Journal of Alternative Perspectives in the Social Sciences (2011) Vol 3, No 3, 817-848

Colonized yet Excluded: The Paradox of Male Involvement in a McDonaldized Family Planning Program

Filedito D. Tandinco, Associate Professor, University of the Philippines (Manila, Philippines)

Abstract: *A qualitative study of male involvement in family planning (FP) was conducted in an urban-poor locale in the Philippines, and in the village health station and its referral hospital, which separately provide FP services to couples residing in the same area. The objective of the study was to describe the context, content, and process of male involvement in FP both as domestic practice and as state-funded program. Key informant interviews (KIIs) of 18 couples, focus group discussions (FGDs) with husbands and with wives, KIIs of 14 FP program managers and field-level implementers and point-of-service observation in clinics were conducted. Primary data were triangulated with secondary data from document reviews. Habermas's distinction between lifeworld and system, as represented by the domestic practice of FP by couples and the state-funded FP program, respectively, guided the data collection. Ritzer's McDonaldization model of rationalization served as framework for qualitative data coding and interpretation.*

The KIIs of couples and FGDs offer a glimpse into the lifeworld experience of couples where the men are generally involved in family planning decisions such as limiting family size, birth spacing, choice of method, and timing of coitus. Here, male involvement in the domestic practice of family planning is expressed in terms of concern for the health and wellbeing of families.

The system, as represented by the state-funded FP program, is not organized in the same way as the lifeworld experience of couples. Data from the study reveal practices, protocols and policies that fit into Ritzer's McDonaldization model of system rationalization, and which directly or indirectly result in the disenfranchisement of men from the program itself. For instance, to ensure efficiency, the husband is no longer required to be present during FP counseling since waiting for him entails additional administrative cost. To ensure predictability and calculability, FP implementers ignore the low acceptance of male methods since this is masked by female-based success indicators that show a high level of overall acceptance. The official design of FP clinics allows for only "one client" (the wife) to be present during FP counseling and service

provision. The lack of physical space to ensure efficient staff mobility and concerns for the privacy of women undergoing vaginal examination are used to justify controlling male access to the clinics. In sum, the McDonaldization of the state-funded FP program systematically, though perhaps unintentionally, excludes men who are otherwise willing to cooperate with their spouses in family planning. Male exclusion from the FP program may be considered an adverse consequence of program rationalization, a product of what Ritzer calls "the irrationality of rationality."

1 Introduction

The examination of male involvement in family planning is an important developmental concern given the well-established connection between male involvement in family planning programs, contraceptive use rates and reproductive health outcomes (Robey and Drennan, 1998; Becker, 1996). Likewise, male involvement in FP is a subject of social theory since it touches on the dialectic of what Habermas calls *system* and *lifeworld*, family planning in the Philippines being both a state-funded program and a cultural practice. Hence, studying male involvement in FP also becomes a way of strengthening the interrelatedness of social theory, social policy and social outcomes.

The study sought to describe male involvement in family planning from the lifeworld and the system perspectives. Specifically, the study described the context, content, and process of male involvement in family planning, both as domestic practice and as state-funded program.

2 Literature Review

2.1 Family Planning in Habermas's System and Lifeworld

Habermas's concepts of system and lifeworld are two ways of looking at one society (Ritzer and Goodman, 2003). The lifeworld is "society conceived from the perspective of the acting subject" while the system "represents an external viewpoint" (Habermas, 1987). The system is comprised of

institutions and governing bodies like the state, which in this study is represented by the local implementation of a state-funded family planning program. The system is described as being imbued with formal rationality. An example would be Ritzer's McDonaldization model, which highlights the principles of efficiency, calculability, predictability, and control (Ritzer, 2000: 12-14). The system, therefore, puts a premium on quantity over quality.

The lifeworld would be its opposite in the sense that it values quality over quantity. The lifeworld consists of societal and individual-level attitudes, beliefs, and values (Bedrous, 2006). It is "the shared common understandings that develop through face to face contacts over time in various social groups, from families to communities" (Bedrous, 2006). According to Habermas, the lifeworld carries all sorts of assumptions about "who we are as people and what we value about ourselves: what we believe, what shocks and offends us, what we aspire, what we desire, what we are willing to sacrifice to which ends, and so forth. Their power is their 'of course' or 'taken for granted' quality" (Habermas 1985).

Synthesizing Habermas, Ritzer (2000) says that a rational society would be one in which both the system and the lifeworld are permitted to rationalize following their own logic. However, in the modern world, the system has come to dominate the lifeworld. This is what Habermas terms as the "system colonization of the lifeworld". For him, colonization reduces the sphere in which communicative and qualitative media operate, thereby increasing the dependence of social life on noncommunicative, quantitative media. However, since the system owes its existence and legitimacy to the lifeworld, colonization also undermines the legitimacy of the system. When this occurs, the system suffers what he calls a "crisis of legitimacy."

2.2 Male Involvement in Family Planning

Current social development and demographic research show that male involvement in FP bears significantly on measures to curb overpopulation and reduce maternal and infant deaths. Studies indicate that the lack of male involvement in FP programs leads to low contraceptive use

rates (Robey and Drennan 1998) and, by extension, poor reproductive outcomes. This means that only a few couples are able to use contraceptives and, consequently, there is less success in achieving birth control and healthier families. The 1994 International Conference on Population and Development (ICPD) held in Cairo emphasizes the joint responsibility of husband and wife in family planning and the need for social policy that promotes gender equity in this area. In many countries, the lack of policy support and institutional opportunities for male participation has been proposed as the major reason for the low level of male involvement in government family planning programs (Robey and Drennan, 1998).

Traditionally, the differential involvement of men and women in FP is a result of female dominance of the health care system including FP program implementation. In the Philippines, women dominate the public health scene. According to the 1999 United Nations Population Fund (UNFPA) Philippine Country Report, the Philippine government has a large proportion of women in midlevel and management positions in the health system (Lee and Norella 2002). The Department of Health (DOH) 2005 Annual Report also shows that the majority of public nurses and rural midwives, who deal with family planning issues at the primary level, are women. Furthermore, female traditional birth attendants, known locally as *hilot* or *partera*, attend a significant number of deliveries even in urban areas.

The Visayas, of which the Waray Region is part, has a rich tradition of women healers and midwives, including the *babaylan* who possessed the shaman's skills of healing and divination (Asong and Seraspe, 2002: 4). The women healers held power in their communities but were later persecuted and marginalized by the Spanish authorities. However, there was a time when all traditional midwives in the Eastern Visayas Region were male. According to Hart (1978: 81), the male midwives were sought because of their greater strength, especially for difficult deliveries. At present, most birth attendants are women even though in practice, husbands are still called upon to help in difficult home deliveries.

In 2005, the United States Agency for International Development (USAID) commissioned an assessment of the

role of men in FP in the Philippines. The assessment found "substantial recent and ongoing male involvement activities in research, policy guidelines, information education communication (IEC), behavior change communication (BCC), as well as service delivery" (Clark Jr. et al, 2006). The study recommended that for male involvement research, "it is vital to make greater use of existing data to assess barriers and facilitating factors for male support for and use of FP, especially the male module for the 2003 National Demographic and Health Survey" (ibid, 2006). For policy, the same study recommended to "designate and fund an agency with policy experience to systematically support relevant policy guidance initiatives." Within the same study conducted by Clark and his co-workers, it was noted that the most commonly examined topics have been men's sexual behavior, and FP knowledge, attitudes and practices. Apparently, there is a paucity of qualitative research particularly dealing with how FP services are provided, including policies, protocols and practices that can either enhance or inhibit male involvement in the state-funded FP program.

2.3 The Philippine Family Planning Program

The state-funded Philippine family planning program (PFPP) began in the 1970s as a birth control-oriented program, focusing only on "achieving fertility reduction through a contraceptive-oriented approach" (DOH, 2006: 3). In 1986, the program's goal was reoriented from fertility reduction to promoting family planning as a health intervention. According to the Philippine Clinical Standards Manual on Family Planning (PCSMFP), "the approach shifted from setting demographic targets to emphasizing health interventions wherein the PFPP will contribute to the improvement of maternal and child health through the prevention of high-risk pregnancies and births."

When the Philippine Local Government Code was passed in 1991, the delivery of basic health services including family planning was devolved from the DOH to the LGUs. "Funding, staffing, and administration of the program were placed under the jurisdiction of the LGUs" (ibid., 4), headed by their respective provincial governor or municipal mayor. In 1994,

the Philippines became a signatory of the International Conference on Population and Development (ICPD), "which encourages all states to take all appropriate measures to ensure, on the basis of equality for men and women, universal access to health care services, including those related to reproductive health, which includes family planning" (ibid.). In the late 1990s, the Philippines committed to achieving its targets under the Millennium Development Goals, which include increasing "access to reproductive health (including family planning) from 60 to 100 percent" and achieving a modern CPR of 70 percent. Also, the Philippine Government adopted a policy of contraceptive self-reliance and gradually phased-down its dependence on contraceptives donated by the United States Agency for International Development (USAID). The first casualty of the phase-down was the male condom followed by the pill (DOH Administrative Order [AO] 158 s. 2004).

The current PFPP is described as integrated, "gender-responsive," and "rights-based." This means that family planning is now integrated within a broader reproductive health framework. This implies that family planning programs are being planned and implemented "with careful consideration of the different needs of women and men. Such services consider the changing but distinct reproductive health needs of women and men as they go through the various life cycles, e.g. from adolescent, to motherhood and through post-reproductive age, as well as other circumstances that uniquely affect each" (DOH 2006, 4). For example, the new FPRH program provides special services to victims of spousal abuse or to men suffering from infertility.

On the other hand, rights-based services "mean that women and men have the right to access a wide range of reproductive health services without coercion" as mandated by the ICPD" (DOH/NCRFW, 2006: 67). In addition, according to the training manual, "all couples and individuals enjoy the basic right to decide freely and responsibly the number and spacing of their children and to have the information, education and means to do so based on ICPD Principle 8."

The current version of the PFPP rests on the pillars of responsible parenthood, birth spacing, respect for life, and informed choice. According to AO No. 50-A s. 2001, the key policy of the current PFPP is to view family planning as "a health intervention to promote the overall health of all Filipinos by preventing high-risk pregnancies, reducing maternal deaths, and responding to the unmet needs of women." The PFPP implementation now involves a broader network of organizations from the public, private, and civil society sectors and counts on the participation of public and private organizations dealing with issues of gender and development. However, in all these, the state remained the leader in family planning program implementation. The family planning program is lumped along with ten other health and demographic programs within the framework of reproductive health. Reproductive health is "the state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity, in all matters relating to the reproductive system and its functions and processes" (ICPD, 1994).

The reproductive health framework also includes maternal and child health including nutrition; prevention and management of abortion complications; prevention and treatment of reproductive tract infections; education and counseling on sexuality and sexual health; breast and reproductive tract cancers and other gynecological conditions; men's reproductive health; adolescent reproductive health; violence against women; and prevention and treatment of infertility and sexual disorders.

While there is a separate component on men's reproductive health, initiatives for greater male involvement are embedded in each of the other components. Berer (1996 cited in Illo, Sobritchea, and Gonaco, 1999: 13) list "what women need most in relation to their sexuality and reproductive rights as regards male involvement":

1. Men taking responsibility for ending gender-based violence, rape, and sexual abuse of women;
2. Men taking responsibility for their own fertility and shared responsibility for the children they make;

3. Men's acceptance of male infertility and not punishing women for being infertile;
4. Men's support for women's own fertility and reproductive rights, including the right not to bear unwanted children;
5. Men participating only in consensual sexual relations with a commitment to shared pleasure and safer sex; and
6. Men seeking to understand masculinity and their own behavior toward women and other men from a gender perspective, and confronting the role of homophobia in expressions of masculinity.

Thus, male involvement in FP may be defined as men's utilization of reproductive health services for themselves and their full support in the fulfillment of their spouses' reproductive health needs. Lee and Norella (2002: 1) identify two "strategic pathways" for male involvement in reproductive health (including family planning): men's interpersonal influences with their spouses and men's individual reproductive health needs. The first pathway involves only the couple and occurs at the husband-wife dyad. This corresponds to the experience of family planning in the lifeworld. The second pathway occurs at the community level and involves the male client and the service providers. This pathway corresponds to how family planning is experienced by couples within Habermas's system.

3 Methodology

The study was qualitative and descriptive in nature and was conducted in Serin District, one of the largest urban slums in Tacloban City, the capital of the Philippines' Eastern Visayas Region. An urban-poor locale was selected for this study in view of demographic surveys that indicate higher unmet needs for FP among the poor.

To provide the lifeworld perspective, KIIs of 18 cohabiting couples from the Serin District were conducted. In addition, two focus group discussions were conducted, one each for the husbands and the wives. The couples were purposively chosen based on a respondent selection matrix

that considered the husband's age, income and education. These demographic factors were purposively selected given findings from previous FP research that show these factors as influencing fertility and FP decisions (Moser, 1993: 28; Card, 1977: 27).

To provide the system perspective, KIIs of seven technical assistance providers from national and local family planning agencies and seven field-level family planning program implementers were undertaken. In addition, point-of-service observation in local health facilities such as the barangay (village) health station (BHS) and the regional referral hospital's obstetrical outpatient clinic (OPC) and family planning clinic (FPC) were also conducted. Primary data from the interviews and observation notes were triangulated with secondary data from document reviews.

4 Family Planning as Domestic Practice: The Lifeworld Perspective

Interviews and FGDs of couples reveal that family planning happens primarily within the context of gender power relations. In the study site, the prevailing construct of gender power relations is still one of male dominance and female subordination. The concrete expressions of these notions are in the recognition by men and women alike that men are primarily responsible for shepherding the family while women are to be consigned to housework. In addition, men and women agree that marriage entitles the husband to have marital sex whenever he pleases. Women can refuse but under pain of physical, sexual, or emotional punishment.

The practice of family planning reflects the same arrangement. Both husband and wife are involved in making decisions about family planning, albeit in varying degrees. However, for the most part, men remain the primary decision-maker. When there is a conflict between the husband's and the wife's fertility options, the husband's decision often prevails. In choosing the method of family planning, both men and women participate, although women tend to choose "modern" methods while men tend to choose "traditional" methods like withdrawal. Couples go through

repeated cycles of initiation, deliberation, and final-say in choosing the method. It was fairly common to find couples shifting from one family planning method to another for various reasons, including side effects or perceived contraceptive failure.

In determining the number of children, most couples desire a small family. However, this goal is not easily achieved especially by couples who by chance are unable to have both a boy and a girl. Deciding over the timing of sexual contact was the most complicated of the family planning decision areas. Men admit it is usually the husband who initiates sexual contact with the wife, although the reverse occasionally happens. The common practice of initiating sexual contact is by "courting the wife again," often by way of bribery. Some of the women interviewees say they sometimes refuse sex but not without violent consequences. Husbands' negative reactions to rejection can range from abandonment of housework to physical and sexual abuse. On the other hand, many female key informants reveal that they do not refuse their husbands' request for sex even when they are tired and weak from housework since it is the right of the husband to demand.

There appears to be no difference in the manner family planning is practiced by young and old couples as well as by income-earning and non-income-earning men. Interestingly, husbands who had no college education tend to be more domineering while husbands who had some college education are more open to spousal cooperation in family planning.

With regard to reproductive outcomes, the research findings are equivocal as to what outcomes certain patterns of fertility decision-making can lead to. A family planning process characterized by spousal cooperation can still have poor reproductive outcomes. In like manner, a male-dominated process can end in good outcomes. Male dominance of family planning occurs under contexts of economic poverty and the experience of illness and disability. Men and women alike rationalize male dominance in family planning as an extension of the shepherding role of the father. After all, it is the man who looks for work to provide

the family's basic needs. In practice, however, it is the experience of illness or disability that exerts the larger influence on men's decision to participate in, if not control, the family planning process. In not a few instances, men took control of the family planning process with the goal of preempting illness or disability in the family. In these instances, women saw male dominance positively as an expression of concern for the family.

5 The McDonaldization of the Family Planning Program: The System Perspective

The local implementation of the FP program in the study site represents how the state-funded program has undergone rationalization or "McDonaldization" (Ritzer, 2000). Here, the principles of the fast-food chain-- efficiency, calculability, predictability, and control—have come to dominate the implementation of the family planning program. Thus, it is probably more than coincidence that the current family planning program calls its contraceptive promotion strategy "cafeteria style" and its list of contraceptive choices a "menu."

The family planning program is part of the broader framework of integrated health sector reform, which was given the moniker "FOURmula One for Health" at the time of this study's completion. By alluding to the Formula One car-racing sport, the program underscored its fascination with numbers and obsession with speed.

The integration of family planning into FOURmula One was formalized through DOH Department Circular issued 9 August 2006, which states that "the Executive Committee of DOH likewise adopted the 'Integrated Reproductive Health Framework' as it sets into operation the holistic focus of health efforts embodied in the reform agenda under the FOURmula One strategy." The FOURmula One strategy is actually a package of health sector reforms that fall into four major categories: health care financing, public health service delivery, health regulations, and hospital reform. According to the DOH, the implementation of FOURmula One is directed toward achieving the goals of better health

outcomes, more responsive health system, and more equitable health care financing. This is in consonance with the health system goals identified by the World Health Organization, the Millennium Development Goals, and the Medium Term Philippine Development Plan. The DOH adds, "FOURmula ONE for Health is aimed at achieving critical reforms with speed, precision and effective coordination directed at improving the quality, efficiency, effectiveness and equity of the Philippine health system in a manner that is felt and appreciated by Filipinos, especially the poor." Given this integration into "FOURmula One", the FP program is constrained by law to utilize the prescribed indicators for measuring program success, which are all quantitative in nature. These are reduced population growth rate (PGR), reduced total fertility rate (TFR), increased contraceptive prevalence rate (CPR), increased use of modern FP methods, and reduced FP unmet needs (see table 1).

The TFR is the number of children that a woman could have during her reproductive period. The CPR is computed as the percentage of (married) women of reproductive age (fifteen to forty-nine years old) who are current users of contraceptive methods. Unmet needs for family planning refer to couples who want to use contraceptives but do not have access to these products. However, the surveys that are conducted to estimate unmet needs include only women.

Table 1: Percentage Benchmarks for Measuring the Adoptrion of PF Practices (2003-2010)*

Benchmark (In %)	2003	2010
Reduced PGR	2.3	1.9
Reduced TFR	3.5	2.1
Increased CPR	48.9	80.0
Increased use of modern family planning	33.4	60.0
Reduced FP unmet need	17.3	8.6

*Modified from PCSMFP 2006.

Words and images by which family planning is promoted by the program reveal a family planning ideology that

preferentially targets women and neglects or alienates the men. For instance, all posters and advocacy materials in the BHS portray only the mother and her children but never the father. Likewise, in the CHO, out of the ten informational posters displayed in its reception area, only two posters featured adult men. Incidentally, these were the posters on tuberculosis and sexually transmitted infections.

There were two posters on family planning, both of which featured only women and children. In one of the posters, the following statement was superimposed:

> Less than 2 in 5 women receive proper counseling on the modern method they use. Family planning information, counseling, and services should be brought to the community and household to reach more women, especially in rural areas and urban slums.

The program's preferential targeting of women is also seen in program statistics. Table 2 shows the number of current users per method as recorded by the CHO over the last seven years (2000-2006).

Table 2: Current Users of Modern Family Planning Methods in Tacloban City (2000-2006)

YEAR	Condom	DMPA[a]	IUD	LAM	NFP	Pills	Male ster[b]	Female ster[b]
2000	2818 (30.31%)	1766 (19.00%)	1449 (16.00%)	1853 (20.00%)	707 (7.60%)	305 (3.28%)	0 (0%)	399 (4.29%)
2001	1579 (17.2%)	1126 (12.2%)	883 (9.6%)	1615 (17.5%)	1360 (14.8%)	2271 (24.7%)	0 (0%)	345 (3.7%)
2002	610 (5.69%)	1637 (15.28%)	918 (8.57%)	1415 (13.21%)	1053 (9.83%)	2363 (22.06%)	0 (0%)	2715 (25.34%)
2003	1181 (9.55%)	1272 (10.29%)	842 (6.81%)	2709 (21.91%)	1373 (11.10%)	3437 (27.80%)	2 (0.02%)	1549 (12.53%)
2004	1640 (10.1	1757 (10.91	1102 (6.84	4327 (26.86	2120 (13.16	3228 (20.04	3 (0.02	1930 (11.98

	8%)	%)	%)	%)	%)	%)	%)	%)
2005	1903 (9.88 %)	2245 (11.65 %)	1292 (6.71 %)	4256 (22.09 %)	3455 (17.94 %)	4235 (21.98 %)	7 (0.04 %)	1869 (9.7%)
2006	977 (5.3%)	2496 (13.6 %)	1103 (6.0%)	2959 (16.1 %)	3761 (20.4 %)	5439 (29.6 %)	44 (0.24 %)	1609 (8.8%)

[a]DMPA stands for depomedroprogesterone acetate, the generic term for the injectable contraceptive for women.
[b]Ster stands for sterilization.

Source: CHO Annual Accomplishment Reports (2000-2006).

The data from the CHO reveal that for 2006, the CPR of Tacloban City was 65.3 percent. This is above the 50 percent benchmark set by the PFPP. However, the CPR does not show the large disparity between the number of male and the number of female contraceptive users. The vast majority of current users are women. In the category of temporary methods, current users of male methods such as the condom account for only 5.3 percent of the total. For permanent methods, 8.8 percent of current users underwent tubal ligation while only 0.24 percent underwent vasectomy. Thus, in terms of permanent methods, female users outnumber male users by 36 to 1.

Table 3: Family Planning Services and Commondities in BHS

Method	Temporary/ permanent*	Service/s offered	Sex of target client
Oral contraceptive pills	Temporary	Information, commodities	Female
DMPA	Temporary	Information, commodities	Female
Condom	Temporary	Information, commodities	Male
IUD	Temporary	Information, commodities	Female
LAM	Temporary	Information	Female
NFP	Temporary	Information	Female

Vasectomy	Permanent	Referral to CHO or hospital	Male
Bilateral tubal ligation (BTL)	Permanent	Referral to CHO or hospital	Female

The data from 2003 to 2006 show that there are fewer new acceptors of pills as an FP method compared with two years ago (see table 4). In 2003 and 2004, there were seven new acceptors each year for pills. In the next two years, however, the interest in pills among new acceptors diminished, with only three new acceptors for 2005 and four in 2006.

Table 4: New Acceptors of PF Methods, Barangay 42-A, Serin, Tacloban City (2003-2006)

Year	Family Planning Method					
	Pills	Injectables	IUD	LAM	Condom	Total
2003	7	2	0	3	0	12
2004	7	3	3	6	0	19
2005	3	2	3	0	0	8
2006	4	2	0	4	0	10

Source: BHS Records

In 2006, there were no new acceptors for IUD in Barangay 42-A. The situation is the same in Barangay 42 and Barangay 39, which are also part of Serin and the BHS catchment area. For the condom, the only male-controlled method available in the BHS, there was no new acceptor for four straight years (2003-2006). This coincided with the start of the gradual phase-out of free contraceptive commodities from the USAID. The gradual phase-out began in 1998 and was expected to end in 2008. However, as early as 2001, the

BHS had already run out of condoms but apparently the BHS ignored this.

To cope with the pill shortage, the midwife began to directly sell commercially available pills to her family planning clients. But while both the pill and the condom were in short supply, the midwife did not sell condoms. According to the BHS midwife, the demand for condoms was not as much compared with pills. The midwife attributed the low demand for condoms to the local culture where men are embarrassed to personally request a condom from a female service provider. She recalls that even when condoms were still being given away for free, it was the women who would come to the health center to pick up the condoms for their husbands. Nevertheless, according to the midwife, the men can easily procure condoms from the local pharmacies. However, the midwife failed to mention that most clerks in commercial pharmacies are also women, and that pharmacies also sell pills.

The family planning program's neglect of men, while perhaps unintentional, is also seen in its record-keeping habits. Unlike family planning surveys, the CHO-BHS's information system or the Field Health Service Information System (FHSIS) does not keep track of couples who use methods such as periodic abstinence (rhythm or calendar method) or withdrawal. These methods are labeled by health authorities as "traditional" and therefore not recommended for use owing to their large failure rates. However, the key informant interviews reveal that many couples still use these methods. Thus, the absence particularly of, the male-controlled withdrawal, in official health reports minimizes the documented male involvement in planning. The female key informants say their husbands rarely, if at all, accompany them during prenatal or postnatal checkups, child immunization, or family planning seminars. Husbands are, therefore, virtually absent from the public sphere of family planning.

According to the midwife assigned to Serin, this has been the case since she became a midwife. She has been in public health for thirty years, and she claims she rarely sees husbands accompanying their wives to prenatal checkups or

family planning sessions. The women say this is because their husbands are busy with work. According to the midwife, "*Napalakpak pa ak hiton kun mayda tatay nga naupod hit iya misis nganhi ha centro.* (I would even clap my hands to congratulate a couple whenever I see the husband accompany his wife to the center."). The midwife estimates that only one out of ten wives who come to the BHS for prenatal checkup is accompanied by the husband. Most often, this is the wife who is on her first pregnancy.

In the KIIs, the female informants also gave the same reason for their husbands' absence from family planning activities. Most of them indicate they understand their husbands' situation since they are the ones who look for means to "keep their families alive." On the other hand, they regret that the program implementers responsible for promoting family planning also do not make conscious efforts to involve the men in family planning activities. For example, according to several female key informants, the health center personnel do not actively invite the men whenever they have a FP seminar or orientation in the community. One female respondent observes, "*Diri man hira nagpapakiana kun hain akon asawa.* (They don't ask where my husband is [whenever I attend family planning activitiy]."). Table 5 below summarizes the daily activities of the BHS.

Table 5: Daily Schedule of BHS Activities

Day	Activities	Nature of activities*
Monday	Medical consultations, birth registration	General health Administrative
Tuesday	Prenatal and postnatal checkup, tetanus toxoid immunization	Maternal and child health (component of reproductive health)
Wednesday	(Primary) immunization and growth monitoring of children	Child health
Thursday	Communicable disease Control	General health
Friday	FPRH, Pap smear	Reproductive health

*The researcher developed the categories for the nature of activities.

Source: BHS poster.

Based on the foregoing schedule, the BHS devotes two out of five working days in a week, or 40 percent of the official working time, for reproductive health services, specifically family planning. These are Tuesdays, for the care of pregnant women, and Fridays, for family planning and other RH services. However, it was observed that in both days, the women-clients go to the BHS unaccompanied by their husbands or male partners. The midwife estimates that 80 percent of the BHS services target women and only 20 percent target men. This also corresponds to the estimated participation of men in family planning activities of the BHS. For instance, very few husbands accompany their wives during family planning sessions, antenatal checkups or child immunization. Likewise, in family planning program activities in the community, only two out of every ten participants are male. The midwife relates that in 2004, the DOH even trained CHO doctors on how to perform vasectomy using the new no-scalpel method. After the training, the doctors targeted to perform the procedure on one hundred clients. However, eventually only two underwent the procedure.

The situation in the regional hospital is no different. From the system perspective, the regional hospital is a vital cog in the FP program. Being a tertiary-care referral center, it is strategically positioned to capture cases of complicated pregnancies arising from a lack of family planning. The assumption is that women experiencing "high-risk" pregnancies will be more receptive to family planning messages given their difficult condition. However, the capacity of the regional hospital to provide appropriate qualitative family planning services is limited by rationalization. The hospital's family planning counselors always appear to be in a hurry. An obstetrician who had trained in the hospital for four years gives an example:

> *Paspasay kay damo trabaho, kliyentye. Kasagaran babaye man la it nagpapa-counseling. Napakiana nala kami kun ginsabutan na ba ini niyo ngan han im asawa. Kun tumangdo, derecho na kami.* (We have to

> move fast because there's a lot of work to do, many clients to attend to. Usually it's only the wife who comes for family planning counseling. We just ask her if her husband knows she's here for counseling. If yes, we proceed [even without the husband].)

The physician who headed the FPC at the time of the study relates that when performing female sterilization, the hospital no longer requires the husband's signature on the informed consent form since waiting for him entails additional delay.

Aside from time for client counseling, the regional hospital also lacks physical space. Like in any government hospital, a large number of clients troop to the hospital every day since the majority of them cannot afford private care. The hospital's corridors are always crowded with in-patients on any given day. The regional hospital's obstetrics and gynecological department maintains an OPC and an FPC. The two clinics are adjacent to each other, separated only by a small room, which serves as the department chair's office. The OPC provides prenatal and postnatal services to women. In addition, the OPC is an important venue for initiating family planning especially for women who are experiencing difficult pregnancies owing to a perceived lack of family planning. OPC clients who agree to submit to family planning counseling are then referred to the adjacent FPC.

However, owing to space limitations, only female clients are allowed inside the OPC. The men are barred from entering the room to prevent overcrowding and violations of client privacy. At any one time, there are three women-clients undergoing physical examination simultaneously. If the husbands are allowed inside the room, their presence is bound to reduce health personnel efficiency since the room becomes crowded, preventing health workers from moving about at emergency-quick pace.

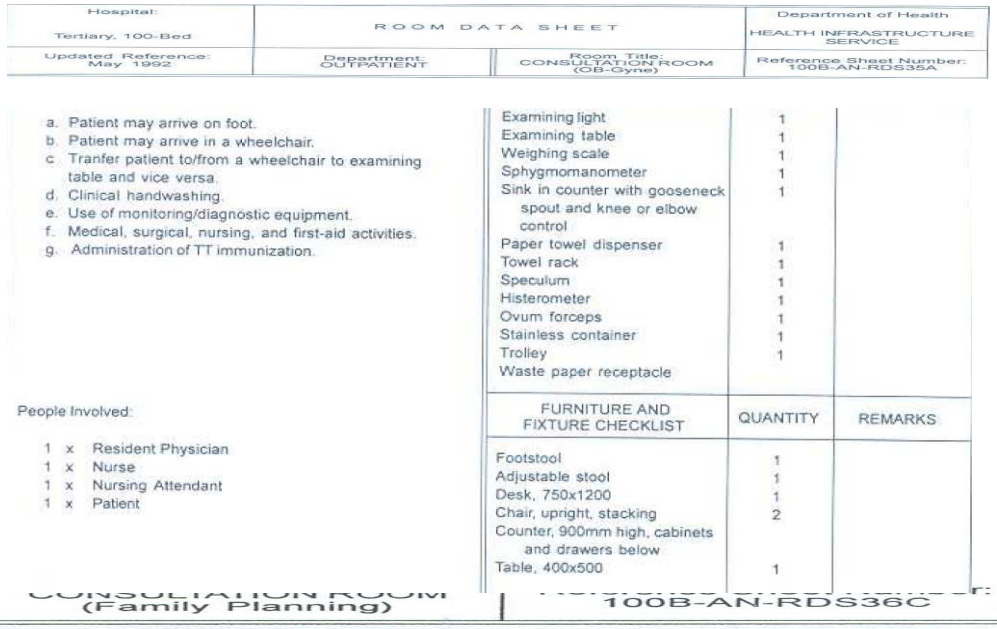
Likewise, when men are allowed inside the room, the women-clients' visual and auditory privacy are compromised. The OPC has three examination tables instead of only one as prescribed by health facility design experts. Two of the examination tables are attached to each other forming an "L" and separated only from the rest of the OPC by thin, short curtains. These examination tables are located near the door

and are used for external (abdominal) examination of pregnant women. The third examination table, located at the other end of the room, is for clients who would require an internal (vaginal) examination. According to the Manual on Technical Guidelines for Hospitals and Health Facilities Planning and Design (DOH-National Center for Health Facility Development [NCHFD] 2001), the OPC and the FPC are supposed to have an area of 18 square meters each. This is the ideal floor area for a room that would accommodate "one resident physician, one nurse, one nursing attendant, and one client" at a time (see Figure 2 below). Here, it is already obvious that the state's health facility developers do not imagine female clients being accompanied by their husbands in family planning sessions since the design they prescribe for both the OPC and the FPC does not contain space provisions for an accompanying spouse.

Figure 3 shows the floor plan for the FPC as recommended by the NCHFD for 100-bed capacity government hospitals. Although the regional hospital is a 250-bed capacity facility, the civil engineer who heads the hospital's maintenance division says they just followed the guidelines for 100-bed hospitals in designing the OPC and FPC for the regional hospital. Based on the floor plan available at the regional hospital's maintenance division, the actual combined area occupied by the hospital's OPC and FPC is 52.5 square meters, which is almost equally divided between the two clinics. Thus, with an area of approximately 26 square meters each, the OPC and the FPC are both large enough to accommodate the prescribed three service providers and one female client at any one time and ensure the client's privacy.

However, based on the experience of obstetricians interviewed for this study, there is usually more than one physician inside either the OPC or FPC. In fact, in the OPC alone, there are four physician's and nurse's desks. Even with an area that is larger than required, both the OPC and FPC are still crowded on any given day.

Figure 2: Snapshot of Room Data Sheet for Outpatient Obstetrical Consultation Room in Regional Referral Hospital



Hospital: Tertiary, 100-Bed	ROOM DATA SHEET		Department of Health HEALTH INFRASTRUCTURE SERVICE
Updated, Reference: May 1992	Department: OUTPATIENT	Room Title: CONSULTATION ROOM (OB-Gyne)	Reference Sheet Number: 100B-AN-RDS35A

a. Patient may arrive on foot.
b. Patient may arrive in a wheelchair.
c. Tranfer patient to/from a wheelchair to examining table and vice versa.
d. Clinical handwashing.
e. Use of monitoring/diagnostic equipment.
f. Medical, surgical, nursing, and first-aid activities.
g. Administration of TT immunization.

People Involved:

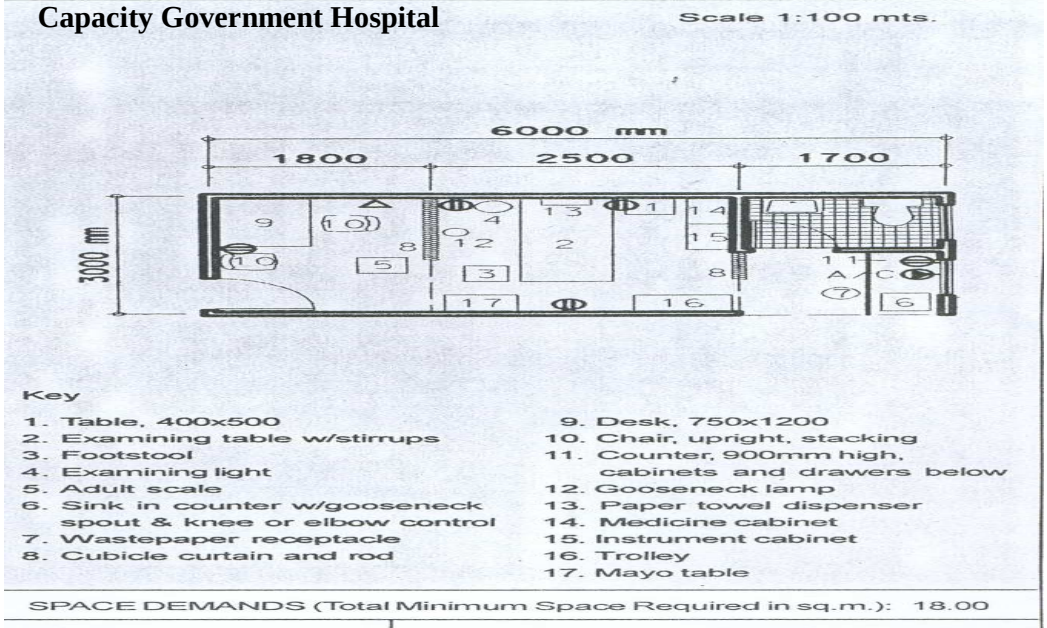
1 x Resident Physician
1 x Nurse
1 x Nursing Attendant
1 x Patient

FURNITURE AND FIXTURE CHECKLIST	QUANTITY	REMARKS
Examining light	1	
Examining table	1	
Weighing scale	1	
Sphygmomanometer	1	
Sink in counter with gooseneck spout and knee or elbow control	1	
Paper towel dispenser	1	
Towel rack	1	
Speculum	1	
Histerometer	1	
Ovum forceps	1	
Stainless container	1	
Trolley	1	
Waste paper receptacle		
Footstool	1	
Adjustable stool	1	
Desk, 750x1200	1	
Chair, upright, stacking	2	
Counter, 900mm high, cabinets and drawers below		
Table, 400x500	1	

(Family Planning)

100B-AN-RDS36C

Figure 3: Layout of the Family Planning Center in a 100-Bed Capacity Government Hospital



Moreover, the DOH Guidelines in the Planning and Design of a Hospital and Other Health Facilities (2004) prescribes that in an outpatient clinic, each staff should have a physical space of 5.02 square meters (sq.m.) while every examination and treatment area should be allotted 7.43 sq.m. per bed. Based on these guidelines, state facility designers and planners imagine that the OPC and FPC can only accommodate one non-staff at a time in order not to compromise staff mobility, patient care and patient privacy. For these reasons, men are systematically excluded from the clinics. Even when a husband accompanies his wife to the OPC or FPC, the clinic staff-members will only call out the name of the wife when it is their turn. There is no active effort on the part of clinic staff to involve the husband either by asking him personally to join his wife inside the consultation room or by asking his wife where he is. Instead, the husband is usually made to wait in the corridors outside of the clinics, along with other clients who are waiting for their turn.

The corridor is on the edge of the outpatient building so more often than not clients have to endure the heat of the sun while waiting. There are several benches in the corridor that waiting clients can use. However, there are usually more clients in the queue than can be accommodated by the benches. Thus, some clients wait by standing along the corridor, careful not to go far, otherwise they may not hear their name when they are called.

Ordinarily, clients have to wait in the corridors for at least two hours from the time they register for the day's OPC or FPC services. They usually arrive shortly before 8 A.M. when the medical records section opens so they can get ahead in the queue. However, they have to wait until around 10 A.M. when the doctors will have completed the endorsement conferences, ward rounds and other related activities. During this two-hour waiting time, clients are requested to stay in the corridors and attend "mothers' classes". The title of the activity reinforces the impression that health care providers do not imagine women being accompanied by their husbands in attending obstetrical consultation and FP clinics, and that in practice the lack of male involvement in FP is being ignored.

As for those who are already inside the clinics, the message is clear: when inside the small, congested, and likewise uncomfortable clinic, one ought not to stay long because many clients are still waiting in line, in even more uncomfortable circumstances. Other institutions that have their own FP program are themselves in various stages of McDonaldization. The best example of this would be the Catholic Church and its natural FP program (NFP). The Catholic Church has a strong organizational presence in the study site. Serin District has its own chapel where mass is said weekly on Sundays. According to the village residents, an attack on the state's FP program is a regular topic of the priest's homily. The midwife who is in-charge of the BHS is herself an active member of a religious organization affiliated with the Catholic Church through its Family Life Apostolate (FALA). The FALA operates an NFP clinic located within the Santo Nino Church, the largest Catholic church in the city. The NFP clinic is open even on Saturdays purportedly to capture more working clients. The FALA also provides NFP lectures in various parts of the Eastern Visayas region to convince more Catholic faithful to abandon artificial contraception and switch to NFP. In addition, the FALA NFP clinic provides IUD removal services for free.

By rejecting artificial contraception, the centerpiece of the state-funded FP program, the Catholic Church interposes itself as a direct competition of the state. But while the state's basis for recommending artificial contraception is biomedical, until recently much of the church's opposition to artificial contraception had been based on qualitative moral grounds. At the same time, the Church has to respond to criticism that the NFP is the least biomedically efficient among the FP methods since it takes time and training for women to perfect the skills of monitoring the biophysical signs even of their own fertility.

Realizing these ideological weaknesses, the FALA representative interviewed for the study revealed that their organization is now collecting and disseminating biomedical studies by "scientists of international repute" if only to prove that NFP is not only a moral choice but an efficient biomedical alternative as well. This newfound reliance of the Catholic Church on biomedical evidence moves it closer to using quantitative data rather than (qualitative) moral

doctrine as it engages the State in the largely positivistic contraceptive debate.

Given that the Catholic Church's FP program only recommends natural methods, the choice of both women and men alike is restricted to only five methods: lactational amenorrhea, cervical mucus, basal body temperature, symptothermal method, and standard-days method. Thus, like the state-funded FP program, the Catholic Church's FP program inadvertently excludes the men since natural methods rely on signs of fertility that are only found in women.

6. Conclusions and Recommendations

Men are variously involved in family planning as domestic practice of couples. This involvement includes participation in domestic decision-making in regard to the use of contraception, the choice of method, deciding on the number of children, and timing of coitus. The dialogue between husband and wife in family planning decisions is dominated by concerns of the husband and wife alike on the health and economic wellbeing of their families. However, this male involvement does not translate to male involvement in the state-funded FP program owing to the effects of McDonaldization. As a fully McDonaldized system, the state-funded FP program adheres to the principles of efficiency, predictability, calculability and control. These principles are operationalized in FP program implementers' practices and policies, which result in the systematic though unintentional exclusion of men from the program.

On the dimension of efficiency, these McDonaldized practices and policies include employing convenient cost-cutting measures that serve a greater number of clients in the shortest possible time such as cutting on consultation time, using measures of success based on characteristics of women, providing preferential attention to women, and ignoring the husband by not requiring him to attend the clinics or soliciting his opinion in regard to his wife's contraceptive decisions.

On the dimensions of calculability and predictability, these practices and policies include utilizing quantitative measures of success based on biological characteristics that

are found in women but not in men and FP implementers' disregard for the low acceptance of male-controlled methods since this is masked by female-based quantitative measures of success that show high overall acceptance

On the aspect of control, male exclusionary practices and policies include providing cues how clients should behave such as crowded corridors uncomfortable waiting areas. In this regard, clients realize they should not stay long in the clinics. Likewise, male access to the clinics is limited by official facility design requirements to ensure efficient staff mobility, patient safety and patient privacy. Needless to say, there is already an inherent limitation in the choice of FP method because, except for condom and vasectomy, currently available contraceptive choices are female-controlled. Finally, state-funded FP program organization is dominated by women so men are generally embarrassed to pick up contraceptives (i.e., condom) from female-run clinics or attend FP activities.

In sum, the domestic practice of family planning by couples has been colonized by the state, and this has led to the unintentional exclusion of men from the state-funded FP program. In the context of family planning program implementation, the men are therefore colonized yet excluded. This seemingly paradoxical situation may be considered an adverse consequence of program rationalization, a product of what Ritzer calls "the irrationality of rationality" (Ritzer 2000, 123).

Given these conclusions, it is recommended that some aspects of the program be "de-colonized" or "de-McDonaldized" (Ritzer, 2000). For instance, instead of conducting seminars and lectures that emphasize the technical aspects of family planning, the program might benefit from holding small group discussions (SGDs) with men in regard to their opinions, feelings, fears or apprehensions towards family planning. FP service providers need to require husbands to attend obstetrical and FP clinics with their wives. Likewise, the subject of these FP sessions should be qualitative in nature such as in the SGDs as recommended above. In relation to this, there may be a need to train more male family planning counselors so that men are not embarrassed to talk about sexuality and gender

issues. Likewise, there should be separate programmatic success indicators for men and women.

There may also be a need for small physical improvements in the FP clinics like installing inexpensive soundproofing in the examination area in order to assure couples of auditory privacy. Keeping the waiting area comfortable, for instance, by installing canopies to shield waiting clients from the sun, might also help. These recommendations, when multiplied in various areas of the Philippines that are similarly situated, may provide and impetus for increasing male involvement in the state-funded FP program.

References

Books

Arce Wilfredo F., (2001). *Systematic Qualitative Data Research: An Introduction for Filipino Practitioners*. Quezon City, Philippines: Office of Research and Publications, Ateneo de Manila University.

Aguiling-Dalisay, Grace, Roberto Moran Mendoza, Edzel Jose L. Mirafelix, Jay A. Yacat, Mariano R. Sto. Domingo, and Francis R. Bambicol, (2001). *Pagkalalake: Men in Control? Filipino Male Views on Love, Sex, and Women*. Quezon City, Philippines: National Association of Filipino Psychology.

Atkinson, Jane Monnig, and Shelley Errington, (1990). *Power and Difference: Gender in Island Southeast Asia*. Stanford, California: Stanford University Press.

Asong Rosario, and Ebonia Seraspe, (2002). "Reproduction and Fertility Practices among the Panay Bukidnon." in Kaaging Bisáya: Gender Research in the Visayas, ed. Merlie Alunan. Quezon City, Philippines: UP Center for Women's Studies and the Ford Foundation.

Avila, Josephine L., and Emelita L. Wong., (2001). "When Fate and Husbands Prevail: Dynamics of Decisions and Behavior Regarding Family Planning in Cebu, Philippines" *Philippine Quarterly of Culture & Society*, pp. -104.

Borrinaga Rolando O., (1995). "Leyte Husbands Set the Family's Number of Children" *Philippine News and Features*, vol. XI, no. 57.

Bourdieu Pierre, (2001). *Masculine Domination*. Cambridge, UK: Polity Press.

Connell, R. W., (2002). *Gender*. Cambridge, UK: Polity Press.

David, Fely P., (1994). "The Roles of Husbands and Wives in Household Decision-Making." *Philippine Sociological Review*, vol. 42, nos. 1-4.

De Beauvoir Simone, (1980). *The Second Sex*. New York: Alfred A. Knopf, Inc.

Department of Health, (DOH). (2006). *The Philippine Clinical Standards Manual on Family Planning (PCMFP).* Manila, Philippines: DOH.

DOH-NCHFD, (2001). *Manual on Technical Guidelines for Hospitals and Health Facilities Planning and Design*. Manila, Philippines: DOH.

DOH and National Commission on the Role of Filipino Women (NCRFW), (2006). *Gender-Responsive and Rights-Based Integrated*

Reproductive Health Service Delivery: A Training Manual. Manila, Philippines: DOH/NCRFW.

Duncombe Jean, and Dennis Marsden, (2002). "Whose Orgasm is This Anyway? 'Sex Work' in Longterm Heterosexual Couple Relationships" In Gender, A Sociological Reader, ed. Stevi Jackson and Sue Scott. London: Routledge.

Eviota, Elizabeth Uy. (1992). The Political Economy of Gender: Women and the Sexual Division of Labour in the Philippines. London: Zed Books Ltd.

Freund, Peter E. S., and Meredith B. McGuire. (1991). Health, Illness, and the Social Body: A Critical Sociology. New Jersey: Prentice-Hall, Inc.

Gutmann, Matthew C. (1996). The Meanings of Macho: Being a Man in Mexico City. Berkeley: University of California Press.

Giddens, Anthony. (1989). Sociology. Cambridge: Polity Press.

Habermas, Jurgen. (1985). Theory of Communicative Action vol. 2. Lifeworld and System: A Critique of Functionalist Reason. Translated by Thomas McCarthy. Boston: Beacon Press.

Hart, Donn V. (1978). “Disease Etiologies of Samaran Filipino Peasants.” In Culture and Curing: Anthropological Perspectives on Traditional Medical Beliefs and Practices, ed. Peter Worley and Roy Wallis. London: Peter Owen Limited.

Martin, M. Kay, and Barbara Voorhies. (1975). Female of the Species. New York: Columbia University Press.

Mehta, Manisha, Dean Peacock, and Lisette Bernal. (2003). “Men as Partners: Lessons Learned from Engaging Men in Clinics and Communities.” In Gender Equality and Men: Learning from Practice. New York: Engender Health.

Moser, Caroline O. N., (1993). Gender Planning and Development: Theory, Practice and Training. London: Routledge.

Nurge, Ethel. (1967). Life in a Leyte Village. Seattle: University of Washington Press.

Pingol, Alicia T. (2001). Remaking Masculinities: Identity, Power, and Gender Dynamics in Families with Migrant Wives and Househusbands. Quezon City, Philippines: University of the Philippines University Center for Women's Studies.

Ritzer, George. (2000). The McDonaldization of Society. Thousand Oaks, California: Pine Forge Press.

Ritzer, George, and Douglas J. Goodman. (2003). Sociological Theory 6th Ed. New York: McGraw-Hill.

Rubin, Gayle. (1975). "The Traffic in Women: Notes on the 'Political Economy' of Sex," ed. Rayna Reiter. In Toward an Anthropology of Women. New York: Monthly Review Press.

Yin, Robert K. (1994). Case Study Research: Design and Methods. Thousand Oaks: Sage Publications, Inc.

Zulueta, Francisco M. (2002). General Sociology. Mandaluyong City, Philippines: Academic Publishing Corporation.

Electronic Resources

Bedrous, A. V., (2006) "The Environment as Lifeworld: Using Habermas's Theory of Communicative Action in the Environmental Discourse." Unpublished paper presented at the Annual Meeting of the American Sociological Association. Retrieved December 2006 from <http://www. allacademic. com/meta/ p103491_index. html>

Commission on Population. State of the Philippine Population Report 2000. (2001). Retrieved May 2006 from <www. popcom. gov. ph / sppr /sppr01 /index.htm>

Danforth, Nick, and Peter Roberts. (1996). Better Together: A Report on the African Regional Conference on Men's Participation in Reproductive Health. Baltimore: Johns Hopkins Center for Communication Programs. Retrieved May 2006 from <http:// www.jhuccp.org/ pubs/sp /4/4.pdf>

Ezeh, Alex C. Seroussi Michka, and Raggers Hendrick. (1996). Men's Fertility, Contraceptive Use, and Reproductive Preferences. DHS Comparative Studies (No. 18), Calverton, MD: Macro International, Inc.,

Retrieved May 2006 from <http://wwwmensurodhs.com/ pubs/pdf/cs18/00frontmatter.pdf>

Greene, Margaret E., and Ann E. Biddlecom. (2000). "Absent and Problematic Men: Demographic Accounts of Male Reproductive Roles." In Population and Development Review. Vol. 26, No. 1, Population Council, Retrieved May 2007 from <http : // links. jstor. Org /sici = 0098-7921%28200003%2926%3A1%3C81%3AAAPMDA%3E2.0.CO%3B2-I>

Interagency Gender Working Group. (2003) Three Case Studies: Involving Men to Address Gender Inequities. Washington, D.C.: U.S. Agency for International Development. Retrieved May 2006 from < http://www.prb.org/pdf/InvolvMenToAddressGendr.pdf>

Lee, Romeo B., and Loyd Brendan Norella. (2002) Between the Thighs: Penile Circumcision, Implants, and Sexual Gadgets. Sydney: Australian National University Demography Department. Retrieved May 2006 from <adsri.anu.edu.au>

Obermeyer, Carla Makhlouf. (1999) "The Cultural Context of Reproductive Health: Implications for Monitoring the Cairo Agenda." In International Family Planning Perspectives, Vol. 25, supplement. The Alan Guttmacher Institute. Retrieved April 2006 from <http://www.guttmacher.org.pubs/ journals/ 25s5099.html>

Orbeta, Aniceto C. (2005). "Poverty, Fertility Preferences, and Family Planning Practice in the Philippines." Makati: Philippine Institute for Development Studies. Retrieved July 2006 from <http: // dirp4. pids. gov. ph /ris /dps/pidsdps0522.pdf>

Robey, Bryann, and Megan Drennan. (1995) "Male Participation in Reproductive Health." In Network Magazine. Spring 1998, 18 (3). Family Health International. Retrieved May 2006 from <http://www.FHI.org/en/ RH/Pubs/Network/v18_3/NW/83ch3.htm>.

Speizer, Ilene S., Lisa Whittle, and Marion Carter. (2005). "Gender Relations and Reproductive Decision Making in Honduras." In International Family Planning Perspectives, Vol. 31, No. 3, September 2005. The Alan Guttmacher Institute. Retrieved May 2006 from <http://www. guttmacher. org/pubs/ journals/ 3113105 .html>

United Nations. International Conference on Population and Development (ICPD). Cairo, Egypt, 1994.

United Nations Population Fund (UNFPA). (1999). "Implementing the Reproductive Health Vision: Progress and Future Challenges for UNFPA." In Evaluation Findings. UNFPA Office of Oversight and Evaluation. Retrieved May 2006 from <http://www.unfpa.org/monitoring/pdf/n-issue27.pdf>. Accessed May 2006.

Government Documents

DOH. Administrative Order 158, 2004.

Lacson, Panfilo. Senate Bill1546: An Act Creating a Reproductive Health and Population Management Council for the Implementation of an Integrated Policy on Reproductive Health Relative to Sustainable Human Development and Population Management, and for Other Purposes, 2004.

AVSC International and International Planned Parenthood Federation (IPPF). (1998). Male Participation in Sexual and Reproductive Health: New Paradigms. Symposium Report, Oaxaca, Mexico: AVSC/IPPF.

DOH. (2006). 2005 Annual Report. Manila: DOH.

Reports

Encarnacion, Jose Jr. (1978). Population and Development in Southeast Asia: A Fertility Model. Mexico City: International Review Group of Social Science Research on Population and Development.

Green, Cynthia P., Cohen Sylvie J., and Hedia Belhadi-El Ghouayel. (1995). Male Involvement in Reproductive Health, Including Family Planning and Sexual Health. UNFPA Technical Report No. 28. The Hague: United Nations Population Fund.

Interagency Gender Working Group (IGWG). (2005). A Summary of the "So What?" Report: A Look at Whether Integrating a Gender Focus Into Programmes Makes a Difference to Outcomes. Washington, D.C.: U.S. Agency for International Development.

Illo, Jeanne Frances I., Carolyn I. Sobritchea, and Ma. Cecilia G. Gonaco. (1999). Assessing the UNFPA Ted Turner Projects in the Philippines. Quezon City, Philippines: University of the Philippines Center for Integrative and Development Studies.

Leyte Family Development Organization (LEFADO). (2006). LEFADO Profile. Tacloban City, Philippines: LEFADO.

Montiel, Cristina, and Mary Racelis Hollnsteiner. (1976). The Filipino Woman: Her Role and Status in Philippine Society: Final Report. Quezon City, Philippines: Institute of Philippine Culture, Ateneo de Manila University.

National Statistics Office. (2006). 2005 Family Planning Survey.

Paxson, Heather. (2002).“Rationalizing Sex: Family Planning and the Making of Modern Lovers in Urban Greece.” In American Ethnologist 29 (2): 307-334. American Ethnological Association.

Porio, Emma, Frank Lynch, and Mary R. Hollnsteiner. (1975). The Filipino Family, Community and Nation: The Same Yesterday, Today, and Tomorrow?: Final Report. Quezon City, Philippines: Institute of Philippine Culture, Ateneo de Manila University.

Tacloban City Annual Reports, 2000-2005.

Tacloban City Health Office. Annual Accomplishment Reports, 2000-2006.

Johnson, David Michael. (2004). “An Analysis of the Worldview and Religious Beliefs of the Waray People.” Ph.D. dissertation, Asia Graduate School of Theology, Baguio City, Philippines. (unpublished)

Tandinco, Filedito D. (2008) “Male Involvement in Family Planning in Serin District, Tacloban City, Philippines” MS thesis. Ateneo de Manila University, Quezon City, Philippines. (unpublished)