per 100 pregnancies. (SAPP 2003)

**f. High incidence of RTIs and predisposition to HIV/AIDS among at-risk groups**

The prevalence rate and transmission of HIV/AIDS in the country remains "low and slow." From January 1984 to February 2003, there were 1,834 HIV antibody seropositive cases reported, of which 598 (33%) have become AIDS cases; of these, 25 (4.2%) have died. Heterosexual intercourse remains the most common mode of transmission at 62.8%, with overseas Filipino workers constituting 27% of those infected. Populations at risk for HIV/AIDS include overseas Filipino workers, sex workers and injecting drug users. While the prevalence of HIV/AIDS may have remained low, the conditions for an epidemic

outbreak are present. Primarily, there is an upsurge in STIs. A survey of social hygiene clinics in 1998 revealed that of those who consulted, 1% had gonorrhea and trichomoniasis, 5% had syphilis, and 6% had chlamydia infections. In 2002, a community survey of STI prevalence done in six areas nationwide showed that women have more types of STIs, and they have higher prevalence of these infections. Among sex workers, the average prevalence rate is 5% for gonorrhea, 35% for chlamydia, 3.5% for syphilis, and 9% for trichomoniasis. (SAPP 2003)

**g. Increasing incidence of violence against women and children (VAWC)**

VAW is defined as “any act of gender-based violence that results in or is likely to result in physical, sexual or psychological harm or suffering to women, including threats of such acts, coercion or arbitrary deprivation of liberty, whether occurring in public or private life.” Of the 6,074 women in especially difficult circumstances served by the DSWD from 1998-2001, 38.1% were physically abused/maltreated/battered, 13.4% trafficked, and 12.3% sexually abused. Of the child victim-survivors, 42% were sexually abused, while 15% were physically abused or maltreated. The 2001 Annual Report of the Philippine National Police (PNP) Women’s Desks, likewise, reported wife-battering (54.8%) and rape (9.92%) as the most common VAW cases. Most of the victim-survivors were 30 years old and younger.

Rape was the most common reported crime against girls at 37.7%. (SAPP 2003)

**Immediate, Underlying and Root Causes**

**Manifestation No. 1: Increasing number of teenage pregnancies**

Many out-of-wedlock teenage pregnancies are the consequence of risky sexual behavior characterized by unprotected sex. The 2002 Young Adult Fertility and Sexuality Survey (YAFSS3) revealed that about 1 out of 5 Filipinos aged 15-24 have had a premarital sex (PMS) experience, with young men showing a level that is double (31.1%) than that of women (15.4%). The 1994 YAFSS data showed that PMS prevalence was much less than, with young men registering a 25% prevalence, and young women only 11%.

YAFSS3 data further showed that only about a third of never-married young adults with PMS experience used contraception during their first sexual contact. (SAPP 2003)

Unprotected sex among the youth, in turn, may be the result of peer pressure, inadequate sex education, or lack of access to family planning services. For young women in difficult circumstances, unprotected sex could be the result of prostitution, rape or incest perpetrated because of their helplessness.

The adoption of a risky lifestyle, however, traces its roots to the type of value system being espoused by our youths. The influence of parents, peers and the environment help



shape the moral fiber and value systems of the youth.

***Manifestation No. 2: Unmanaged family size***

Many individuals and couples fail to realize their desired family size due to unmet need for family planning services. There is a large unmet need for family planning — 20.5% based on the 2002 Family Planning Survey (FPS). This is broken down into unmet need for spacing births (10.6%) and unmet need for limiting births (9.9%). Data on contraceptive prevalence rate (CPR) from the same report showed a decline from 49.5% in 2001 to 48.8% in 2002. This is below the MDG and ICPD target of 55%. (SAPP 2003)

In terms of economic groupings, the poorest quintile has the lowest CPR as well as the highest fertility. This condition hits the poor on two fronts: their having meager resources, and having more children to feed, clothe and educate. This condition chains impoverished Filipinos to a cycle of poverty. (SAPP 2003)

The reasons for this high unmet need and low CPR are many: influence of religion which looks at children, no matter how many, as gifts from God; inability to afford the prices of contraceptives; limited information about how contraceptive techniques work, how to use them and how to avail of them; inadequate access to the sources of contraceptive supplies and services; and husband's objection to family planning coupled with the wife's

powerlessness to assert her reproductive rights. (SPPR 2001)

The root causes of this problem may be traced to culture and religion, poor governance and poverty.

***Manifestation No. 3: Pregnancy-related complications***

In the Philippines, 10 women die every 24 hours from causes related to pregnancy and childbirth. From 1991 to 1997, there were 172 maternal deaths per 100,000 live births.

The MDG goal is to bring down the maternal mortality rate (MMR) to 105 per 100,000 live births in 2000, and to further reduce it by half in 2015. Most maternal deaths are due to hemorrhage, hypertension and complications from sepsis or widespread infection, obstructed labor, and complications arising from abortion. In the 1998 NDHS, prolonged labor came out as the most common complication (17%), followed by excessive bleeding (7%). The risk factor increases for mothers who are in poor health, who are younger (under 18) or older (over 35), and whose pregnancies are narrowly spaced. (SPPR 2001)

The high level of maternal deaths could be due to gaps in maternal care and to the poor nutritional status of Filipino mothers. While 94.1% of women received some form of prenatal care, only 67.5% of pregnant women had four or more prenatal visits, while 5.9% did not have any visits at all. Moreover, while births assisted by trained health personnel increased from 56% in 1998 to 60.4% in 2002, there were

still 38.5% of births that were attended by traditional birth attendants, many of them untrained. Furthermore, over 18 million Filipinos, mostly women, have iron deficiency anemia, and about half of the 2 million pregnant and breastfeeding women are deficient in iodine, energy and protein intake, and vitamin A. (SAPP 2003)

Women who have closely spaced births and multiple pregnancies are more vulnerable to nutritional deficiencies. These conditions, coupled with the demands of lactation, can lead to “maternal depletion,” a condition that contributes to low birth weight, infant mortality and maternal mortality. Poor nutrition aggravated by multiple pregnancies also make mothers more susceptible to infectious diseases, as well as to complications in labor and delivery, such as massive bleeding, prolonged labor and convulsions. (SPPR 2001)

From a demand point of view, the gaps in maternal care can also be traced to the poor health-seeking behavior of women who are unable to utilize services, either because the facilities are inaccessible (due to distance) or unaffordable (due to cost). From a gender perspective, poor nutrition can be traced to the low priority that wives and mothers give themselves vis-à-vis their husbands and children during meals at home. In view of all these, the root causes can then be traced to poverty, and cultural and traditional values.

#### **Manifestation No. 4: High incidence of reproductive cancers**

The high incidence of reproductive cancers in men and women may be a product of risky behavior and lifestyle, and delayed interventions. Risky behavior and lifestyle refer to bad habits such as smoking, drinking and taking drugs, and having multiple sex partners. Infections and cancers of the breast and reproductive tract are not detected early enough because Filipino women are not in the habit of observing and feeling their bodies, and either neglect to pay attention to or disregard changes

in their bodies or secretions. Furthermore, they are not comfortable with having their private parts examined by doctors, especially if these are men; often, they would seek medical attention only when it is already too late. Again, this can be traced to cultural and religious values.

#### **Manifestation No. 5: High incidence of induced abortion**

The high incidence of abortion can be traced to unplanned and unwanted pregnancies. The UPPI study cited the top three reasons given by married women for terminating a pregnancy: (1) economic reasons; (2) too many pregnancies; and (3) large number of children. Among unmarried women, the most common reasons are: (1) unpreparedness; (2) work demands; and (3) economic reasons. The common denominator is that pregnancy is ill-timed, unplanned and unintended. (SPPR 2001)



Economic difficulty is the most common reason, implying that a good majority of these women are poor. Their primary concern when they opted for abortion was the survival of the family, not the illegality or the health hazards of abortion. Although they considered the prevailing religious prohibition of abortion, the cost of having another child and the impact of this on the entire family prevailed over religious, social, health and legal considerations. (SPPR 2001)

Unplanned and unwanted pregnancies, in turn, are also deeply rooted in gender power relations between husband and wife. The husband's objection to family planning and the wife's acquiescence in the face of spousal disapproval constitute a major factor explaining unmet need. Recent studies show that men tend to be the ultimate decision-makers in sexual relations, childbearing, and child-rearing among couples. There is a belief that by virtue of marriage, a woman becomes her husband's possession and the husband has the right to her body. Sex becomes a woman's obligation to her husband. Some researchers conjecture that wives submit to their husbands' decision in order to preserve marital harmony. This is part of a deeply ingrained cultural value and expectations about women's role. (SPPR 2001)

***Manifestation No. 6: High incidence of RTIs and predisposition to HIV/AIDS among at-risk groups***

The high incidence of RTIs and the predisposition to HIV/AIDS in the

country may be traced to risky behavior, forced sex, weak surveillance and case-finding, and delayed interventions. Majority of sexually active young Filipinos stick to one sexual partner. However, the 2002 YAFSS shows that an estimated 3.4% or 1.6 million of the group aged 15-24 have multiple sex partners. Peer pressure, substance abuse and media influence are key determinants of this risky behavior. Meanwhile, the DOH has estimated the number of injecting drug users at about 10,000. (SAPP 2003)

YAFSS also revealed that while awareness of HIV/AIDS is high among young people, a substantial 23% believe that it is curable. Moreover, 60% of the young have the notion that they are immune from AIDS.

A 1998 survey of the International Labor Organization (ILO) estimated the number of sex workers to be about 500,000 to 2 million. Ofreneo and Ofreneo estimated that about 0.5% of the rural population and about 1% of the urban adult population may be involved in sex work, which predisposes them to HIV/AIDS. (SAPP 2003)

The National HIV Sentinel Surveillance System was established in 1993 to actively monitor HIV/AIDS cases in the country. Starting with two cities and later expanding to 10, the sentinel surveillance at first covered six high-risk groups. These, however, were reduced to four groups in 1997: registered female sex workers,

freelance female sex workers, men who have sex with men (MSM), and injecting drug users.

Currently, surveillance of MSMs, male commercial sex workers (MCSWs) and male clients of STI clinics has stopped in most of the sentinel sites. Thus, changes in the prevalence among these groups can no longer be monitored. Moreover, the surveillance does not cover other at-risk groups such as the overseas Filipino workers and child sex workers. The present sentinel system is thus quite limited in terms of the number of sentinel sites and at-risk groups covered.

Passive surveillance through other existing facilities, on the other hand, suffers from a number of inadequacies, such as underreporting and multiple reporting of cases. (DOH Consensus Report on STI, HIV, and AIDS Epidemiology, 2002)

Access to diagnosis and management of STIs, especially HIV/AIDS, is quite limited; often, interventions are delayed. Aside from the technical difficulty of waiting for the six-month window period after exposure and the cost of the test (which could run up to P500), only about 300 private and public clinics have been accredited as HIV Testing Centers, most of which are located in Metro Manila.

While the care and treatment of HIV/AIDS patients has been decentralized to regional medical centers and some private tertiary hospitals in various parts of the country, most of the equipment, expertise and access to drugs remain concentrated at the San Lazaro

Hospital and the Research Institute for Tropical Medicine. (SAPP 2003)

### **Manifestation No. 7: High incidence of VAWC**

The rising incidence of violence against women and children may be traced both to the psychological makeup of the perpetrator, and the helplessness and powerlessness of the victim. Social learning theorists emphasize that early exposure to violence at home increases the risk of a child becoming abusive in later life. The family provides children with their first experiences in life, and they learn social and gender roles from parents and other influential members of the household.

Thus, parents are a significant influence on their children, frequently serving as role models of good as well as abusive behavior. Empirical studies in the US estimate a 30% likelihood of a child becoming abusive in adulthood, which means that other factors also come into play. (UPCWC, *The Many Faces of Violence*, 1999)

In many societies, women choose to stay in an abusive situation even if they are at death's door. This is due to fear of more violence, embarrassment about the "reputation" of the "good family," and powerlessness to leave the conjugal home because of inadequate financial and employable skills.

Also, many health personnel are not equipped to handle cases of domestic violence, or refuse to report or record this because of



hesitancy to go to court. Police officials do not record wife battering cases as such but label these as physical injuries, or even as "misunderstanding between husband and wife."

From a feminist perspective, analysts see wife abuse as a husband's way of mainstreaming dominance within a patriarchal system, where women are expected to submit to the authority of the men. Male violence is thus a means of controlling women. In a system that expects men to be aggressive, tough and "in control," and women to be tender, gentle and nurturing, any deviation from this model spells trouble for the woman. Hence, the root cause of the high incidence of VAWC is the patriarchal system which assigns a low and inferior status to women. (UPCWC, 1999)

### ***Problem No. 2: Imbalance Between Rapid Population Growth and Socioeconomic Development***

The Philippine population continued to grow rapidly at 2.36% per year from 1995-2000. Given the inherent momentum of population growth, the population will continue to grow well into the second half of the 21<sup>st</sup> century even if fertility declines rapidly. Population projections by the National Statistics Office (NSO) show that the population will grow to 106 million in 2020 and to 125 million in 2040, under the assumption that replacement fertility will be achieved in 2020. (SAPP 2003)

In the meantime, the economy continued to experience a boom-bust cycle. The economy recovered from the Asian financial crisis in 1999, posting a 3.3% growth which increased to 4.5% in

2000. However, economic growth again faltered in 2001 to 3.2% with the political crisis that led to the ouster of President Joseph Estrada. The economy recovered since then, achieving an annual growth rate of 4.6% in 2002. (SAPP 2003)

The uneven economic performance coupled by high population growth partly explain the lack of sustained reduction in poverty incidence. The estimates prepared by the National Statistical Coordination Board (NSCB) show a decline in poverty rate from 49.3% in 1985 to 36.8% in 1997. But poverty incidence increased again to 40.0% in 2000. Rural poverty was twice the rate in urban areas in 2000. (SAPP 2003)

### **Manifestations of the Problem**

The manifestations of this problem were identified at three levels: the individual/household, the community, and the society levels. At the individual/household level, the imbalance takes concrete form in the growing number of street children, the shortage of food, high mortality and morbidity among women and children, more people engaged in hazardous jobs, informal settlers and squatters. At the community level, the imbalance translates into an unstable peace-and-order situation, overcrowding and environmental degradation. At the society level, the imbalance manifests itself in terms of low consumption, investment, government expenditure and net export or, in other words, low gross national product (GNP).

#### ***Manifestation No. 1: Individual/household level***

##### Street children and child labor

Mobility makes it difficult to have an accurate estimate of the number of

street children in the country. The more recent estimate from a study done by Lamberte puts the number of street children at 43,629 in the year 2000. Data from the 2001 National Survey of Working Children conducted by the NSO and ILO showed that of the 24.9 million child population aged 5-17 years, one-third or around 4.0 million were working children. Filipino working children were mostly male, worked in rural areas, and 59.4% or 2.4 million of them were exposed to either hazardous or exploitative conditions, thus compromising their physical, psychosocial and overall well-being. About 23.4% of total working children experienced injuries while at work and 19% suffered work-related illnesses. (UNICEF Mid-Term Review 2002)

#### Shortage in food supply

The aggregate food supply available in the country from domestic production and imports more than satisfies the consumption levels of the population. Based on the 1998-2000 Food Balance Sheets of the Philippines, food supply-consumption ratios for calories, protein and fats were estimated at 133.9%, 136.9% and 139.4%, respectively. And yet, the perception of a food shortage is strong. This is primarily because people are poor and do not have the money to buy the food they need. (Philippine Progress Report on the MDGs, January 2003)

#### High mortality and morbidity among women and children

As earlier discussed, maternal mortality remains high at 172 deaths

per 100,000 live births, based on the 1998 NDHS. This is way above the MDG target of 52.2 deaths per 100,000 live births in 2015. The lifetime risk of dying from pregnancy was 1:100 in 1999, but in remote areas, it went as high as 1:35.5. Maternal mortality accounts for 1% of total deaths in the country and 14% of the deaths of women in the age group 15-49.

The infant mortality rate (IMR) declined from 45.6 to 35.3 deaths per 1,000 live births between 1985 and 1996. Under-five mortality rate was reduced from 72.3 to 48 deaths between 1985 and 2000 based on NSO estimates.

The figures, however, are still much higher than the 2015 MDG target of 19 infant deaths per 1,000 live births and 26.6 deaths per 1,000 children below five years old. The leading causes of infant deaths were respiratory infections, congenital anomalies and diarrhea. Acute respiratory infection (ARI), particularly pneumonia, was one of the leading causes of child deaths. (SAPP 2003)

Over 18 million Filipinos, mostly women, have iron deficiency anemia, while about half of the annual 2 million pregnant and breastfeeding women are deficient in iodine, energy and protein intake, and vitamin A. Among children, the 1999 Multi-Indicator Cluster Survey showed that 16% of children under five had ARI within two weeks prior to the survey.

On the positive side, a marked reduction in measles cases was reported by the DOH, from 35,035 in 1996 to 6,987 in 1999. The



Philippines was declared polio-free in October 2000. (UNICEF Mid-Term Review 2002)

#### Informal settlers and squatters

About 1.3 million informal settler families were counted in key urban centers, 57% of them in Metro Manila, in October 2000. These settlers occupy spaces as follows: government-owned lands - 34%; private lands - 24%; danger areas - 21%; national government infrastructure - 20%; local government infrastructure - 1%. Given an average family size of six, the total number comes up to about 7.5 million informal settlers in October 2000. (Philippines Progress Report on the MDGs, January 2003)

#### ***Manifestation No. 2: Community level***

##### Unstable peace and order situation

The recent war (and continuing violence) in Iraq has had a major impact on the peace and order situation in the country. Terrorist threats by foreign terrorist organizations (FTOs) are now more common and are expected to increase against the US and its allies, including the Philippines. Meantime, in spite of separate negotiations between the Philippine Government and the Communist Party of the Philippines-National Democratic Front (CPP-NDF) and the Moro Islamic Liberation Front (MILF), no end appears to be in sight to the sporadic clashes between government forces and these rebel groups.

The Armed Forces of the Philippines has an ongoing offensive against "embedded terrorist cells" within the

MILF, and this has resulted in a series of bombings by this group in Mindanao and Manila. The NPA has recently resorted to raids of remote police stations, indicating that they remain active and dedicated to their cause.

The more common threat related to living in a large metropolitan city is criminality. Everyday, there are reports of various types of crimes against the general populace, such as snatching and petty robbery to burglary and assault. (UNFSCO 2003)

##### Environmental degradation

The country's natural resource base is rapidly getting depleted. Total forest cover has decreased from 6.2 million hectares in 1990 to 5.4 million hectares in 1997. Mangrove forest cover has been reduced from 139,000 hectares in 1988 to 115,000 hectares in 1996. Only 4.3% of corals remain in excellent condition. An alarming rate of biodiversity loss has also been reported.

Despite being one of the 17 mega-diversified countries with its high concentration of endemic plants and wildlife, the Philippines has been identified by Conservation International as one of the "eight hottest spots in the world" where exceptional concentrations of endemic species are undergoing continued loss of habitat.

Moreover, carbon dioxide emissions, particularly from fossil fuels, have increased. In 1998, the national carbon dioxide emission from fossil fuel burning, cement manufacture

and gas flaring was estimated to be 21 million metric tons of carbon. Per capita emission is at 0.28 metric tons and is still expected to increase. (Philippines Progress Report on the MDGs, January 2003)

**Manifestation No. 3: Society level**

Consumption, investments, government expenditures and net exports

The 4.6% economic growth registered in 2002 was underpinned by a vigorous rise in personal consumption spending and the recovery of exports. On the other hand, investments did not accelerate and the national government deficit exceeded the programmed level, becoming a potential source of macroeconomic instability. (NEDA Socioeconomic Report 2002)

Personal consumption expenditures rose at a healthy pace of 3.9% while government consumption increased to 1.08% (from 0.3% in 2001), due to higher personal services expenditures. Investments took a downturn due to an inventory drawdown of over 100%. The national government deficit stood at PhP210.7 billion (5.3% of GDP) or 62% higher than the original target of PhP130 billion (3.3% of GDP). Exports recovered in 2002, growing by 3.3% from a 5.2% contraction in 2001.

**Immediate, Underlying and Root Causes**

**Manifestation No. 1: Individual/household level**

The growing number of street children can be the result of many

school dropouts due to poverty. Their parents are either jobless or have insufficient incomes to send their children to school; their first priority is the purchase of the family's most basic need: food. It is also poverty that drives parents to force their children to work, even if working conditions are hazardous or exploitative.

High mortality and morbidity among women and children may be caused by supply and demand factors. On the supply side, there may be limited access to quality health information and services. Limited access may be due to the inability of limited health resources to cope with a rapidly growing population. On the demand side, this may be traced to the poor health-seeking behavior of women. Again, this may be because these women are too poor to pay for the cost of health services, and they give priority to the health needs of their husbands and children, sacrificing their own.

The proliferation of informal settlers and squatters is brought about by rural-to-urban migration due to the lack of productive employment opportunities in the rural areas. It can also be traced to the lack of capacity to own land which, in turn, could be due to the inequitable distribution of land, ineffective government housing and zoning policies, and insufficient family income to buy the land. The large number of migrants, in turn, is putting pressure on the environment, and is affecting government's capacity to provide basic services for the population. Cities face serious environmental health challenges and worsening conditions due to rapid



population growth, lack of proper infrastructure to meet growing needs, contaminated water and air, and more garbage than they can handle.

***Manifestation No. 2: Community level***

The armed conflict in Mindanao and rising criminality are the major factors affecting the peace and order situation of the country. The war in Mindanao is deeply rooted in the economic, political and social disparities that Muslims and indigenous peoples have suffered through centuries of neglect.

The determinants of rising criminality, on the other hand, include insufficient family income and the culture of violence and materialism. This can be traced further to poor human capital and rapidly changing social norms and values. Poor human capital is a result of poor health and poor education. Common criminals usually do not have employable productive skills, so they resort to violent acts in order to survive.

More people are using more resources with more intensity than at any point in human history. These factors have combined to put increasing pressure on the environment: population growth and rising consumption; pollution and excessive waste generation; and persistent poverty coupled with the lack of resources and technology, and the lack of power to change these circumstances. Poverty is causing many poor people to use and abuse fragile natural resources

in order to survive; and this puts more pressure on the environment. Limited land availability also leads many poor people to settle in fragile areas. (SWPR 1999)

Where there is overcrowding, environmental conditions contribute significantly to communicable diseases. An estimated 60% of the global burden of disease from acute respiratory infections, 90% from diarrheal disease, 50% from chronic respiratory conditions, and 90% from malaria can be avoided by simple environmental interventions. Unclean water and associated poor sanitation kill over 12 million people globally each year. Densely populated megacities such as Metro Manila subject their populations to air pollution far in excess of levels recommended by the World Health Organization (WHO). (SWPR 1999)

***Manifestation No. 3: Society level***

The rise in personal consumption spending can be traced to the higher per capita income of the population and low inflation. The average inflation rate slowed down to 3.1% in 2002, the lowest since 1987. Higher net factor income from abroad also helped finance consumer spending.

Meanwhile, government consumption rose due to the lifting of the hiring ban, which facilitated the hiring of more teachers and government personnel. Salaries of military personnel were also increased. (NEDA Socioeconomic Report 2002)

Investments slipped due to unforeseen events, such as the September 11 attack in New York, tensions in the Middle East, slow growth of credit to the private sector, and the huge government deficit which eroded business confidence.

The recovery of exports can be traced to the global recovery of the information technology (IT) sector in 2002. There was an expansion of semiconductors and electronic micro-circuits, while agriculture exports, such as desiccated coconut and centrifugal sugar, continued to fare well. One reason for the recovery of exports is the country's growing reliance on East and Southeast Asian markets.

Robust domestic production pushed imports growth to 4.9% from last year's 0.8%. The recovery of exports increased imports of electrical machinery (25.1%) and other machinery (16.0%). Net exports contracted to 15.9%, less steeply than in 2001 (-45.9%).

One reason for the ballooning budgetary deficit is low revenue collection. Total revenue in 2002 grew by a mere 0.6% to reach PhP567 billion, 9.2% below the original program target. The slippage in tax collection may be due to a number of factors, which include lower-than-expected domestic production of oil, decline in collections of taxes from banks due to falling lending rates, underpayment of VAT, excise taxes, and corruption.

### ***Problem No. 3: Weak Policy Environment and Poor Institutional Capacity to Address RH, Population and Development Problems***

#### **Manifestations of the Problem**

This major problem is manifested in unresponsive government policies, poorly designed programs, and poor program implementation.

#### ***Manifestation No. 1: Unresponsive policies***

A review of population policy statements from various official documents from 1969 to 2002 shows that there has been a lack of stable consensus on the policy on fertility, population growth and family planning. While there was a strong fertility reduction objective during the Marcos era, there was none during the Aquino Administration. Instead, family planning as a means to reduce fertility and population growth was rejected, and FP was seen only as a health intervention with possible demographic consequences. The Ramos Administration revived the policy of reducing fertility through the FP program in the early years, but subsequent POPCOM plans showed that FP became part of promoting reproductive health. The Estrada Administration called for an aggressive family planning program to reduce fertility but this administration was short-lived. Under the Arroyo Administration, family planning is again primarily a health intervention and a means to help couples achieve their fertility preference. (Herrin, 2002)



***Manifestation No. 2: Poorly designed programs***

Given the lack of stable consensus on the policy of population and fertility reduction, the family planning program was characterized by shifting objectives of fertility reduction, responsible parenthood, safe motherhood and reproductive health. Operationally, the program started from a clinic-based delivery system to one which incorporates IEC, training and research under the National Population and Family Planning Outreach Project (NPFPOP). A parallel set of population workers vis-à-vis health workers were hired, trained and mobilized under this program during the Marcos era. When FP became a health intervention in 1986, population workers were left with little or no support.

Likewise, the program was transferred institutionally from the Commission on Population to the Department of Health. POPCOM found itself attached to various agencies, depending on what the prevailing policy was during the period. Originally it was under the Office of the President, then it was moved to the National Economic and Development Authority (NEDA) during the Marcos years. In the early years of the Aquino Administration, it was attached to DSWD only to be returned to NEDA during the term of Secretary Solita Monsod. It remained with NEDA under the Ramos and Estrada Administrations, and now has been attached again to the DOH.

***Manifestation No. 3: Poor program implementation***

Family planning program performance is usually measured through the ultimate indicator, fertility, or its intermediate output, contraceptive prevalence. As earlier reported, there is a difference of one child between actual fertility, which is 3.7 children per woman, and desired fertility, which is 2.7 children per woman, based on the 1998 NDHS. Contraceptive prevalence rate even declined from 49.5% in 2001 to 48.8% in 2002, according to the Family Planning Survey. This is below the MDG and ICPD target of 55%. These results point to problems in the implementation of the population and reproductive health program.

**Intermediate, Underlying and Root Causes**

***Manifestation No. 1: Unresponsive policies***

Unresponsive policies may be traced to the lack of a POPDEV perspective among the leaders of government, as well as the shifting thrusts of changing administrations. The change in policy thrusts, in turn, could be attributed to certain major influences to Philippine policymaking in population. These include various international conferences that helped shape the population and development framework, such as the United Nations Conference on Environment and Development (UNCED), ICPD, Fourth World Conference on Women, WSSD, and United Nations General Assembly Special Session (UNGASS).

But perhaps the single most important factor influencing population policymaking since its formulation in 1969 is the persistent and consistent opposition of the Catholic Church to artificial contraception (Herrin, 2002). No organized population group has yet been able to carry out an effective and sustained advocacy campaign against the Church position. There is a lack of a corps of population advocates who will organize, muster support, and carry forward the population agenda. Civil society alliances are weak due to lack of a unifying cause, inadequate technical capacities, and limited resources.

In the end, however, all these boil down to the level of priority attached by the government to the population program. And priority is heavily defined by political motives and intentions. At present, the Arroyo Administration is part of the global alliance with the United States in the fight against terror; this has reaped benefits in terms of upgrading the Philippine military's fighting capacities and securing economic opportunities in Iraq. At the same time, she espouses the conservative views of the Bush Administration on population and family planning.

***Manifestation No. 2: Poorly designed programs***

Current population and RH programs need to be reviewed and redesigned in the light of new evidence provided by recently completed studies and surveys. For example, results of the 2002 YAFSS

should feed into the revision of the adolescent reproductive health program. Moreover, the current programs, including those supported by UNFPA, lack particular focus on the poor and do not incorporate gender rights. The poor design of programs can be traced to the inadequate technical capacity of those tasked to formulate these programs, and the lack of support of the leadership in terms of resources and political commitment.

***Manifestation No. 3: Poor program implementation***

Population and RH programs are poorly implemented because of a number of problems. These include:

- a. Inadequate manpower due to the high turnover of health personnel, especially nurses who leave for better work opportunities abroad. Current salary rates for health personnel, especially for provincial and municipal health staff who were devolved to the local government units (LGUs), are low. The lack of manpower can also be traced to the ban on hiring, which prevents vacancies from being filled up. This is because a certain portion of the health budget must be put in reserve due to the large government deficit.
- b. Poor technical capacities and social skills of service providers arising from the lack of training or the lack of protocols and standards to guide their work. Training and the development of protocols, in turn, cannot be conducted if



- resources are limited and if technical assistance from experts is not available. Only high-priority programs are fully funded.
- c. Lack of health facilities, medical supplies and medicines due to inadequate estimation of requirements, and procurement and distribution mechanisms. For instance, there appears to be a shortage of contraceptive supplies in many areas but the Secretary of Health assures that supplies are adequate. The problem, he says, is in the distribution.
  - d. Inaccessibility of RH services, especially in remote areas because of physical distance and cost of services. Physical barriers are, in turn, due to lack of roads, bridges and communication facilities, while services are unaffordable because people are poor. Finally, programs are poorly implemented in the war-torn areas of Mindanao because of the massive displacement of people. Pregnant women and children are the most affected by the war. War aggravates poverty and violates all rights.
- ponsive policies and programs which impact on the provision of, and access to, quality population and RH information and services.
- b. Inability of the government to integrate population factors in socioeconomic development contributes to poor governance and ineffective delivery of pro-poor, gender-responsive and rights-based services and program implementation.
  - c. Inability of civil society to organize contributes to the inability of government to formulate and implement more responsive programs on population and RH.
  - d. The supply and demand of RH services are affected by culture and gender inequality, inequitable distribution of resources and the level of support/political will of policymakers. It is aggravated by lack of involvement/participation of communities and other stakeholders.

In conclusion, poor RH conditions and powerlessness among the poor and vulnerable groups are mutually aggravated by high population growth rate, inequitable distribution of the benefits from slow economic growth, and the incapacity of government to respond in terms of pro-poor, gender-responsive and rights-based policies and programs in a biased culture.

### ***Interlinkages***

After the causality analysis of the three major problems, the following interlinkages among these problems were identified:

- a. The problem of imbalance between population and socioeconomic development stems from unres-

## IV. Capacity Assessment

A capacity assessment of key stakeholders (DOH, POPCOM, UNFPA, local government units and non-government organizations) was undertaken to determine whether these agencies are ready to address the three main problems that came out of the causality analysis. The strengths, weaknesses, opportunities and threats (SWOT) that each of these stakeholders currently face were identified and discussed. Capacities were assessed using the 7 M's: mandate/mission, management, manpower, money, mechanisms, materials and machine.

### A. Department of Health

The Department of Health is the agency responsible for formulating policies, guidelines and technical standards, and coordinating support for the delivery of reproductive health services. In addition, its 72 national and regional hospitals are engaged in the direct delivery of tertiary services.

The DOH's mission and mandate is to ensure accessibility and quality of health care to improve the quality of life of all Filipinos, especially the poor. Its vision is "health for all." It subscribes to the basic principles of universal access to basic health services, and priority on health and nutrition for vulnerable groups. The national objectives for health include: the improvement of the general health status of the population through a decrease in infant mortality, child mortality, maternal mortality, and total fertility rate; increase in life expectancy, promotion of a healthy lifestyle, promotion of health and nutrition

of families and special populations; the promotion of adolescent and youth health, women's health, health of indigenous peoples, adult health, health of the urban and rural poor; and the promotion of environmental health and sustainable development.

DOH believes that its mission and mandate is already pro-poor, gender-responsive and rights-based. However, there is lack of continuity in programs due to the changing administrations and health priorities. Also, POPDEV is not strongly integrated.

Its main mechanism for operationalizing these objectives is the Health Sector Reform Agenda (HSRA) which is the framework for policy formulation and program implementation of the health sector. The HSRA has five pillars: the local health system, the hospital system, the public health system, health regulation, and health financing, with particular bias for the poor. A well-established system of planning, implementation, monitoring and evaluation for the HSRA has been put in place.

The Management Information System (MIS), Field Health Services Information System (FHSIS), Contraceptives Delivery and Logistics Management Information System (CDLMIS), service protocols, communication plans, Quality of Care/Continuous Quality Improvement (QOC/CQI) standards, and Sentrong Sigla all support the HSRA. Moreover, a restructuring of the national and regional offices was undertaken to conform with the institutional requirements

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of the HSRA. For RH, multisectoral management committees have been set up at the regional offices to facilitate the implementation of the program. Nevertheless, the system is challenged by poor monitoring at the regional level. This is due to the absence of an integrated monitoring checklist and an adequate feedback mechanism. It also suffers from weak results-based management and lack of client segmentation of the poor in terms of targeting the truly “indigent.”

DOH has a large personnel complement of doctors, nurses and midwives serving national and regional hospitals. It has influence over rural health units and barangay health stations now under local governments, with each RHU serving an average of 29,746 people and each BHS catering to the needs of 5,277 community residents. The low compensation and lack of incentives and benefits, however, result in the high turnover of personnel, especially nurses who leave for more lucrative jobs abroad. Also, many program managers do not have a holistic perspective of the HSRA; hence, programs continue to be vertically oriented rather than integrated.

The National Health Accounts reveals that the share of health expenditures to GNP rose from 2.9% in 1991 to 3.3% in 2000, while the share of total government spending for public health care rose from 8% to 12%. There may have been an increase in resources available to the sector, but the per capita health expenditures are still low compared to the per capita spending in neighboring countries.

The DOH views the following as important opportunities which strengthen and promote the poverty, rights-based and gender dimensions of the RH program: the international commitments of the Philippine

Government to ICPD, Convention for the Elimination of All Forms of Discrimination Against Women (CEDAW), Convention on the Rights of the Child (CRC) and the MDG; the anti-poverty pronouncements and programs of the national government; and the inter and intra-partnerships with NCRFW, DSWD, TESDA, DOLE, NEDA and the NGOs. It looks at the presence of other donors in the area of family planning and reproductive health as an avenue for complementation and convergence of programs to attain better impact. Culture and tradition can be harnessed to support the program by emphasizing the need to strengthen and promote the health of the Filipino family through the provision of quality RH information and services. Even religion can serve the program through interfaith groups which can be mobilized to advocate population and RH.

DOH considers the following as the major threats to the RH program: changing administrations with the concomitant shifts in program and policy orientation, and lack of political will; lack of donor coordination resulting in overlapping and duplicating programs; slow adaptation to cultural change, and perpetuation of the patriarchal system which propagates the unequal status between men and women; and the highly conservative doctrinal principles of the Catholic Church which run counter to choice and rights.

### **B. Commission on Population (POPCOM)**

POPCOM is the government agency mandated to set policies and plans, and coordinate and monitor population and development programs in the country. Its comparative advantage is in the area of integrating the population dimension into development concerns. This provides an opportunity to develop and strengthen

lateral and vertical linkages with other sectors. Unfortunately, the POPDEV initiative has not been sustained, and only a few of what was once a large pool of technically trained staff remain.

POPCOM has existing multisectoral mechanisms for establishing partnerships, such as the Board, the Secretariat and the Regional Population Offices which are being tapped for advocacy, population and development systems (PDS), and adolescent reproductive health (ARH) work. It has developed adequate POPDEV and adolescent health and youth development (AHYD) tools (manuals, resource materials) and is currently building its capacities in advocacy.

Part of the capacity building required is the need to shift the orientation of program managers and staff from a functional to a more programmatic orientation. Also, slow government processes and bureaucratic procedures are currently hindering the efficient and effective implementation of the program. Moreover, Executive Order 188, which transfers POPCOM under the supervision of the DOH, may limit POPCOM's capacity to broaden its partnership base.

POPCOM has its own resources from the government budget. It has prepared a Population Investment Plan designed to facilitate resource generation and mobilization. However, POPCOM resources are small due to the low priority given by the government to the program.

POPCOM views its high credibility among donor partners as an opportunity to generate and mobilize resources for its own program. However, competition for the dwindling resources in population is getting stiffer, and POPCOM views donor fatigue as an ominous threat to the promotion of the population agenda.

The adoption of the Strategic Operations Plan (SOP) which targets the 45 poorest provinces with corresponding high TFR is POPCOM's way of contributing to the fight against poverty. Meanwhile, gender has been effectively mainstreamed in the Philippine Population Management Plan (PPMP), and technical capacities have been built at the national and regional offices to take the lead in gender concerns. POPCOM subscribes to the rights-based approach, particularly the right to information.

### **C. United Nations Population Fund (UNFPA)**

UNFPA's mandate and mission is to extend assistance to developing countries, at their request, to help them address reproductive health and population issues, and raise awareness of these issues. UNFPA's three main areas of work are: (a) to help ensure universal access to reproductive health, including family planning and sexual health on or before 2015; (b) to support population and development strategies that enable capacity building in population programming; and (c) to promote awareness of population and development issues, and advocate for the mobilization of resources and political will necessary to accomplish its area of work.

The organization subscribes to the full provision of quality RH information and services and strongly advocates reproductive rights. Its country programme has a pro-poor focus and incorporates a gender-responsive and rights-based orientation. UNFPA's mandate, however, is limited to population and reproductive health as other UN agencies cover other sectoral concerns — like ILO for gainful employment, the Food and Agriculture Organization (FAO) for sustainable

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agriculture, and UNICEF for matters related to children. Also, because population is a highly controversial issue, UNFPA is an easy target of anti-population and anti-family planning groups.

The local UNFPA Office has a corps of multidisciplinary technical and management experts capable of implementing its multi-million dollar country programme. The staff has established systems and procedures to implement and execute the programme. The local staff is backed by an equally capable international group of consultants from the Country Support Team based in Bangkok and at Headquarters. However, the local office needs to be strengthened in the areas of population and development strategies, with special focus on poverty, reproductive rights and gender and operations research. Moreover, the staff needs additional training on the rights-based approach as well as on mobilization and negotiation skills. It needs to develop better monitoring and assessment tools, and to set up an MIS database.

From a management perspective, there is an urgent need for a cohesive team characterized by knowledge sharing, open communication, sincerity and transparency in relationships. Responsibilities of programme officers need to be clearly defined, and activities prioritized. Time must be effectively managed: There must be time to read, absorb and learn. Information technology is limited and IT infrastructure is particularly inadequate in rural areas. There are lots of RH materials but no systematic way of managing and sharing these materials.

UNFPA as a funding agency generates its own resources. However, these resources are never enough. UNFPA must fully utilize its established partnerships with donor agencies and its

tried and tested resource mobilization strategies to look for new sources of funds. Considering donor fatigue and the preference of donor agencies to run their own programs, UNFPA must seek new partners, perhaps in the private sector, and develop new and more creative approaches in raising funds.

There are lots of opportunities for UNFPA to push the population and RH agenda. UNFPA is global and draws strength from being a member of the UN system. It enjoys the respect of national and local government partners, civil society and other donors. The Philippines is a signatory to the MDG, ICPD and other global conferences; and UNFPA is in a position to check on the government's commitment to these conferences. Moreover, UNFPA has been in the Philippines since 1969; it has established networks and gained substantial experience in assisting government in addressing population and RH issues. Currently, involvement in UN reform and in CCA/UNDAF provides UNFPA with opportunities to highlight its comparative advantage in population and RH. New programming guidelines and strategic directions open up avenues for new and/or better partnerships and more focused programming.

Among the agency's perceived threats are: continued opposition to the promotion of reproductive rights by ultraconservative groups; lack of political will by the government to implement the population program; and dwindling resources in the light of local and international events such as the Iraq war, etc. In the CCA/UNDAF exercise, a perceived threat is the weak positioning of UNFPA, which may prevent population dimensions from being highlighted in the document. Also, the application of the new programming guidelines will require changes and the introduction of new

procedures which will not be easy on UNFPA and its partners. The promptness and readiness of the country office (CO) to create an effective team in developing strategic options is another concern.

#### **D. Local Government Units**

LGUs regard as major strengths the presence of a development-centered vision and mission, and the availability of people with a development orientation and skills in planning, implementation, monitoring and evaluation. Inspired by the vision and mission, it is these people who are responsible for the local initiatives on RH, population and gender, and the integration of RH programs in local development plans.

Appropriate systems and procedures have been developed and installed in the LGUs. Existing multisectoral alliances provide opportunities for convergence of RH initiatives. Also, LGUs have a regular budget from the Internal Revenue Allotment (IRA) which they can use to fund RH initiatives. In fact, a portion of the IRA has been set aside for Gender and Development (GAD) activities.

Unfortunately, the development-centered vision and mission is not fully translated into action. There are no common poverty indicators and no technical expertise for effectively targeting the poor, and for incorporating gender-responsive and rights-based approaches in their development programs. Local policies on population and RH are limited. Moreover, local executives give priority to and put their money on high visibility infrastructure projects which, they perceive, could earn them votes for another term. Instead, they depend on donor funds for the implementation of population and RH projects. When the donor funds run out, the project also dies. LGUs have poor resource mobilization skills and must build capacity in this area.

LGUs also suffer from the fast turnover of technical personnel. Overworked and underpaid, LGU staff, especially the younger, more dynamic and creative ones, look for better work opportunities in the cities or abroad.

Nevertheless, the LGUs have identified several opportunities that will help them accelerate the implementation of the RH program at the LGU level. These include: the localization of health sector reforms at the LGU level; national policies that encourage convergence of initiatives at the local level; increased awareness of the population about RH; and the RH bill. These could serve as a rallying point for various sectors and help develop RH champions from the LGUs.

Meanwhile, changing administrations, unstable peace and order conditions, declining levels of foreign assistance, and the continued opposition from the Catholic Church to artificial contraception are perceived by the LGUs as the major threats to RH implementation at their level.

#### **E. Nongovernment Organizations (NGOs)**

NGOs' visions and mandates are inherently pro-poor. They address sectoral concerns of marginalized women and children, and disadvantaged groups, such as indigenous peoples, commercial sex workers, and homosexuals. Many government agencies are partnering with NGOs because of their experience in working with the poor. Nevertheless, government agencies, particularly the military, are wary of NGOs because of their ideological beginnings. Because of their strong adherence to principles, NGOs find it difficult to accept different perspectives and cannot escape political labelling. Staffs of NGOs are highly committed and are very professional about their work. They are creative, resourceful, and are



gender and culture-sensitive. They have the ability to develop appropriate organizing, advocacy and research methods. The demand of funding agencies for professional staff becomes an incentive for NGO personnel to seek further training and enhance their capabilities. However, further training and professionalization lead to fast turnover, as more skilled and experienced staff find better work opportunities and salaries elsewhere. Another downside of professionalization is it misses out on the highly experienced workers who have no degrees.

NGOs are flexible, less bureaucratic; and management is characterized by participation and consultation. Programs emanating from their vision and mandate are generally pro-poor, gender-sensitive and rights-based. There is a lot of emphasis on evidence-based research, cost-efficient service delivery, and people empowerment. However, while NGOs have a lot of experience, they are very poor in documenting these. They have limited capability in producing good reports, which is a requirement of funding agencies.

NGOs can easily establish alliances behind a pressing issue, and most of the time, the LGUs support them due to the issuance of RA 7160. However, political branding limits their development of new partners, and existing alliances are only tactical, not permanent.

NGOs are very creative in resource mobilization. Because of their track record and credibility, plus their grassroots grounding, they have an edge in fund sourcing. Unfortunately, most NGOs have problems of sustainability and often projects are donor-driven. Moreover, fly-by-night NGOs compete for scarce resources with accredited legitimate NGOs. Also, NGOs have difficulty adjusting to the shifting priorities of funding agencies.

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