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Family Planning in the Philippines

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Advancing Family Planning in the Philippines: a review of current evidence

Executive Summary

Some 73% of married women want to adequately space their next birth or stop childbearing altogether. The government targeted 60% use of modern methods by 2010, which will not be met as modern CPR reached only 34% in 2008. At the fastest growth rate recorded in the last 30 years, it would take until 2020 to reach 60% modern CPR. There are an estimated 5.52 M married women with an unmet need for modern contraception, with some 2.32 M belonging to the two lowest wealth quintiles.

Available evidence point to old and new interlocking factors that contribute to the large gap between the demand for regulating births and the use of modern contraception. The major ones include:

- unfounded fears about the safety of modern methods, fanned by influential forces opposed to contraceptives, and not sufficiently addressed by the public health and education sectors
- inadequate quality and quantity of family planning care and interactions
- inequity in access by poor women to sterilization services (tubal ligation)
- inability of local governments in general to compensate for the termination of the nationally-organized supply of contraceptives
- the focus of the last national government (2001–2010) to promote only natural family planning; and
- the decision of some major local governments to ban artificial contraceptives in areas they control.

Available evidence indicate that women in the highest quintile have been able to lower their fertility rates to replacement levels through a combination of delayed childbearing due to more years in school, and the higher use of sterilization. There are also preliminary indications that abortion, though generally disallowed in the Philippines, is overtaking contraception in regulating fertility.

Unmarried adolescent (15–19) and young women rely heavily on sexual abstinence to regulate childbearing. However, unmarried young men have departed substantially from this pattern, and many more are sexually active, with a large proportion engaged in higher-risk sex. Adolescents in union, most in live-in arrangements, have the lowest rate of modern method use among married women. A significant lowering of abstinence among adolescent women will put them at great risk of unintended pregnancies.

The following key steps are needed to advance the family planning program:

- revitalize a strong national government-led FP program that will provide universal access to all modern methods, and that supports and coordinates the services done by local governments
- provide public funding to ensure sufficient levels of health personnel, facilities and FP supplies, with a special focus on promptly eliminating the accumulated unmet need among poor women and marginalized areas
- develop a strong quality of care program and a public information and education program, including the integration of sexual and reproductive health education in the formal school system, to address safety and other concerns about contraceptives and the specific issues of young people
- conduct researches to open avenues to solving persistent problems, such as the large reliance on traditional methods, the low use of vasectomy and other male methods, and the problems faced by health service providers in giving better quality care, and
- recognize the reproductive rights of women and couples, and provide strong safeguards against violations of these rights, including through the enactment of a reproductive health law.

Background Information

The Philippines is an archipelago of 7,107 islands—some 4,000 of which are named and 1,000 inhabited—located off the southeast coast of mainland Asia. The total land area adds up to 300,000 square kilometers. The dispersed character of the country is heightened by its diverse and often difficult terrain: mountains, volcanoes and plateaus broken up by plains, valleys, rivers and lakes¹.

The country has an estimated population of 94 M in 2010² with 171 languages, the top 15 of which are spoken by 500,000 or more people each³. The official languages are English and Filipino—a lingua franca mandated by the 1987 Constitution. Filipinos value education as a way to get out of poverty, hence the relatively high functional literacy rate of 86%, with a 4.5 percentage point advantage by females⁴.

The country had a GNI per capita of US\$1,890 in 2008, slightly below the US\$2,078 average for lower middle-income countries by World Bank classification, and 28% behind the East Asia and Pacific region's US\$2,631 average.⁵

The Philippines has an urban population that went up from 27% in 1950 to 48% in 2000, and is predicted to grow to around 65% by 2020⁶. Consistent with an urbanizing trend, the persons employed in agriculture, forestry and fishery has gone down from 45% in 1989⁷ to 34% in 2009⁸.

Around 83% of the people identify themselves with the Catholic religion, 5% Islamic faith, and the rest various other Christian faiths⁹. Catholicism came with Spanish colonialism which lasted for more than 300 years, from the mid-1500s to 1898. The operation of Catholic hospitals and medical schools that began in the 1800s continue until today and play an important role in service provision and—through graduates that enter the health department and other government agencies—the crafting of health policies. Catholicism and the church hierarchy play a critical role in family planning policies.

The Philippines has a unitary presidential form of government with universal suffrage. State powers are divided among three coequal and separate branches—the executive, legislative and judicial—patterned after the USA which replaced Spain as the colonial power in the early 1900s. Election-based, autonomous governance in localities was fully developed during the American colonial period¹⁰. Currently, tens of thousands of local government officials—all elected every three years—wield extensive executive and legislative powers in numerous and complex layers of local government units (LGUs), mirroring the geographically and linguistically fragmented character of the country. From highest to lowest level, the LGUs are composed of 80 provinces, 138 cities, 1,496 municipalities and 42,025 *barangays* (villages)¹¹.

Nodal Points in the Family Planning Program

The official Philippine Family Planning Program (PFPP) was created by the Population Act (RA 6365), a law passed in 1971. From 1988 up to the present, the PFPP has been led by the Department of Health (DOH) and framed as a public health program with desirable demographic impact. Within this broad framework, major variations occurred as a result of three main factors: the president's position on artificial contraception, an issue that has been elevated to the highest office due to the strong opposition of the Catholic hierarchy; the devolution of health personnel, facilities, budget and decision-making to local government units (LGUs); and the reproductive health framework and international commitments made at the Cairo ICPD*.

* 1994 International Conference on Population and Development in Cairo, Egypt

The first period (1988 – 1991) was a transition phase in many ways: the whole government was rebuilding old and new institutions and processes after 14 years of authoritarian rule, * and a law that would radically change the health sector through devolution was proposed and ultimately passed in 1991. The constitutionality of and the need for a family planning program were debated¹² at the highest level of government. From a population program under the Commission on Population (POPCOM), family planning survived and was redefined as a health program under the health department.

The second period (1992 – 2000) was dominated by health devolution and the ICPD. The actual transfer of health personnel, facilities and resources occurred from 1993–94; legal efforts and mass campaigns from public health workers and some officials to renationalize the sector continued until the late 1990s; and a new health sector strategy to "make devolution work" was released in 2000.¹³ High-level commitments and efforts to promote family planning and reproductive health were slowed down by the very new and fragmented structure of the health sector.

The third period (2001–2010) was defined by the president's consistent support for the Catholic Church's doctrine on contraception: the promotion of natural family planning (NFP) and lack of commitment to artificial contraception and the RH agenda of Cairo. Wittingly or unwittingly, the president also pushed local autonomy to an extraordinary degree and weakened her own national health department by allowing LGUs to ban artificial contraceptives in their jurisdiction, as was done in the city of Manila.

The following table provides details to these three periods, and the succeeding section lists important events in family planning history.

Organizational Structures of the Family Planning Program, 1988–2010

	1st period: 1988–1991	2nd period: 1992–2000	3rd period : 2001–2010
President	Corazon Aquino	Fidel Ramos (1992–1998) Joseph Estrada (1998–Jan 2001)	Gloria Macapagal Arroyo (Jan 2001–June 2010)
DOH FP Program	Family Planning Service (FPS) was placed under Office for Public Health Services of the DOH (EO 119, 1987)	1994-1997: FPS added a Project Management Team for FP/RH Project 1998: RH Program created under Office for Special Concerns (OSC); National RH Advisory Committee to be convened by OSC, with two chairpersons—Asst. Sec. of OSC and Director of FPS (AO 1-A, 1998) 2000: National RH Program Management Committee created under Center for Family Health (CFH); FPS placed under CFH (AO 24-A, 2000)	2001 – Family planning placed under Center for Family and Environmental Health (CFEH); the RH structure created in 2000 was not implemented (AO 50-A, 2001) 2002-2004 – the Natural Family Planning (NFP) Program was created, strengthened and finally separated from the Family Planning Program (AO 125, 2002 and AO 132, 2004); the President declared her preference for NFP

* President Ferdinand Marcos declared martial law in 1972, revised the constitution and gave himself executive, legislative and judicial powers. He was ousted through massive, peaceful protests in 1986.

	1 st period: 1988–1991	2 nd period: 1992–2000	3 rd period : 2001–2010
Health Devolution	<p>DOH still has control over all hospitals, health centers and health posts during this period</p> <p>Local Government Code was enacted (Oct 1991), but devolution does not start immediately</p>	<p>1992–1993: health personnel, facilities and resources transferred to LGUs</p> <p>1994: Health sector fully devolved: DOH – controls regional hospitals & medical centers Provinces – control provincial, district and lower level hospitals Cities – control city hospitals & city health centers Municipalities – control health centers (Rural Health Units or RHUs) and health posts (Barangay Health Stations or BHSs)</p>	<p>The President announced publicly that LGUs may decide to provide artificial contraceptives in their locality, or go NFP-only and cited Manila as an example (the Manila LGU has effectively banned all artificial contraceptives in the health centers and hospitals it controls since 2000, through an Executive Order by the mayor¹⁴)</p>
Contraceptive Self-Reliance	None	<p><i>Contraceptive Independence Initiative (CII)</i> created, with a strong role for the national government (AO 24-A, 2000); for the first time, the DOH asked for budget to purchase contraceptives</p>	<p><i>Contraceptive Self Reliance (CSR)</i> strategy created, which declared that the main responsibility for FP lies with LGUs (AO 158, 2004); USAID-donated commodities phased out from 2004–2010</p> <p><i>Amended CSR</i> – assigned a strong role once again to the national government, but this policy was done a week before end of the Arroyo government (AO 27, 2010)</p>
Commission on Population (POPCOM)¹⁵	<p>POPCOM transferred its family planning program to the DOH</p> <p>POPCOM was moved from the social welfare department to the Office of the President (1990), then to the National Economic Development Authority (1991)</p> <p>POPCOM began its Population and Development (POPDEV) planning</p>	<p>POPCOM introduced the Population-Resources-Environment (PRE) framework into Philippine Population Management Program (1993)</p>	<p>POPCOM transferred to the DOH (EO 188, 2003)</p> <p>POPCOM directed by the President to lead the Responsible Parenthood and Natural Family Planning Program (2006)</p>

Important Events in Family Planning

Early years and the beginning of the FP Program

- 1957: Tariff and Customs Law prohibited the importation of anything for "preventing human conception or producing unlawful abortion," including printed matter giving direct or indirect information
- 1964: University of the Philippines Population Institute (UPPI) established
- 1965: Revised Administrative Code declared as "absolutely non-mailable" anything for "preventing conception or producing abortion, or for any indecent or immoral use," including anything that gives direct or indirect information
- 1966: R.A. 4729 restricted even the free dispensation or distribution (e.g., as practiced by non-profit organizations) of contraceptive drugs and devices to licensed drug stores and pharmaceutical companies
- 1967: President Ferdinand Marcos and 17 other heads of state signed the UN Declaration on Population
- 1969: Policy study group on population created (Commission on Population)
- 1969: Catholic bishops released a pastoral letter on *Humanae Vitae* and called on Filipino Catholics and clergy to obey the pope's decision upholding the ban on artificial birth control and sterilization¹⁶
- 1971: Population Act (RA 6365) passed; a family planning program to reduce population growth rate for economic and development goals was created, along with the Commission on Population (POPCOM) under the Office of the President; POPCOM was tasked "to put up family planning clinics in cooperation" with the Department of Health (DOH)
- 1972: Martial law was declared over the entire country; Pres. Marcos gave himself executive, legislative and judicial powers
- 1972: Pres. Marcos issued P.D. 79 and revised the Population Act; POPCOM was given added authority to "employ physicians, nurses, midwives to provide, dispense and administer all acceptable methods of contraception"; "utilize clinics, pharmacies as well as other commercial channels of distribution for the distribution of family planning information and contraceptives"; and "call upon and utilize any department, bureau, office, agency or instrumentality of the Government for such assistance as it may require"; family planning became a vertical program under POPCOM
- 1973: Catholic bishops started to label as abortion artificial methods which act in the "interval between fertilization and implantation of the embryo"¹⁷ and painted the population program as a part of martial law's violation of human rights, a "contraceptive mentality" movement that will turn from "the voluntary towards the compulsory"¹⁸
- 1978: Modern CPR rose to 17% from 2.9% in 1968, the fastest pace of growth that will be achieved (20% annually). From hereon, modern CPR growth slowed down to 2–3% annually.¹⁹
- 1979: Leader of Catholic bishops, Cardinal Jaime Sin, stepped up criticism of martial law's human rights violations and "anti-life" record, which include the promotion of "abortifacient" IUDs and injectables.²⁰
- 1986: Marcos fled the country after massive *people power* protests and military defections. Corazon Aquino became the new president. Cardinal Sin played a key role in the ouster of Marcos.
- 1987: New Philippine Constitution ratified. A provision in the martial law constitution that justified

population control was removed ("It shall be the responsibility of the State to achieve and maintain population levels most conducive to the national welfare"). In its place, the 1987 Constitution now says that the State shall defend "the right of spouses to found a family in accordance with their religious convictions and the demands of responsible parenthood."

Catholic bishops succeeded in the inclusion of this provision in the 1987 Constitution: "[the State] shall equally protect the life of the mother and the life of the unborn from conception." The bishop proponent of this provision now says that this was meant to also prohibit "abortifacient" methods of family planning.²¹

1988–1991

1988: The family planning program was transferred to the DOH after an intense debate within the new government on whether or not to continue with it. The health secretary managed to rescue the program and, consistent with the ongoing democratization processes, framed family planning as a rights-based health program to reduce maternal and child mortalities and morbidities that would lead to desirable demographic changes as a matter of course.²²

1990: Catholic bishops began campaigning against contraceptives for being unsafe for both the mother and fetus²³.

1991: DOH Administrative Order AO 114 codified the place of FP in its range of health programs by classifying family planning "according to couple's choice" as part of "services for the reproductive health of mothers"—a basic maternal and child health service to be delivered by all frontline health units.

1991: The Local Government Code (LGC) was passed into law.

1992 – 2000

1992-1994: Health services were devolved to more than 1,600 local government units (LGUs). Provinces and big cities got control of hospitals. Municipalities and cities got health centers (rural health units or RHUs) and health posts (barangay health stations). Family planning became the responsibility of LGUs. The transfer of personnel, facilities and resources was completed in 1994.^{24, 25}

1994: The ICPD agreement to move family planning away from demographic targets and reframe it within reproductive health and rights was readily accepted, since this was the general direction taken by the country's FP program after martial law.

1998: DOH AO 1-A—Creation of a Philippine Reproductive Health Program. A reproductive health (RH) program with 10 elements was created; a lead office for each element identified; and a coordinating mechanism was set-up to run the program.

2000: DOH AO 24-A—Strengthening of the DOH Reproductive Health Program. A regular structure for managing the RH program was formed under the Center for Family Health. A Contraceptive Independence Initiative (CII) was established to integrate RH funding, including the purchase of contraceptives, into the health financing and social insurance plans and programs of the health department. Funds to purchase contraceptives—a first for the country—were included in the 2001 DOH budget request. The RH program was further detailed in AO 43: Reproductive Health Policy.

2001 – 2010

2001: A new government (headed by Pres. Gloria Macapagal Arroyo) came to power after mass protests triggered by events in a corruption trial of Pres. Joseph Ejercito Estrada forced him out of office. The Catholic hierarchy played a key role in the ouster. The new president is a follower of Catholic Church doctrines on contraception, and would hold on to power for the

next nine years. The budget for contraceptives and the CII was never implemented. Later, the national effort was shifted to promoting Natural Family Planning (NFP).

2001: AO 50-A—National Family Planning Policy. A strong, detailed and comprehensive FP program was outlined in this AO, but the 2000 RH program and structure was replaced. National funding for the FP program, including the purchase of contraceptives, was included and framed as part of eliminating dependence on foreign donors through the CII. An ambitious target of 50% modern CPR by 2004 was set, from a baseline of 28% in 1998 (10% annual CPR growth, 4–5 times the annual rate of growth since 1978). It is unclear how or why this AO—never seriously implemented—was crafted at all.

2002: AO 125—National NFP Strategic Plan Year 2002-2006. This marked the shift of the national government to focus almost exclusively on natural family planning. An ambitious target was set to raise NFP use from less than 1% baseline, to 20% by 2006.

2003 and later years: Legislators prod the DOH to purchase contraceptives by allocating their discretionary development funds ("pork barrel") for this specific purpose. Most of the funds were simply not used by the DOH. The small proportion of funds used went to a fairly complex funding window (established by DOH Memo 2008-0100) that LGUs must apply and qualify for.

2004: AO 132—Creating the DOH Natural Family Planning Program and its Program Management. The NFP Program was further enlarged by separating it from the current FP program; and its narrow focus was reinforced by directing it to work more closely with groups "which want to promote NFP exclusively". Family planning was now based on "four pillars: responsible parenthood, birth spacing, informed choice and respect for life," a phrase used by the President to distance herself from the ICPD language.

2004: AO 158—Guidelines on the Management of Donated Commodities under the Contraceptive Self-Reliance Strategy. This marked the formal passing of responsibility for family planning from the DOH to LGUs. The health secretary clarified that self-reliance is not indicative of a need for the national government to begin purchasing its own supplies, but of "the end-users and the [LGUs] outgrowing their dependence on the donors of these contraceptives."²⁶

2008: Modern CPR measured at 34% (NDHS* 2008). It took 30 years to double the 17% CPR in 1978, equivalent to a slow 2.3% annual growth rate.

2008-2009: House Bill 5043²⁷—"An act providing for a national policy on reproductive health, responsible parenthood and population development, and for other purposes"—reached plenary debates at the House of Representatives, the furthest that a law on reproductive health or population has gone since various bills were filed after ICPD. The bill was not voted upon due to lack of time, a result of delaying tactics by those opposing it.

2010: AO 2010-0027—Amendment to Administrative Order No. 158, Series of 2004 entitled Guidelines on the Management of Donated Commodities under the Contraceptive Self-Reliance Strategy. This AO strengthens the role and responsibility of the national government in ensuring the availability of and access to family planning and RH commodities. However, this was issued a week before the scheduled change of government on June 30, 2010.

2010 –

2010: Benigno Aquino III takes over the presidency. The president has publicly announced a 5-point position on family planning: *"(1) I am against abortion; (2) I am in favor of giving couples the right to choose how best to manage the families so that in the end their welfare and that of their children are best served; (3) the state must respect each individual's right to follow his or her conscience and religious conviction on matters and issues pertaining to the unity of the*

* National Demographic and Health Survey

*family and the sacredness of human life from conception to natural death; (4) in a situation where couples, especially the poor and the disadvantaged ones are in no position to make an informed judgment, the state has a responsibility to so provide; and lastly, (5) in the range of options and information provided to couples, natural family planning and modern method shall be presented as equally available.*²⁸

The new health secretary has included a request of P400 M to purchase contraceptives in the regular budget of the DOH for 2011. The new Speaker of the House of Representatives has pledged that the RH Bill will be put to a vote at the plenary.

Current Issues in the Family Planning Program

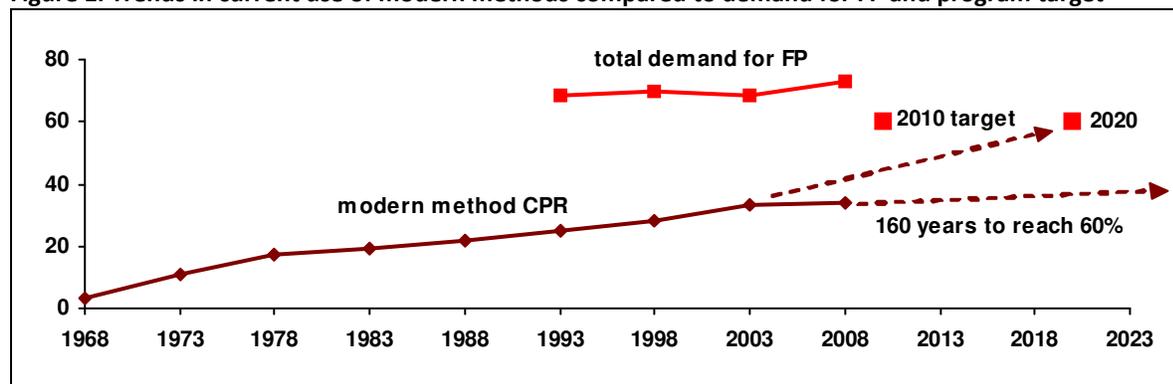
Modern contraceptive use

Modern contraceptive use is low to moderate, with steady but slow growth since 1978. Only a third or less of married women of reproductive age use any modern method. Average annual growth was 19% from 1968 to 1978 and 2–3% from 1978 to 2003. The fastest growth in the last 30 years was 3.4% from 1998 to 2003. Even if this rate is sustained, it would take until 2020 to reach 60% modern CPR*, a decade behind the government's 2010 target²⁹ (Figure 1). From 2003 to 2008, growth dropped steeply to 0.36% which, if left unchanged, would mean that a modern CPR of 60% can only be reached after 160 years.

Modern method CPR was 34% in 2008, while the total demand for family planning stood at 73%, which means that less than half of the demand was met through modern methods.

(Note for all figures: see the Appendices – Data Tables for further details and sources.)

Figure 1. Trends in current use of modern methods compared to demand for FP and program target



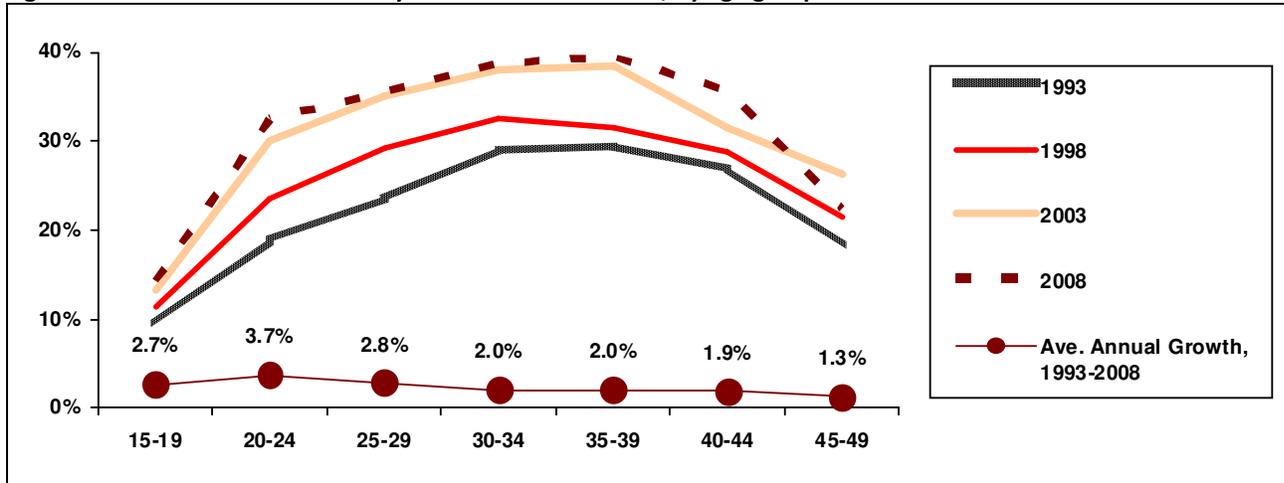
Trends in modern contraceptive use

By age group

Current use by age follows an inverted U shape, with peak use by women in their 30s for any modern method (Figure 2). All age groups increased their use from 1993 to 2008, but at different rates of growth. The largest gains came from the three youngest age groups, with those aged 20-24 at the lead, having increased by 3.7% per year for 15 years. The oldest group, the 45-49s, had the smallest gain at 1.3% per year. It is the only group where current use dipped during the 15-year period, from 26% in the 2003 survey to 22% in 2008.

* Contraceptive prevalence rate

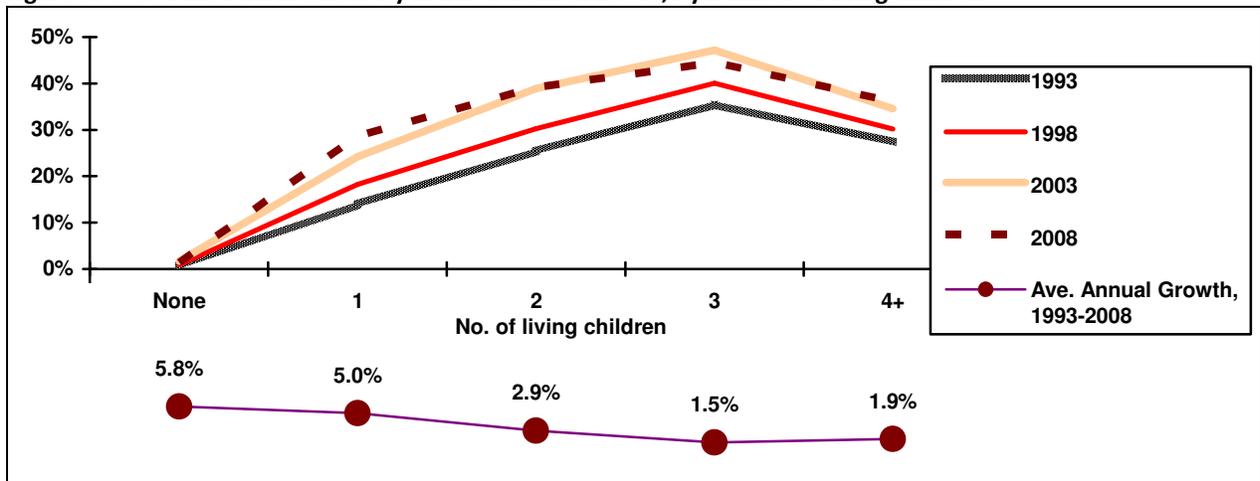
Figure 2. Use of modern methods by married women 15–49, by age group



By number of living children

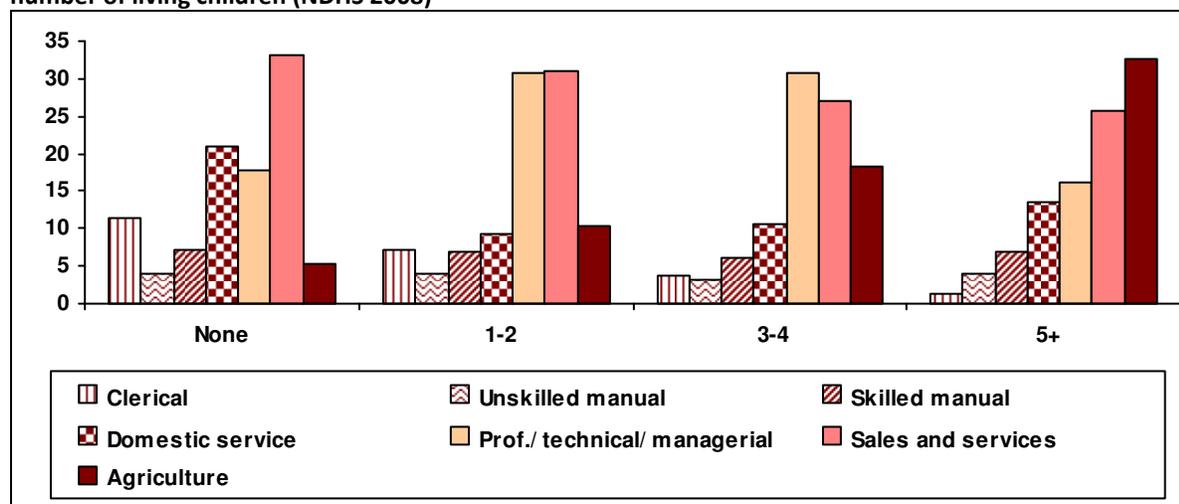
The use of modern methods increases steadily until it peaks at women with three children, then the rate dips (Figure 3). Over the past 15 years, those with one child showed the most significant annual rate of growth at 5%, almost 2½ times the average for all. Those with no children had 6% growth, but this had little impact as the baseline was near zero. Those with three or more children improved their rate of use, but below the 2.1% average growth rates. Those with three children even registered a slight drop in current use from 2003 to 2008.

Figure 3. Use of modern methods by married women 15–49, by number of living children



The NDHS 2008 showed that women with only one to two children were usually in professional, technical and managerial work (31%) and in sales and services (31%), while those with five or more children were into agriculture (33%) and also sales and services (26%, see Figure 4). In general, women in agriculture tended to have more children. Among women with children, domestic service (house help) is the only occupation other than agriculture that increased with the number of children.

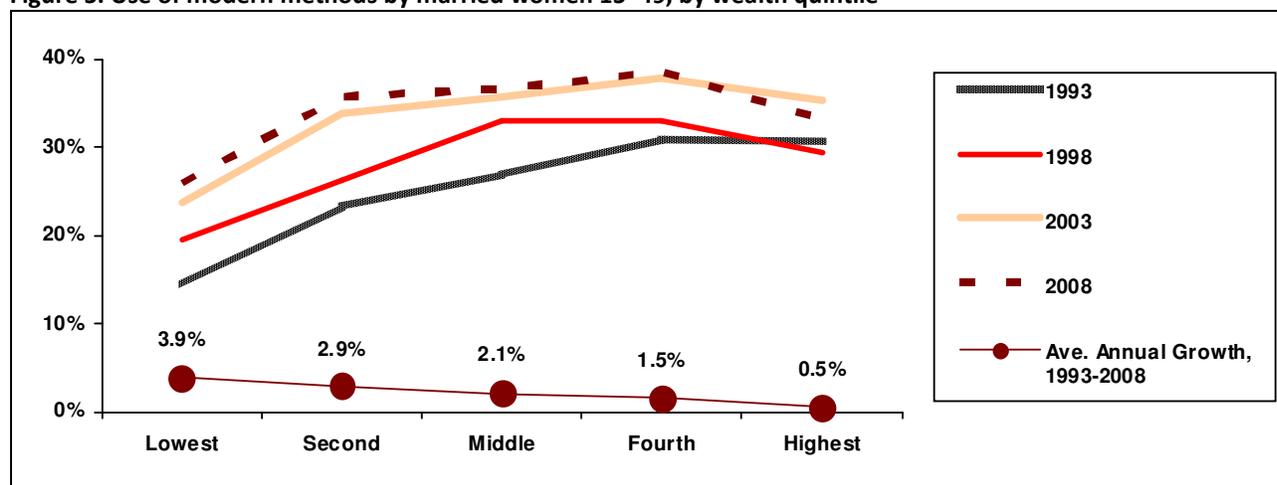
Figure 4. Percentage distribution of all women 15-49 employed 12 months preceding survey, by occupation and number of living children (NDHS 2008)



By wealth quintile

In 1993, women in the highest wealth quintile were 2.1 times more likely to use modern contraception than those in the lowest quintile. Fifteen years later in 2008, the ratio has gone down to near equality at 1.3. Over the past 15 years, the two poorest quintiles had larger and more consistent CPR growth rates, averaging close to 3–4% annually. In contrast, those in the highest quintile rose by less than 1% annually and even had two periods of decline in contraceptive use (Figure 5). CPR use in the middle quintile grew at the same rate as the average for all married women.

Figure 5. Use of modern methods by married women 15–49, by wealth quintile



Summary of growth trends

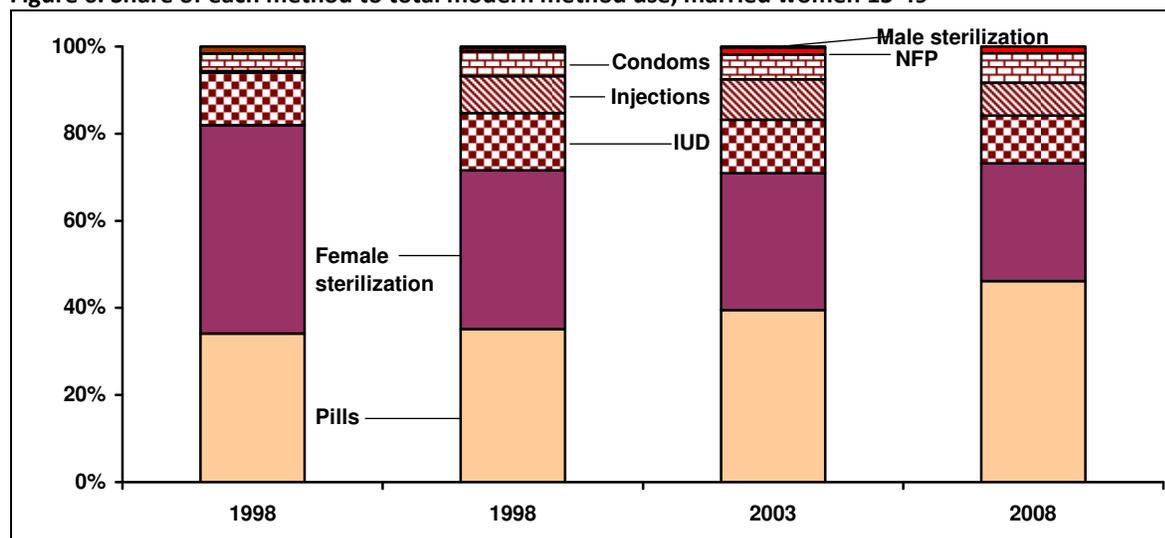
From the preceding information, it appears that from 1993 to 2008, growth in contraceptive use among married women has been led by those who are poor but not in agricultural work, in their 20s, and with one or two children. These are the segments of the population that had lower rates of use in the past, and have caught up to some extent in the last 15 years. However, the rates of CPR growth achieved by these best performing segments are still slow in absolute terms. For example, the NDHS 2008 shows that women in the poorest wealth quintile need to increase its CPR from the current 26% to 68% in

order to eliminate their unmet need and the use of traditional methods. At the 3.9% annual growth rate that the poorest women have achieved—the fastest among all quintiles—it will still take 25 years to go from 26% to 68% CPR.

Modern contraceptive method mix

From 1993 to 2008, the top two methods—pills and female sterilization—have consistently accounted for 71% or more of all modern method use (Figure 6). However, both methods are undergoing substantial shifts. Sterilization has gone down from first to second, changing place with the pills. The movement is due to an 85% increase in pill current use (8.5% to 15.7%) and a 23% drop in sterilizations (11.9% to 9.2%). The proportion of sterilized women who have moved out of the reproductive years have not been adequately replaced by the program. Although the increase in pill use has more than made up for the drop in sterilizations, the better fit of the latter to women who want no more children should not be underestimated. Discontinuation is also a problem with pills. In the 2003 NDHS, more than a third of women on pills, excluding those who want to get pregnant, stopped within 12 months: 17.4% due to side effects and health reasons; 3.7% due to method failure; and 14.6% due to other reasons.

Figure 6. Share of each method to total modern method use, married women 15-49



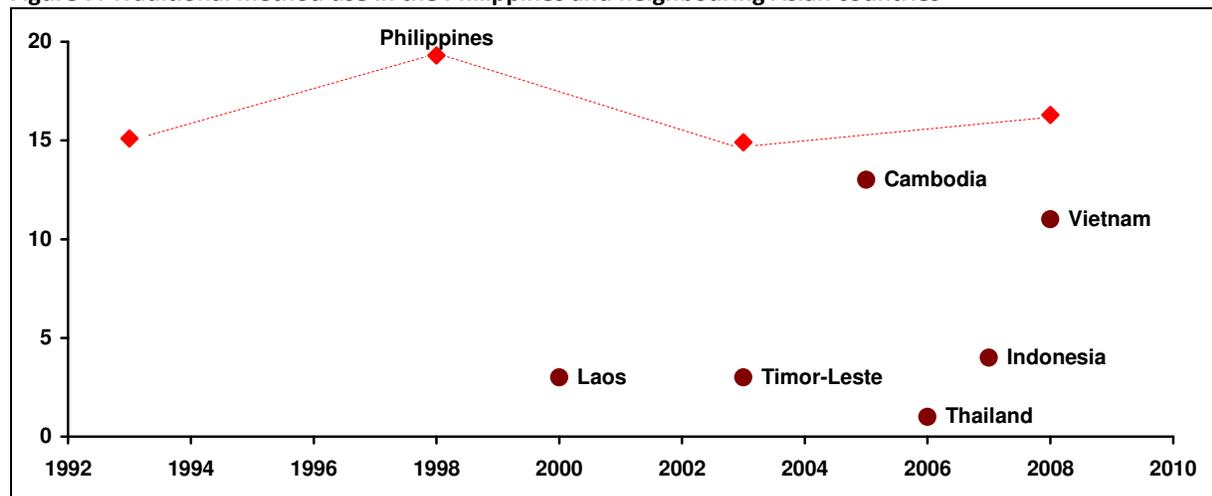
The next three methods—IUDs, injections (DMPA, reintroduced in 1994) and condoms—make up the next cluster, accounting for some 25%–27% of modern methods in the last 15 years. All three have registered increases in current use over the past 15 years, but the base levels in 1993 are too small (3% use or less), which means the upward trend may not be stable. From 2003 to 2008, the use of IUDs has actually gone down from 12.3% to 10.9%, and injections dipped from 9.3% to 7.6% use.

The last two methods—modern NFP and male sterilization—have consistently registered less than 1% use over the last 15 years. These methods have been part of the government's program for a long time, much earlier than the injectable which has overtaken the two. Specific studies should be done to explain the very low uptake, and policies adjusted accordingly. A large-scale, distinct (i.e., separate from the regular family planning program) and nationwide push for modern NFP was done by the national government since 2002, with a goal of reaching 20% current use by 2006 (DOH AO 125, 2002). This campaign should be evaluated promptly and thoroughly since the end-results are in, and an extremely large gap exists between the 20% target and 0.5% rate that was accomplished.

Traditional method use

Traditional methods—mainly the rhythm method* and withdrawal—have had a long history of use by a significant proportion of married women. The country's first National Demographic Survey in 1968 recorded 11.5% use, which has risen almost constantly although at a slow pace—under 1% annually—until it reached 16.3% in 2008. This level is relatively high compared to the recent rates of neighboring countries in Southeast Asia like Thailand (1% in 2006), Timor-Leste (3% in 2003), Laos (3% in 2000), Indonesia (4% in 2007), Vietnam (11% in 2008) and Cambodia (13% in 2005).³⁰

Figure 7. Traditional method use in the Philippines and neighbouring Asian countries



The rhythm method became an official part of the family planning program at its inception and discontinued by the health department in 1994³¹. Among rhythm users however, only a minority know the correct timing of a woman's fertile period—between 26% to 48% in the four surveys from 1993 to 2008. This suggests that most users have not had any formal orientation, much less training, about the method.

The health department's 2010 goal of 80% total CPR and 60% modern CPR³² implies a target of 20% use rate for traditional methods, which means raising further the current high levels. This seems to contradict the health department's own official method mix. Policy clarification is needed in this area.

Unmet need for modern methods

Unmet need measures the proportion of married women who are fecund, want to space the next pregnancy by two years or more, or stop childbearing altogether, but are not using any method of contraception. By this definition, users of traditional methods are classified as having 'met' their need for preventing pregnancy. Due to the large risks of traditional methods in leading to unintended pregnancies, and the exclusion of these methods in official family planning programs, combined counts of women with unmet need (not using any method) and those using traditional methods are now used by researchers from the Guttmacher Institute ("unmet need for effective contraception"³³) and ICF Macro of the DHS project ("unmet need for modern methods"³⁴). This combined count is especially useful for countries with high levels of traditional method use, and the concept will be used in this report.

* Calendar-based periodic abstinence

Unmet need for modern methods provides a simple basis for targeting levels of contraceptive use that is based on the expressed desires of women to regulate their childbearing. With the unmet need approach however, a problem occurs if women and couples desire a large number of children that, when aggregated, will lead to unsustainable population growth. This desire may have been true for the Philippines in the earlier decades, but the latest studies show a different picture.

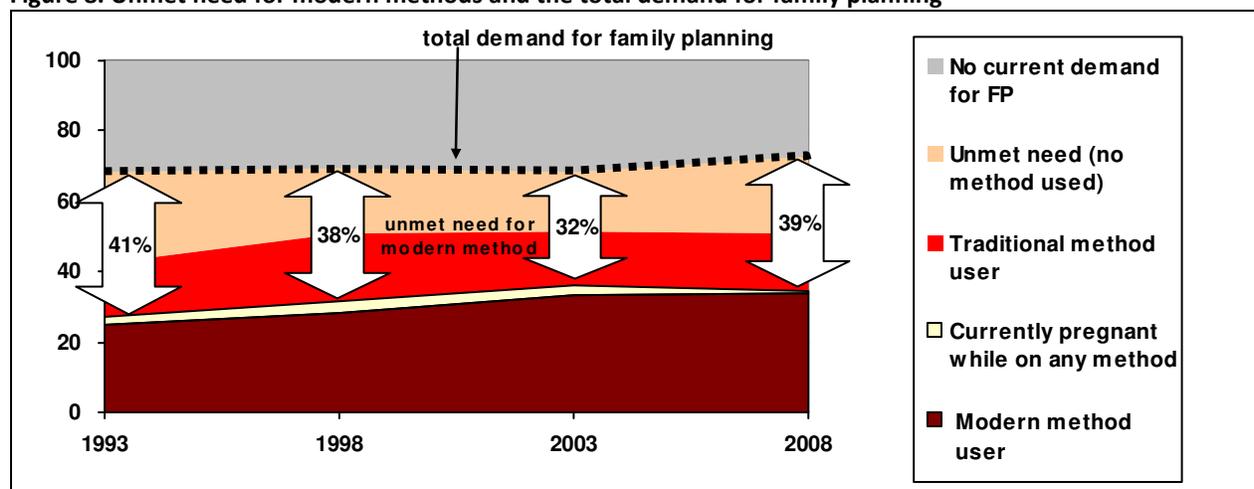
Westoff³⁵ calculated in a 2006 multi-country study that a TFR* of 2.4 to 2.8 will result from eliminating or reducing the unmet need based on the 2003 DHS data. Shifting the large number of traditional method users to modern methods will likely reduce further the predicted TFR and move it near the 2.1 replacement level.

In a 2006 study using cross-tabulations and multivariate analyses of socioeconomic status and demographic behaviour, Orbeta³⁶ concluded that "it is not the demand for more children that is the reason for [the poor's] large family size but their use of ineffective fertility control measures." He proposed three factors that can explain this outcome: "(a) the crowding out of women from poor households by a significant percentage of women from richer households that are getting their supplies of modern contraception also from public sources, (b) the lower education of women from poorer households, and (c) the lower capacity of women from poorer households to pay for private supplies."

Proportion

The Philippine government does not have a target for unmet need reduction but gave a CPR target of 80% for all methods and 60% for modern methods by 2010, and a CPR of 100% by 2015³⁷. The 100% CPR target is likely a mistake because there will always be women who want to get pregnant. This is an area that needs policy clarification from government.

Figure 8. Unmet need for modern methods and the total demand for family planning



From 1993 to 2003, the proportion of women with unmet need for modern method went down from 41% to 32% (Figure 8). The improvement came almost solely from a drop in those not using any method; traditional method use remained practically the same. From 2003 to 2008 however, unmet need for

* Total fertility rate

modern method went up again to 39%. The increase came from both non-users and traditional method users, with the former contributing the larger hike.

Magnitude

The single-digit movements in unmet need percentages mask the huge number of women affected. The country has millions of married women in their reproductive years because the population is young and growing, and the proportion of women in union (married or in live-in arrangement) has not gone down (i.e., a rise in the average age of marriage may bring the proportion down, but this has not occurred). There is evidence that the proportion has even gone up slightly: women in union was 58.2% in the 2000 Census and 61.9% in the 2008 NDHS.

Figure 9. Estimated number of married women with unmet need for modern methods

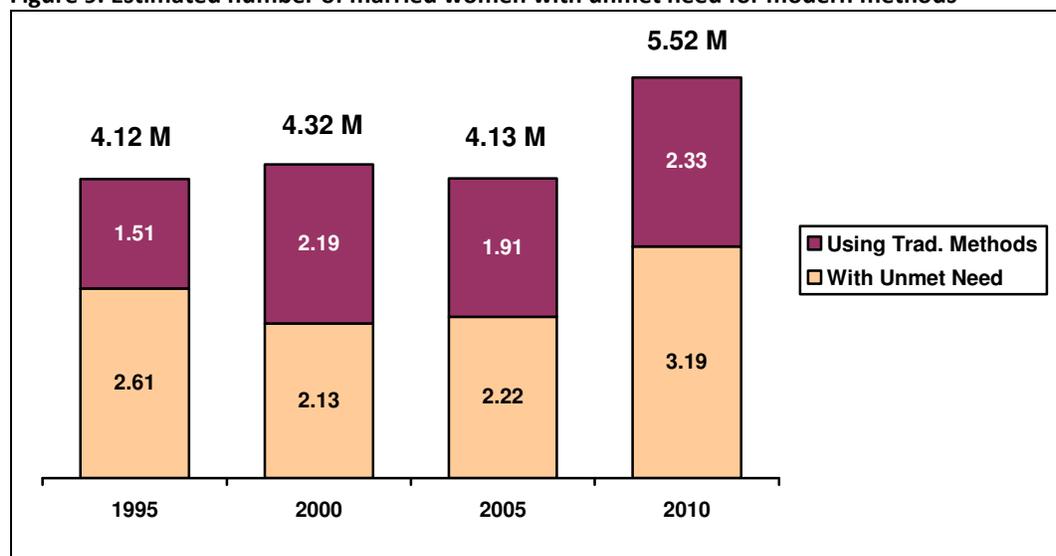


Figure 9 presents an estimate of the number of married women who do not want a pregnancy now or ever but are not using any modern method of contraception. It uses the medium series population projections nearest a survey year (i.e., the 1993 survey was matched to the 1995 population projection, 1998 survey to the 2000 projection, and so on). The estimate used the lower, census-based percentage of women in union (58.2%).

The estimates show that there are 3.19 M married women of reproductive age with an unmet need in 2010, up by 0.97 M from 2005; and 2.33 M using traditional methods, up by 0.42 M. Over-all, the family planning program needs to reach as many as 5.52 M women in 2010 to help them access modern methods of contraception. Around 42% of these women—some 2.32 M—belong to the two lowest wealth quintiles.

Women users of traditional methods and those with unmet need contribute to 24% and 68% respectively of unintended pregnancies in the Philippines. Darroch³⁸ and colleagues estimated that in 2008, if all women at risk of unintended pregnancies were able to use a modern method of contraception, there would have been:

- 0.8 million fewer unplanned births
- 0.5 million fewer induced abortions
- 0.2 million fewer spontaneous abortions
- 2,100 less maternal deaths

- 120,000 less DALYs* of women
- fewer infant deaths (births spaced by 2 or more years have lower mortality rates, but 33% of all births do not meet this ideal)

Reasons for not intending to use modern contraception

Among women not using any method, 53% stated in 2008 that they do not intend to use one in the future, up from 46% in 1993. These are relatively high rates. In a 2007 comparison³⁹ of 34 countries with 2000–2005 DHS surveys, the range of intended non-use was 23% to 79%. The Philippines ranked fourth from the top, after Mauritania, Eritrea and Nigeria (Figure 10). But unlike most of the other countries with high intended non-use of contraception, the country fared better in terms of current use of any modern contraception (3rd among the 15 countries in Figure 10). These cross-country comparisons can shed light on the Philippine's pattern of contraceptive use. The increasing total demand for family planning (seen in Figure 8) probably indicates a widespread desire to control fertility that is matched by strong resistance or barriers to modern method use. The result is low to moderate levels and slow growth of modern contraceptive use, a large reliance on traditional means to control fertility, and a high percentage of those not planning to use any method at all.

Figure 10. Intended future non-use among married women not using any method, top-15 countries with 2000–2005 DHS, compared with % use of modern methods

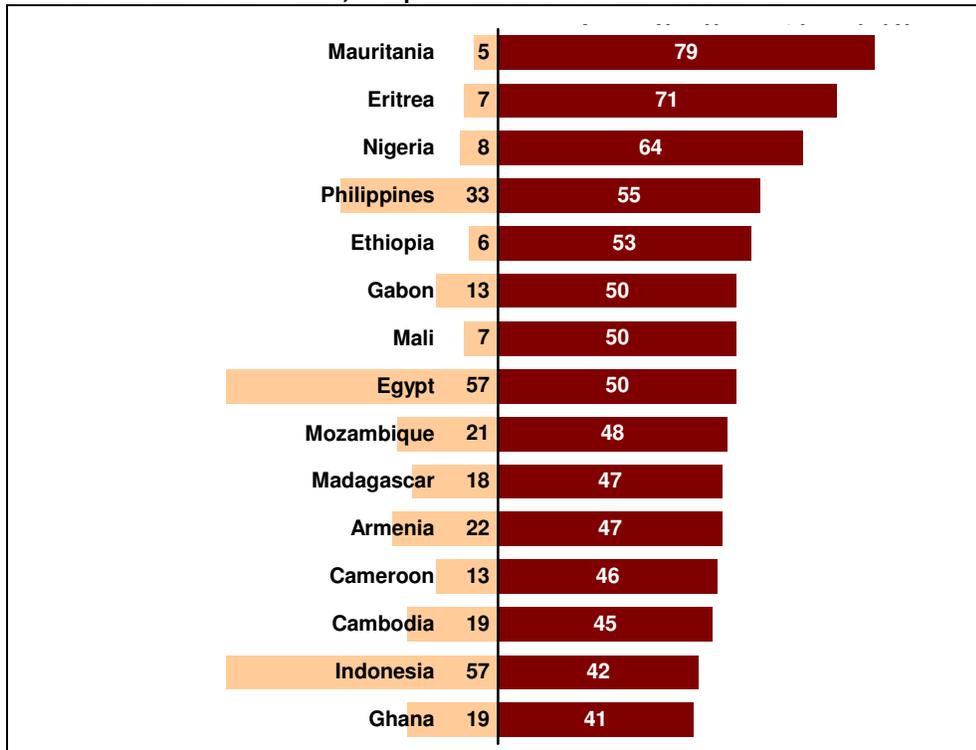


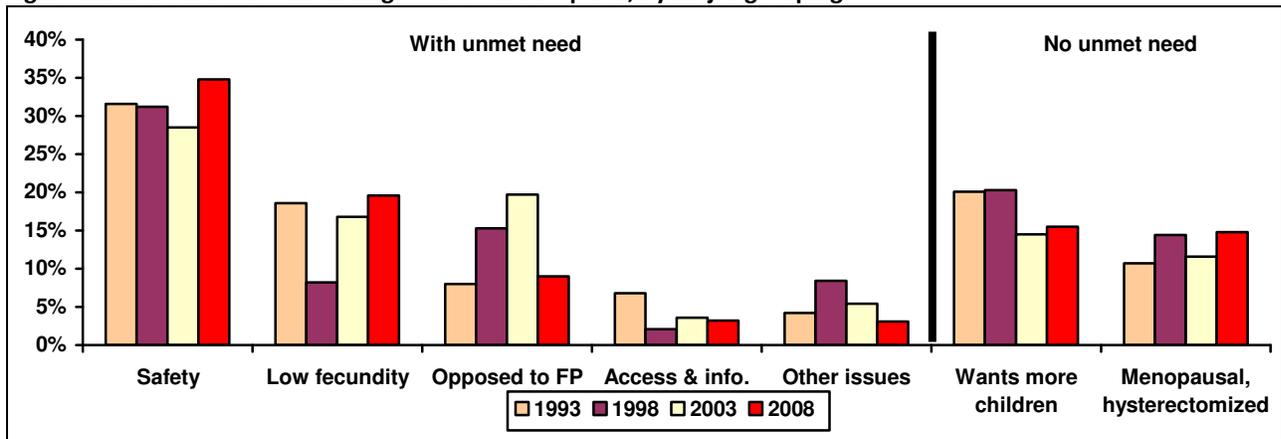
Figure 11 summarizes the explanations[†] provided by women when asked for one main reason why they do not intend to use any method of contraception. Around a third want to get pregnant or cannot get

* DALY – disability adjusted life years. One DALY can be thought of as one lost year of "healthy" life.

† The reasons in the DHS were re-organized into major groups by the authors. Table 15 provides the component details for all groups.

pregnant anymore*. The other two-thirds probably have an unmet need, and will continue to have an unmet need unless the resistance or barriers to use are successfully addressed.

Figure 11. Reason for not intending to use contraception, by major groupings



Safety concerns

The top group of reasons is about safety, cited by half of those with an unmet need. The issues in this group revolve around doubts about the intrinsic safety of contraceptive products or their suitability or fit (*hiyang* in Filipino) to the user. Focus group discussions typically open up concerns about cancer, weight loss, dangerous levels of chemical buildup due to prolonged use, excessive bleeding, the buildup of unclean blood if menstruation stops, loss of physical strength which leads to inability to work, debilitating headaches or stomach aches, devices that get lost or entangled inside, and many more fears.

Filipino women have relatively high levels of formal education—71% of women not using any method in the 2008 NDHS had high school or college education. However, contraception is not a standard part of the curriculum. The Department of Education had a much publicized attempt to pilot-test the inclusion of sexuality and family planning topics in some public high schools in the last few months of the previous government, but this was blocked by lobbying from the Catholic bishops and clergy. A policy of integrating age-appropriate reproductive health and sexuality education into the formal school system are also part of numerous reproductive health bills filed in Congress since 2001, but all these have been successfully blocked by intense and widespread lobbying by the Catholic hierarchy.

* Due to menopause or hysterectomy

Perceived Effects of Family Planning Methods (from FGDs and in-depth interviews)⁴⁰

Condom	Injectable	IUD	Tubal Ligation	Pill	Vasectomy
No satisfaction when having sex, because it is too slippery	Will cause tumors in the uterus because one does not menstruate	May melt inside the body and doctors will not be able to find it anymore	The woman can turn into a maniac because there is nothing to stop her from being promiscuous	Does not dissolve well so some residue is left in the woman's uterus, which can cause cysts, infection, or worse, cancer	Part of the man's testicles are cut off
Could be left inside the vagina	Causes one to be irritable because menstruation is not regular	May be washed away by strong menstrual flow	Not good for women with asthma	Causes headaches, irritability, weight gain, weight loss, dry skin, loss of (and reduced) libido	The testicles are tied together, so it hurts
Gives you a feeling that you are eating an unpeeled banana	Causes edema, bloated stomach, headache, irritability, loss of libido and sexual satisfaction, frequent bleeding, skin diseases, e.g., pus	Itchy on the vagina	Could cause weight loss, loss of libido, pus	When it does not work, the baby is born with abnormalities	The man loses his manhood because his penis is cut off ("kapon")
Could offend partner (because she might think you find her dirty)	Prevents menstrual flow since blood remains in the uterus	Permanent; one will not have children anymore	Not fully effective, woman could still get pregnant	Could trigger thyroid problems	
Sexual intercourse becomes painful for both man and woman		May become entangled around the man's penis and the man and woman cannot be separated	Results in mortal sin because it is against church teachings	Causes bleeding when taken in large doses	
Used only for casual sex		Messy, especially when inserted during menstrual period		Not advisable for women with lots of veins	
Not effective because it could have holes		Painful to insert			
Users are like sex maniacs					
Does not taste good					

Another factor for the prominence of safety questions is the open and continuing campaign by Catholic bishops, lay groups, some Catholic medical practitioners and politicians to raise doubts about the safety of contraceptives.⁴¹ Some of the worst documented cases occurred in Manila (pop. 1.7 M). In a 2006 video documentary,⁴² the mayor of Manila justified his ban of contraceptives in the city with the following assertion: "Contraceptive materials actually are poison to the woman's body. You look at the internet, it's even described as a pesticide. Why should I be teaching people how to take pesticide?" In 2007, medical doctors employed by the city government admitted in interviews about the contraceptive ban in the city that they teach people that contraceptives are unsafe or ineffective, that oral pills contain pesticides and cause cancer, and that condoms are not effective in preventing HIV because the virus is smaller than the condom's pores and can penetrate through.⁴³

Low fecundity

Focus group discussions (FGDs)⁴⁴ reveal misconceptions about fertility that may lull women into a false sense of being protected from pregnancy. Some beliefs are rooted in tradition, and some are probably due to the absence of sexual health topics in the school curriculum discussed earlier. A common traditional practice, still flourishing, is called *pagpahilis ng matris* (misaligning the uterus) which involves a *hilot* (traditional birth attendant and healer) manipulating the lower abdomen, supposedly to reposition the uterus in such a way that the woman becomes safe from pregnancy. Other beliefs include

correlating the number of children to women's natural resistance or propensity to pregnancy (*hindi buntisin* or *buntisin*); and that a woman's fertility decreases as the age of her youngest increases.

In the 2008 NDHS, 93% of those who cited infecundity, subfecundity or infrequent sex as their reason for not using contraception were 30 years old and above. For sexual frequency, it is possible that women may be overestimating the decline in sexual activity since the percentage of women reporting sexual intercourse within the past four weeks of the survey show an almost constant 66% to 64% for those aged 30–44, and a not so large drop to 56% for those aged 45–49.

Opposition to family planning

Religion-based opposition to family planning is low, ranging from 3% to 6% during the four surveys. It appears that other issues are more important to women even though majority of them belong to the Catholic faith. However, it

is possible that the Catholic hierarchy's sustained campaign against contraception may be contributing through other routes, like enhancing women's worries about the safety of contraceptives.

Those who cited opposition by their husbands were few, about the same as that from religious beliefs. However, the 2008 NDHS shows that 20% of women have husbands that want more children than they do. The percentage peaks at 27% for women in the lowest wealth quintile. This could mean that some women who say they want more children are merely echoing the wishes of their husbands, thereby underestimating the role of men in the non-use of contraception.

A community health worker (CHW) participant in an FGD narrated, "We had a patient, her husband would feel her up inside to check for the IUD strings. Once he knew for sure, he had them removed. As a result, some of the women stopped using the IUD." Other women however, responded by "devising ways" to circumvent their husband's dictates, like putting pills in vitamin bottles, hiding them in their mother's house, or having their DMPA shots while bringing their children for treatment in the clinic.

Access and information issues

Access and related issues are low, ranging from 2% to 7% during the four surveys. It is possible however, that many non-users have not tried any method at all or for a significant amount of time to be able to feel access problems like cost, distance and availability. It is also possible that when women are able to overcome their main barrier like safety issues, other problems like access may now come to the fore, especially for women in the lower quintiles. Evidence for access problems exist in another section of NDHS 2008. When women were asked about problems in getting health care for themselves when sick, 65%–74% in the two poorest quintiles identified "money for treatment" as their top problem, and 59%–71% picked "no drugs available" as their second to the top concern.

In a focus group discussion with long-time community health workers, some of them tried four modern methods—usually pills, DMPA, condom, breastfeeding and IUD, in different orders, before they settled on a method that was most comfortable to them. A few used a combination of modern methods and herbal "menstrual regulators" e.g., roots of *achuete*, *makahiya*, *makabuhay* and *marabilos*. The shift to different methods are triggered by side effects such as headaches, lightheadedness, gastritis; unexpected effects such as cessation of menses with pills and IUD; and continuous method failure—usually with pills and DMPA; heavy bleeding with DMPA. A few used withdrawal. Despite the difficulties, women persist in using because of many reasons.

In their experience, clients who have difficulty sustaining use are those who experience side effects, some of which are contrary to the postulated effects of methods—amenorrhea with IUD and pills, monthly bleeding with injectables—or symptoms which are not logically related to the methods, like chest pain, mass, and asthma. There are those who fear experiencing pain on getting an IUD because they think it is a surgical procedure, or because of previous experiences with

Quantity and quality of care

Insufficient quantity and quality of contact and interaction with health providers on family planning matters may contribute to the persistently high safety concerns of women, and possibly other problems that may be remedied by face-to-face counseling and education. In the 2008 NDHS, 31% of women non-users visited a health facility in the last 12 months, and only 32% of them were at least told about the availability of family planning*. Another 8% of all women surveyed were visited by FP workers at their homes. Over-all, only 18% of women non-users had a family planning interaction in one year.

Aiming for quality in health care is a vital goal in itself, built on shared values of caring for the vulnerable, fairness and equity. In addition, good quality encourages sustained use of services and expansion of the user base. In family planning, the first empirical evidence on the practical value of quality care came from a 2003 published study by RamaRao⁴⁵ and colleagues on 1,460 new family planning users at 80 service delivery points in the Philippines[†]. They found out that the quality of care received at the time a woman adopted a contraceptive method influenced her contraceptive use at follow-up, with probabilities of continued use increasing as quality increased: 55% for low quality care, 62% for medium quality care, and 67% for high quality care. The quasi-experimental operations research component of this study done by Costello⁴⁶ and colleagues provided a very detailed look at how family planning services measure up to a proposed quality of care framework by Judith Bruce, shown as categories in the table below.

Quality of care in some facilities in Davao del Norte and Compostela Valley

Detailed Aspect of Quality of Care	Client got this aspect of care (%)	Quality of Care Category
Provider was friendly	99	Client-provider interpersonal relations
Received chosen method	98	Choice
Respondent satisfied with service	98	Client-provider interpersonal relations
Facility was clean	97	Client-provider interpersonal relations
Was asked type of method she preferred	91	Choice
Received information without a single method being promoted	89	Choice
Told how to use the method	88	Information clients received
Told timing of next visit	88	Service offered
Asked timing preferred for her next birth	85	Assessment of client's FP needs
Told about possibility of switching to another method	85	Information clients received
Respondent allowed to ask questions	85	Client-provider interpersonal relations
Asked about previous family planning experience	84	Assessment of client's FP needs
Respondent's questions answered to her satisfaction	84	Client-provider interpersonal relations
Told how her chosen method works	76	Information clients received
Was told about other methods	68	Choice
Respondent felt her privacy was respected	68	Client-provider interpersonal relations
Told how to manage problems that arise	66	Information clients received
Told about side effects of the method	62	Information clients received
Asked if she desired another child	59	Assessment of client's FP needs
Told about warning signs associated with method	56	Information clients received

* 32% of the 31% of all women non-users that visited a health facility equals 10% of all women non-users.

† Davao del Norte and Compostela Valley

Detailed Aspect of Quality of Care	Client got this aspect of care (%)	Quality of Care Category
Provider used IEC material	47	Client-provider interpersonal relations
Told of other sources of supply	33	Service offered
Told about methods that protect against STDs	32	Information clients received
Given an appointment card for follow-up visit	30	Service offered

In facilities where no intervention was done (control sites, representing the typical situation in the areas studied), 859 family planning clients were interviewed about whether or not each detailed aspect of quality care was done. Looking at the top one-fourth of the quality of care list, it appears that public health facilities in these areas do great on friendly and satisfying interpersonal relations, clean facilities, and respecting and supporting their clients' chosen methods. However, they performed quite poorly in addressing clients' safety concerns—side effects, warning signs, how to manage problems, and even IEC materials that can tackle these issues—which landed at or near the bottom fourth of the quality care list.

The NDHS 2008 asked three similar questions on information given to women who started a method within the last five years. The results roughly match the percentages for equivalent items in Costello's study: 68% were informed about possible side effects or problems; 67% were told about what to do in case side effects develop; and 63% were informed about other methods that could be used.

The Department of Health (DOH) recognizes the key role of quality of care and has identified as one of its three main goals a "more responsive health system"—one which respects patients' dignity, privacy and autonomy; and gives prompt care, adequate amenities, access to social support network and freedom to choose a health provider. In its 2005–2010 National Objectives for Health, the DOH candidly described the public's poor perception of primary facilities (rural health units, health centers and barangay health stations), which provide the bulk of non-surgical family planning. Perception and reality impact on one another, so this baseline observation is important. According to the DOH, "Public primary facilities are perceived [to be of] low quality. Those who bypass the primary health facilities are not satisfied with their services. Diagnosis is poor, resulting in repeat visits. Medicines and supplies are inferior and rarely available. The personnel are often not available, especially in rural areas, and are perceived to lack both medical and people skills. Waiting time is long, facility schedule is very inconvenient, and facilities are rundown."

Other barriers to seeking FP shared by FGD participants:

- Requirements for patients to present donation and barangay clearance at health centers or any ID and prescription at the drugstore
- Patients overhear some providers complaining that they "look shabby, dirty, like they came straight from the garbage dump"
- Some providers "do not like to serve those coming from a different barangay, so what they do is ask for barangay clearance to prove that you are within the health center's area of responsibility", which leads to hoarding and waste of available supplies
- Some providers require proof of menstruation as assurance of non-pregnancy prior to method provision, especially IUD and ligation: "They will ask you to swab a cotton ball and show it to them." For injectables, "patients must do the pregnancy test, drop urine, in front of them." A woman who did the test in the toilet was scolded.
- "I saw a patient who was probably at one month after childbirth and she wanted to have a method. A midwife told her, 'Just come back after your sixth month.' That's all she

said."

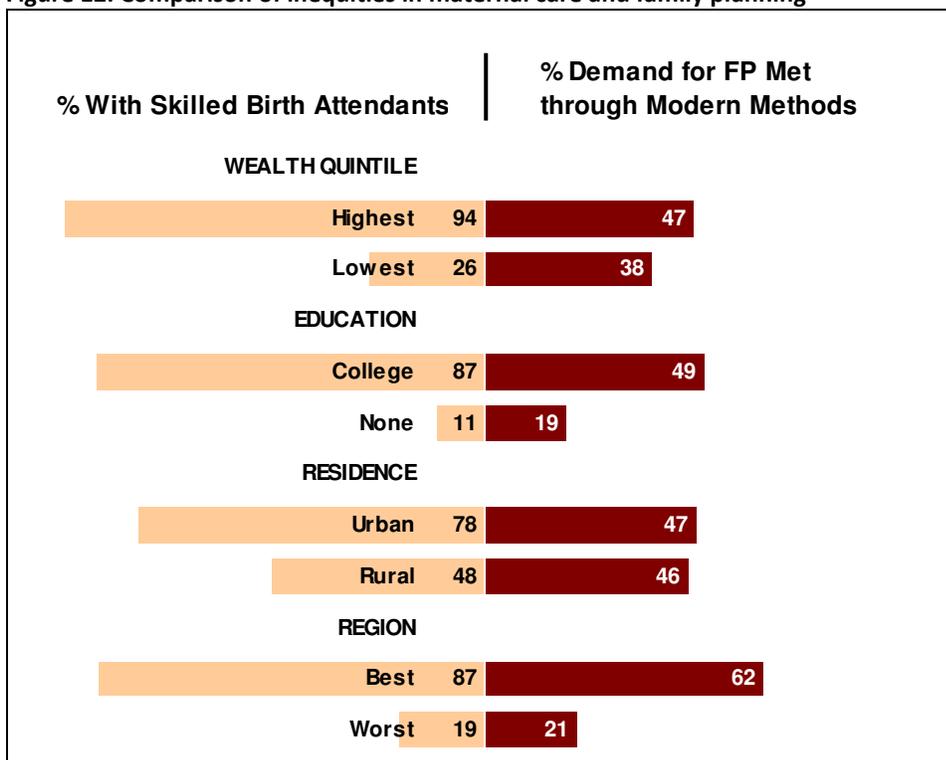
- "I had a friend who was in a maternity hospital who told a young girl, 'So what do you do now, they won't let you go home without an IUD.' The young girl did not want an IUD."
- "They do not cut the IUD strings after insertion. They tell you to return for follow-up so they will cut the strings."

Inequity

Use of services

Inequities in the use of modern contraception to fulfill the demand for family planning is less pronounced than the inequities exhibited in maternal care, as exemplified by the use of skilled birth attendants (SBAs, see Figure 12). Urban vs. rural differentials show the least inequity for contraception. Urban dwellers had a mere 4% advantage over rural dwellers, compared to the use of SBAs wherein urban dwellers had a 62% advantage. Regional differentials show the worst inequity for contraception. The best performing region (Cagayan Valley) had a 201% advantage over the worst performer (ARMM). However, SBAs by region exhibited an even wider 352% gap (Metro Manila vs. ARMM). The same pattern is found in inequities based on wealth, with a 25% gap for contraception compared to a wider 267% gap in SBAs; and inequities based on education, with a 166% gap for contraception compared to a wider 698% gap in SBAs.

Figure 12. Comparison of inequities in maternal care and family planning



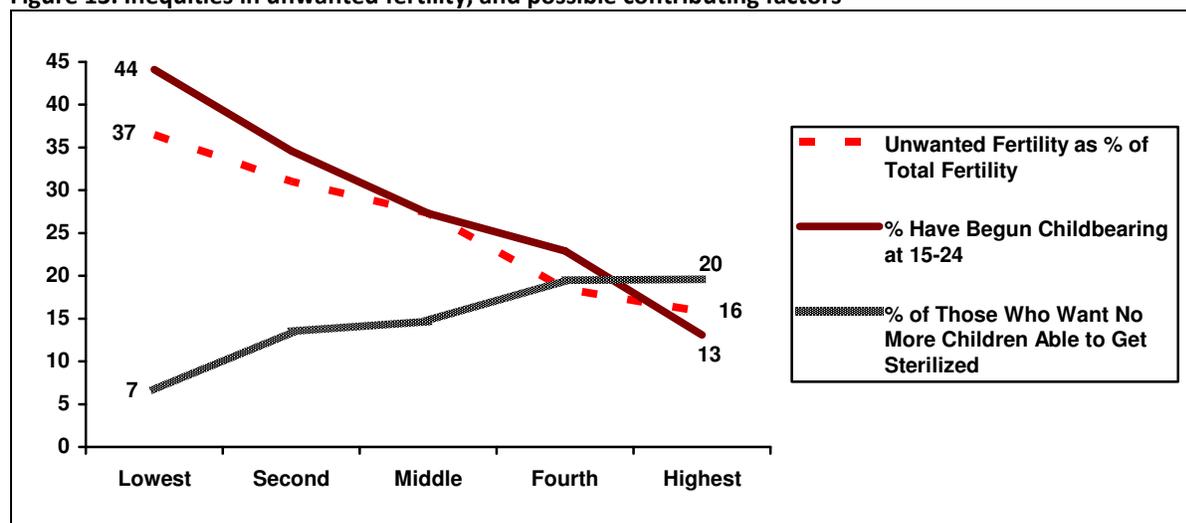
For contraception, it is apparent that percentages for the most advantaged sectors (highest quintiles, college educated, urban dwellers and best regions) are unusually dampened. Whereas these high-performing sectors got 78–94% in skilled attendants, they achieved only moderate levels of 47–62% in contraception. For the most disadvantaged sectors, contraception provided somewhat better rates than

SBA use for those in the lowest quintiles (38% vs. 26%) and those with no education (19% vs. 11%). Thus, better equity in contraception was achieved through dampened use among the most advantaged sectors, and slightly improved rates in the most disadvantaged groups.

Unwanted fertility

Although inequities in contraceptive use are somewhat moderated, large inequities exist in unwanted births. In the 2008 NDHS, 37% of births of women in the lowest quintile are unwanted, compared to 16% in the highest (Figure 13). Two possible explanations are highlighted here. First, poor women fare worse at avoiding early pregnancy. Some 44% of women in the lowest quintile have already begun childbearing at age 15 to 24, compared to 13% in the highest quintile. This may be related to the length of time in school—66% of women in the highest quintile finish high school or reach college, while only 11% of women in the lowest do so. Second, poor women have lower rates of using sterilization to limit their childbearing—7% for the poorest compared to 20% for the wealthiest*—most likely due to the higher up-front costs of the procedure compared to other family planning methods. The median cost of female sterilization was recorded by the 2008 NDHS at PhP1,476 in the public sector and P9,929 in the private sector, around 30–33 times the cost of an IUD[†] in the same sector.

Figure 13. Inequities in unwanted fertility, and possible contributing factors



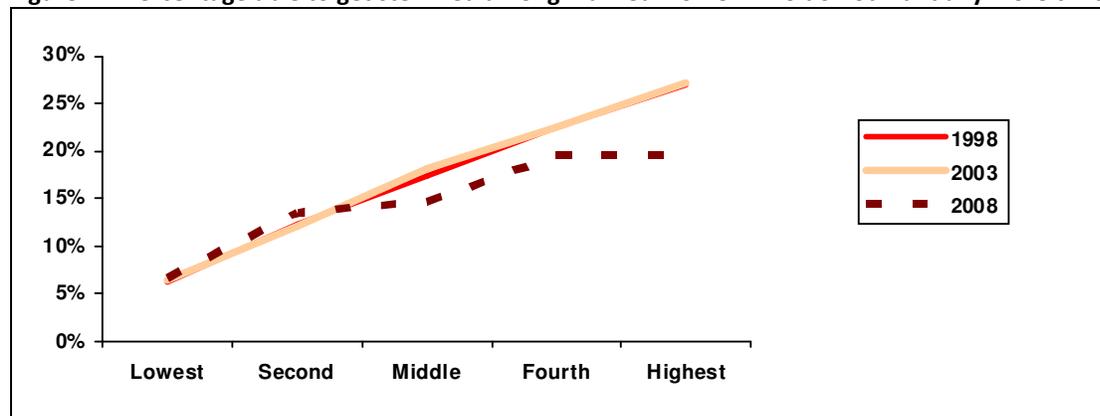
Sterilization and inequity

Inequity in female sterilization rates has been observed since wealth quintiles were added to the DHS. In the 1998 and 2003 surveys, among women who do not want any more children, the percentage that got sterilized increased at a constant rate with every rise in wealth quintile, with the highest getting four times the rate of the lowest (Figure 14). This pattern changed in 2008. The percentage among the highest, fourth and middle fell while the second and lowest quintiles remained the same. The highest ended up with just three times the rate of the lowest. Lessening inequity came from declines in the better-off quintiles, not from any improvement for the poor.

* Percentage use of female sterilization among married women who want no more children

[†] There is no inequity by wealth quintiles in IUD use. Around 4% of the lowest to the fourth quintiles and 2% of the highest use IUDs.

Figure 14. Percentage able to get sterilized among married women who do not want any more children



To both eliminate inequity and return to the 2003 peak rate achieved by the highest quintile (i.e., 27% of all those who want no more children are able to get sterilized), it is estimated that by 2010, around 1.13 M sterilizations are needed: 370,000 for the lowest; 260,000 for the second; 240,000 for the middle; 136,000 for the fourth; and 126,000 for the highest quintile. The two poorest quintiles need 55% (630,000) of all these procedures and require easier access to subsidies from public health funds to eliminate the equity gap. In October 2008, the country's national health insurance program (PhilHealth) raised its benefit for tubal ligation and vasectomy to P4,000 total per procedure⁴⁷, which means the two poorest quintiles need about 2.5 B pesos (US\$ 59 M) to eliminate the accumulated need for sterilization services. Steps are also need to correct the inequity in access to health insurance. In the 2008 NDHS, only 21% of women in the lowest and 32% in the second quintile had any type of health insurance, compared to 58% of women in the highest quintile.

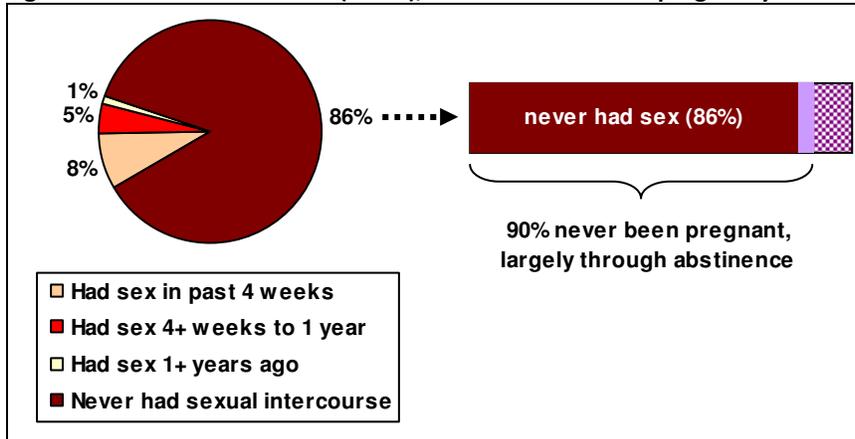
Adolescents

Adolescent women aged 15-19 in the Philippines have relatively low pregnancy rates compared to those in other developing countries. In a 2008 comparison by Khan and Mishra⁴⁸ of 38 countries with recent surveys (DHS 2001–2005), the Philippines at 92% ranked 6th in the percentage of adolescents who had never been pregnant. Slightly ahead of the Philippines were Vietnam (96%), Rwanda (96%), Armenia (95%), Moldova (94%) and Morocco (93%). Other Asian countries in the study had far lower percentages: Nepal at 44%, Bangladesh at 28% and Indonesia at 27% (ranked 37th). The 2008 NDHS recorded a slight decline to 90%, which would leave unchanged the country's ranking in this study.

The low rate of teen pregnancy is not due to the high use of effective contraception. On the contrary, married* adolescents have the lowest use of modern methods at 14% compared to 23–40% for the other age groups; and the highest rate of unmet need at 36% compared to 18–26% for the other groups. There are plenty of anecdotal reports of public health facilities refusing to provide contraceptives to adolescents. It is possible that health providers do not know or have no guidelines on how to handle young couples in live-in relationships, and 7 of 10 married adolescents are in this type of marital arrangement.

* Unless qualified with the word "formal/formally", the term married includes those living together in informal unions.

Figure 15. Adolescent women (15-19), sexual behavior and pregnancy rates



The 2008 NDHS shows that sexual abstinence is the main strategy used by adolescent women to avoid an unintended pregnancy (Figure 15). Among all women 15-19, 86% had never had sexual intercourse, almost equivalent to the 90% that had never been pregnant.

Abstinence is also a key strategy for unmarried young women aged 15-24. In the Khan and Mishra study, the Philippines ranked third at 97% in the percentage of never-married young women practicing *primary abstinence*, meaning those who have never had sex. Vietnam and Armenia are ranked first, both with 100% rates. Countries with 50% or less of unmarried young women practicing primary abstinence include Zambia (50%), Benin (49%), Mozambique (39%) and Congo (34%).

The sexual behaviors of young men are different. Only 75% of never-married young men practice primary abstinence, enough to rank the Philippines in fourth, but substantially different from the practice of young women. The same study shows that among all youth (married or unmarried) who had sex in the past 12 months, 49% of young men had *higher-risk sex*, or "sex with a nonspousal, noncohabiting partner," with 24% condom use among those who had higher risk sex. Only 6% of young women had higher-risk sex, with 11% condom use. Among all young men who had sex* in the past 12 months, 25% had multiple sex partners.

It is unclear how long unmarried adolescents can continue to rely on very high abstinence rates to prevent unintended pregnancies. From 1993 to 2008, the percentage of women 15-19 that have begun childbearing has increased from 6.5% to 9.9%, a growth rate of 2.8% per year. However, 69% of these births and pregnancies are wanted, and most occurred among women in union. If abstinence rates go down and the poor use of modern contraception in this age group continues, then rates of unintended pregnancies will surely go up. What is clear is that women and men in this age group have diverse and possibly changing behaviors that must be addressed using tailor-fit strategies.

Contraceptive Self-Reliance

According to the DOH, the US Agency for International Development (USAID) has shouldered 80% of the country's FP commodities in the past, at an estimated amount of US\$3M annually for 36 years,⁴⁹ with the rest shouldered by other international donor agencies. In the late 1990s, USAID and the DOH started discussions about ending these donations and the Philippine government taking over funding for

* Data is unavailable for young women.

contraceptive supplies. This eventually resulted in the issuance in March 2000 of an Administrative Order (AO 24-A) called *Strengthening the DOH Reproductive Health Program* wherein a National Program on Reproductive Health with its own national program manager was organized under the Center for Family Health unit of the DOH. A *Contraceptive Independence Initiative (CII)* was created, described as a special multisectoral initiative that will be a priority of the national program. The general objective was to make all relevant RH services, including family planning, available in all DOH and LGU health facilities. Financing of RH services would be integrated into the general health financing and social insurance programs. Funds for the purchase of contraceptives—a first for the country—was included in the DOH's regular budget for 2001. However, a premature replacement of the Philippine president occurred in 2001, with a new president^{*} who was a follower of Catholic Church doctrines on contraception. The budget for contraceptives was not realized and the CII was not implemented.

In 2004, a new AO was issued entitled *Guidelines on the Management of Donated Commodities under the Contraceptive Self-Reliance Strategy (CSR)*. Most of the AO's content was on the phase-out schedule of USAID donations and mechanisms for dividing up the diminishing supplies: end of condom donations in 2004; phase-out of pills from 10.55 M cycles in 2004 to zero in 2008; phase-out of injectables from 1.17 M vials in 2004 to zero in 2009; and the eventual phase-out of IUDs.[†] The CSR was different from CII in that responsibility for funding contraceptives was assigned to LGUs.

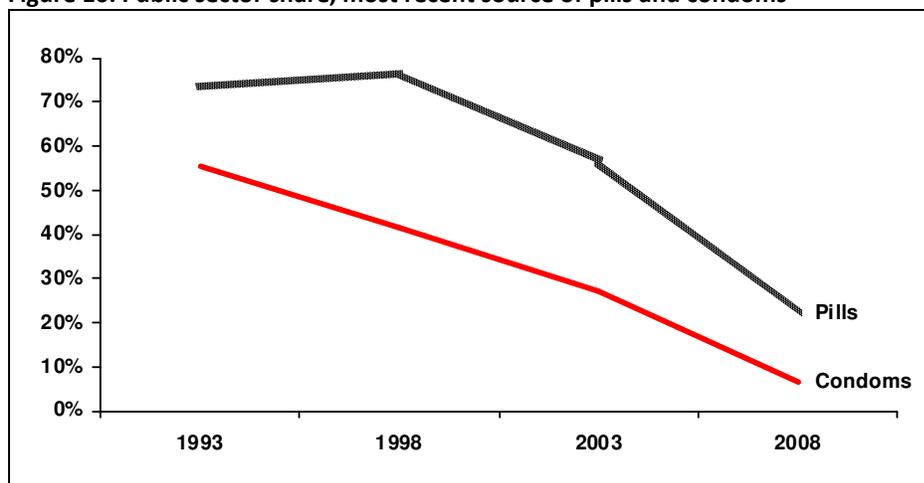
CSR Rapid Assessment⁵⁰ The first attempt to assess the CSR revealed that more than half (67/122) of LGUs (75 provinces, 1 region, ARMM representing all its component provinces and 46 cities) procured oral contraceptive pills (OCP) in 2007, with 27 LGUs procuring at a level above or equal to the estimated full requirement of their constituents. The remaining 40 LGUs procured below requirement levels. These figures, augmented by the fact that almost all 67 LGUs that procured (64/67) used local budgets to finance their OCP procurement, indicate encouraging initial CSR response initiatives. There is also some indication that these LGUs plan to maintain or increase their current level of OCP procurement. However, sustaining these promising trends in the longer term remains to be seen especially with the stark reality that often, family planning is not a priority by some LGUs and is easily influenced by personal religious convictions of LGU chiefs or a strong church lobby. Moreover, more pertinent local barriers to increasing CPR include geographic isolation, poverty, contraceptive supply shortcomings, LGUs without a strong commitment to procuring and allocating for FP commodities, and lack of male involvement in FP.

Fall in the public sector share. The 2008 NDHS revealed a disturbing trend that began to be detected in 2003. From high levels in 1993, the public sector share in condoms has fallen continuously since 1998, the same with pills since 2003 (Figure 16). It is unsafe to explain away these trends as innocuous redistribution between the private and public sector because the country's modern CPR is just half the targeted level for 2010, growth has been very slow and has stopped in the last five years. It is possible that provincial and city LGUs cannot adequately forecast, fund, coordinate and deliver the contraceptive needs of a growing population. Around 1500 municipalities have direct responsibility and control over all health centers and health posts that provide non-surgical supply methods. Thus, it is also possible that the impact on municipal FP supplies and services of the CSR policy has not been studied enough.

* Pres. Gloria Macapagal Arroyo replaced Pres. Joseph Ejercito Estrada in January 2001 after anti-corruption mass protests forced him out. The new president held on to more than 1½ terms in office, until June 2010.

† The final shipment reportedly arrived in 2010.

Figure 16. Public sector share, most recent source of pills and condoms



In June 2010, AO 2010-0027 was issued by the outgoing secretary of health to replace the CSR AO of 2004. The goal was made clearer: availability and access to all family planning methods and RH commodities. Objectives were focused towards ensuring RH commodity security to eliminate unmet needs for FP and RH services; free commodities to poor women; a national procurement system; and a logistics management information system to track the distribution, storage and utilization of supplies. The AO now contains explicit language that the national government will directly finance or ensure the financing of FP and RH commodities, not as an option of last resort, but as part of its regular role to build safety nets for the poor.

Abortion overtaking contraception in regulating fertility

Cabigon (2008) adopted the Bongaarts' proximate determinants to decompose the contribution of marriage, contraception, induced abortion and postpartum infecundability to the slow fertility change using the 1993, 1998 and 2003 NDHSs. The analysis is done at the national and regional levels with the national updating an earlier work using all surveys done before 1993. The study clearly demonstrates that overall, contraception has been the primary factor explaining the decelerating decline in fertility from the 1960s to early 1990s but has been outranked by induced abortion since the late 1990s. The minor fertility-inhibiting effect of marriage and the counteracting effect of breastfeeding from the 1960s to early 1990s were reversed in the most recent period.

Broader Issues that Impact on Family Planning

Legal issues on abortion, contraception and the 1987 Constitution

One of the major legal issues holding up the passage of a reproductive health law is the provision in the 1987 Constitution which says that "[the State] shall equally protect the life of the mother and the life of the unborn from conception." This is commonly interpreted as merely a safeguard against any future attempt to change the strict clauses in the Penal Code which criminalize abortion without any explicit exception.⁵¹ However, Catholic representatives in the Constitutional Commission interpret the phrase as encompassing even contraceptives that they suspect act against a fertilized ovum—the "unborn from conception." Fr. Joaquin Bernas, a Catholic priest, influential constitutional law expert, and member of the Commission argues this position clearly:⁵²

Our constitutional provision was discussed and crafted at a time when many were aware of the United States Supreme Court decision in *Roe v. Wade* which allowed abortion up to the sixth month of pregnancy. This is contrary to both our Penal Code and Canon Law.

The prevention of the adoption of the doctrine in *Roe v. Wade* was certainly one of the purposes of the provision. But Commission deliberations indicate that the provision goes beyond *Roe v. Wade*.

The unborn's entitlement to protection begins "from conception," that is, from the moment of conception. The moment of conception is popularly understood as the moment of fertilization which takes place outside the mother's womb. The intention of the Constitution is to protect life from its beginning, and the assumption is that the gradual development of human life begins at conception and that conception takes place at fertilization (even if medical literature seems to see conception as the moment of implantation). ...

The practical implication of this is that there may be a need to analyze scientifically what kind of contraceptive means are now being dispensed to determine whether they are merely contraceptive or already have the effect of preventing implantation and consequent loss of a fertilized zygote.

While Fr. Bernas concedes that scientific analysis of contraceptives are needed before declaring which ones may be prohibited by his interpretation of the 1987 Constitutional, Catholic bishops have already made up their minds on which ones are "abortifacients." Bishop Teodoro Bacani, a Constitutional Commission member and one of the main authors of the unborn clause, defines and identifies "abortifacients" as follows:⁵³

If [fertilization of the egg by the sperm] be the correct understanding of conception, then abortifacients can be defined as devices or drugs whose action prevent the conceptus (the conceived unborn) from coming to term. ...

All the measures which impair the viability of the zygote at any time between the instant of fertilization and the completion of labour constitute, in the strict sense, procedures for inducing abortion.

Hence, the IUD, injectables like Depo-Provera, and the emergency contraceptive pill (morning after pill) Levonorgestrel, RU-486, and implants like Norplant should be classified as abortifacients, for they do not only prevent fertilization (conception), but also prevent the implantation of the fertilized ovum.

A bill called the "Protection of the Unborn Child Act of 2010" is currently filed at the House of Representatives and the Senate. It defines conception as fertilization; gives human personality and protection to an "unborn child" from fertilization; and declares anything that interferes with its natural development from fertilization until birth as an act of abortion, punishable with increased prison terms. This bill is currently supported by ex-president Arroyo, now a representative in Congress, and by the president of the Senate.

"Middle ground" proposals are also being floated to approve an RH bill minus "abortifacients", which typically point to hormonal contraceptives and IUDs. If passed into law, millions of current users of these methods will be affected.

Health devolution

From its establishment in the early 1900s until 1991, public health services in the Philippines have always been led and managed by a corps of medical professionals and civil servants, where policies, personnel and resources emanate from a central body.⁵⁴ With the 1991 Local Government Code (LGC), more than 100 years of practice was changed almost overnight, and the health sector is still coping with the new set-up. After 16 years of full implementation, basic problems like limited capacity, mispriority

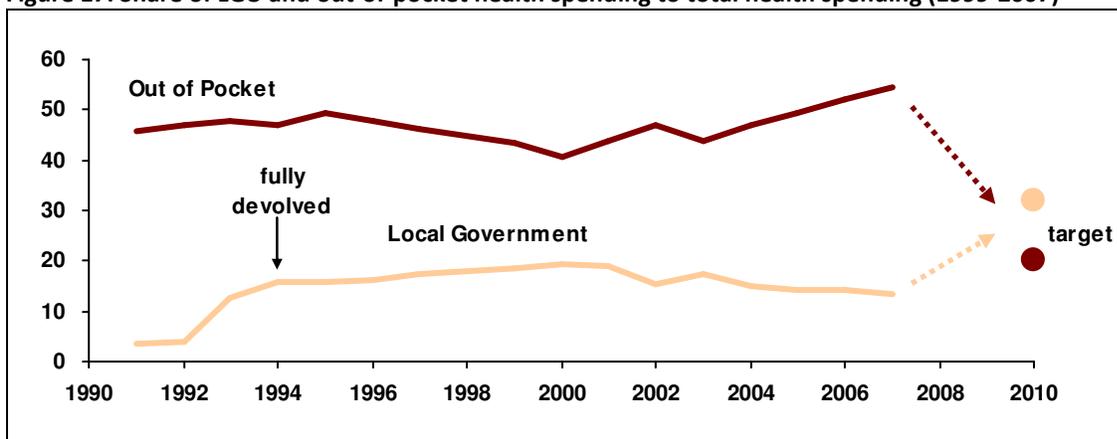
and varying interpretations of responsibility abound, as described by a 2010 evaluation of the health sector by the DOH:⁵⁵

The implementation of national health programs at the local level has become complex due to devolution. Although some LGUs have accepted the challenge with minimal assistance from the national government, a majority have limited financial and technical capacity to manage health within their catchment areas. Some local chief executives prioritize projects with results that can [be] seen by their constituents. Some LGUs are unaware of the kind of health services that LGUs should deliver. For instance, RHUs in Ilocos Sur have not been providing communicable and non-communicable control services because health workers assumed that such programs were the responsibility of the DOH.

LGU health financing

Under the LGC, funds from national revenues are transferred to LGUs without any earmarking, except for the general proviso that at least 20% are devoted to "local development projects." In its 2005-2010 National Objectives for Health, the DOH set a target that LGUs should shoulder 32% of the country's total health expenditures by 2010, from a baseline of 17.5% share in 2003. This will then help reduce out-of-pocket health spending to 20% by 2010, from 44% in 2003. Instead of increasing however, the share of LGUs has actually gone down to 13.3% in 2007, making the target impossible to meet (Figure 11). Evidence from the national health accounts indicate that LGUs as a group may have been underspending for health.

Figure 17. Share of LGU and out-of-pocket health spending to total health spending (1999-2007)



Under the LGC, family planning is listed as a "basic service" of municipalities and cities. Provinces are supposed to provide "population development" services and hospital services⁵⁶, which should include functions such as surgical FP that were being done by public hospitals prior to devolution. When donated FP commodities were reduced and stopped in the latter half of this decade, family planning services became vulnerable to any underspending in health. This may explain the drop in modern CPR growth rates from 2003 to 2008, and the steep drop in public sector share of pills and condoms.

LGU bans on contraception

Health devolution also opened up a new arena for anti-contraceptive forces to ban or restrict its use. In 1995, a provincial governor (Laguna, pop. 1.6 M) who was a board member of Pro-Life Philippines* banned artificial contraceptive supplies and services in all health facilities controlled by the provincial

* An active anti-abortion and anti-contraception organization

LGU^{*}. This was followed in 2000 by the city mayor of Manila (pop. 1.7 M), who was also an officer of Pro-Life Philippines. The ban was severe since all public health facilities in a city are controlled by the mayor, and he extended the ban to NGOs and private practitioners through harassments and the regulatory power of LGUs⁵⁷. Similar bans are reported to be in place in the province of Northern Samar (pop. 0.5 M) and Bulacan (pop. 2.8 M).

While these bans arguably violate the 1991 LGC, and a case by poor Manila residents has been filed in court to overturn the policy, the issue has not yet been settled by the judiciary. The past president has publicly approved the Manila contraception ban as within the powers of autonomy conferred by the LGC to LGUs, which explains why the DOH has not exercised its duty as a standard-setting body against these LGUs.

Complaints have also been lodged at local and international human rights bodies. On 7 October 2010, the Commission on Human Rights (CHR) of the Philippines ruled in favor of complaining Manila residents. The CHR found the City of Manila in breach of CEDAW obligations "to protect health including the safeguarding of the function of reproduction, to provide health care and enable women to access services related to family planning, and to allow women to decide freely and responsibly on the number and spacing of children." CHR decisions do not have the power of court decisions, but do have persuasive moral force. It remains to be seen whether this will be enough to persuade the city government to follow the CHR recommendations and begin providing all family planning methods in their health facilities.

* Under the LGC, Rural Health Units (health centers) and Barangay Health Stations (health posts) are controlled by municipal governments, so it is possible that services and supplies were maintained in some localities.

Impact on Population Growth

Figure 18. Population and Average Annual Growth Rate, Census Years 1903–2007

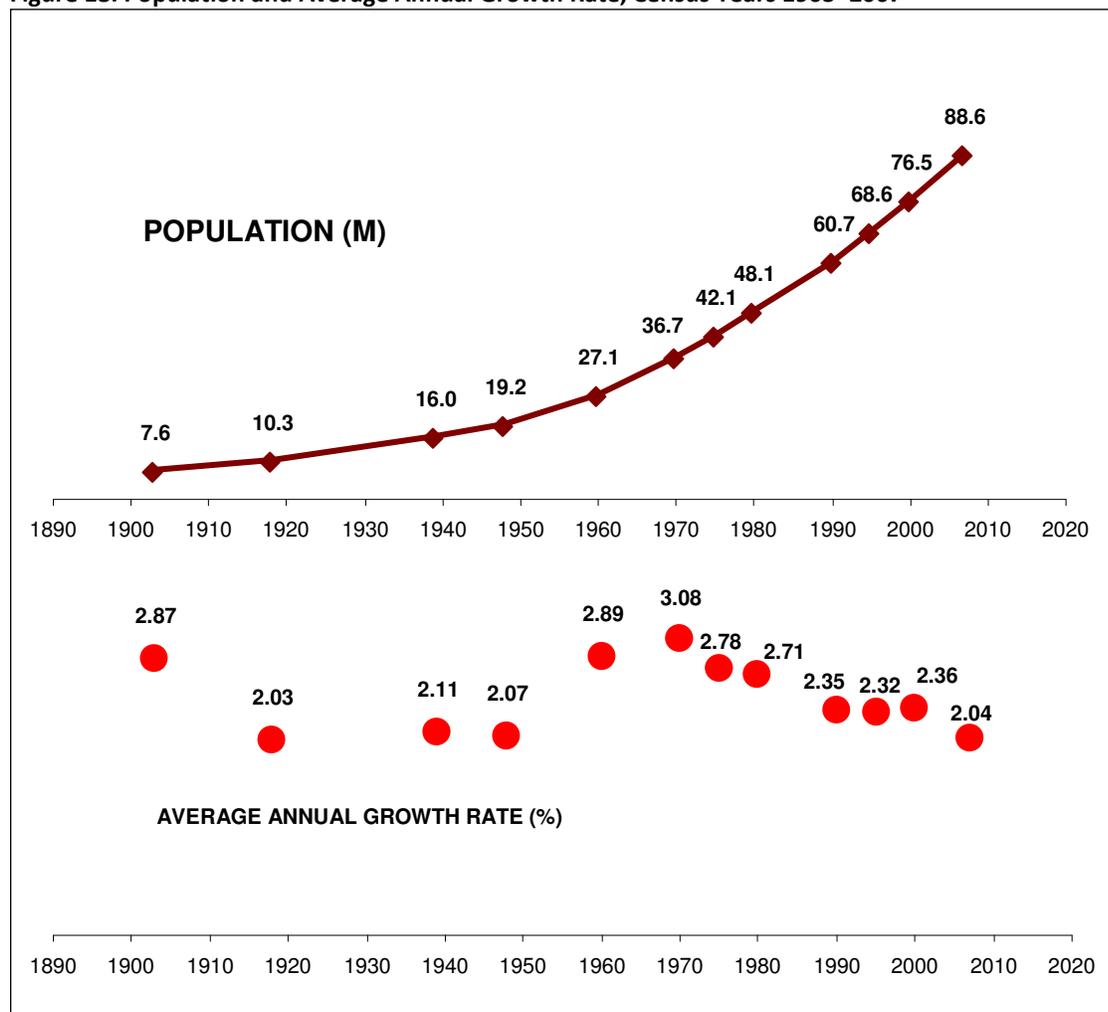
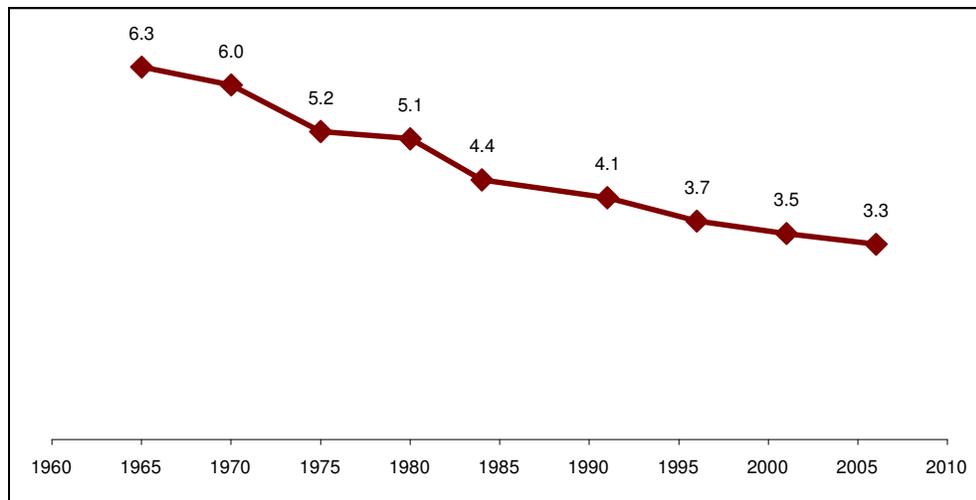


Figure 18 clearly shows that the Philippines has not kept pace with significant changes in the international scene in demographic experience. The country's population tripled in 47 years, from 27 million in 1960 to 89 million in 2007. The population growth rates show a peak in 1970, a declining trend until 1990, a slackening of decline during the 1990-2000 period, and then a reduction during the latest seven-year interval (2000–2007). Despite the seeming fall, the Philippine population is still growing above two percent per year, still a fast growing population such that globally, the country is projected to advance from being the 13th most populous country in 2010 to 12th by 2050 (see Table 19).

Moreover, the apparent fall in average annual growth rate from 2.36% to 2.04% during the latest period should be taken with reservation as the trend in fertility appears inconsistent, as seen in the slowly declining trend in Figure 13. Its fertility as measured by the total fertility rate (TFR) has declined very slowly in the past 41 years (1965-2006) by about 48%, from 6.3 to 3.3 children per woman. Philippine fertility has minimally gone down from 3.5 to 3.3 during the 2001-2006 period.

Figure 19. TFR per Woman, 1965–2006



The latest NDHS survey which shows a little above 3 children per woman implies that the population still grows at a rate of a little more than 2% because of population momentum or the tendency of a young population to continue growing for a number of years. If a population is young, with many people in the younger age groups, even two-child families will mean a growing population for several generations. This also means that the country continues to face a large youth dependency burden and a small proportion of working age adult generating income and savings (demographic onus).

Recommendations

1. Restore Family Planning as a pillar health and development program under the Department of Health, at the same level as Maternal and Child Health, Expanded Program on Immunization and TB & Malaria Control. FP services can best be integrated with MCH, post-abortion care and the prevention and treatment of STIs and HIV-AIDS under a revitalized Reproductive Health Program. For this policy framework, two steps are necessary:
 - a. Clarify the medical scientific, legal and social grounds of a strong Family Planning program, particularly in relation to health and development goals like the MDGs. This is important in the light of a continuing misinformation by religious opposition and a decade of muted information from government agencies. Citing evidences from authoritative sources like the WHO, UN human rights instruments, and academic experts from respected universities will clarify the facts.
 - b. Strengthen human rights, social equity and women empowerment principles in the provision of FP information and services. Operatively, this means that no coercion or discrimination will be allowed to influence people's choices either for or against the use of FP services. Additionally, it means that affirmative action, particularly from government, will be done to correct longstanding inequities towards the poor, women, young people, ethnic groups and other disadvantaged groups. The standards and protocols and actual interactions between FP providers and clients must affirm these core principles.
2. Strengthen the delivery of and access to FP services, especially in the primary and secondary levels of public health care, in all geographic locations. This will require the following steps:

- a. Train and or deploy a mix of primary and secondary level FP providers adept in basic comprehensive FP skills, particularly to areas with high unmet need. The current itinerant teams can be reinforced with the long view of consciously developing local personnel capacities for FP/RH, especially IUD and surgical contraception.
 - b. Raise the quality of FP providers through training in client-centered care and patients' human rights, timely monitoring and evaluation, provision of adequate and continuing FP logistics, and other provider-enabling mechanisms, the most basic of which is adequate compensation.
 - c. Harmonize the current conflicting protocols in the initiation and follow-up of FP methods. Ensure that medical barriers are minimized and standard practice, such as the use of the Medical Eligibility Criteria (MEC) institutionalized.
 - d. For the long-term supply of FP/RH providers, FP/RH must be integrated in the medical, nursing and midwifery curricula.
3. There needs to be a strong and sustained national public information campaign explaining the health and social benefits of Family Planning, including the effectiveness and safety of the various methods. This is necessary in the light of massive, systematic and continuing disinformation from opponents of Family Planning. The public campaign can include the following:
 - a. Mass media, particularly television and radio, which are the most effective media for the target sectors—poor women, poor youth, and ethnic groups—have to be maximized.
 - b. Communication messages must be crafted that respond to the needs and queries of the particular target group. In Metro Manila, for example, women listen to TV-and-radio programs where medical resource persons discuss common problems and respond to questions from the audience.
 4. Research must be continually undertaken to assess the effectiveness and responsiveness of FP programs, especially to the most marginalized groups, and their impact on other social indicators, like poverty, employment, gender equality, migration, environment and others. Research can include the following:
 - a. The National Statistics Office must be supported in their continuing surveys on Family Planning use and its linkage to other health indicators, especially maternal mortality, maternal health and access to health care services.
 - b. The Population Commission (POPCOM) must strengthen its mandate of monitoring the demographic impact of FP, including its linkage to the social and physical environment. It can also assist the DOH in maintaining the contraceptive management information system, contraceptive procurement, storage and distribution.
 5. Financial resources must be mobilized, especially by national government, to meet the large unmet need that accrued from a decade of neglect and which affects poor and disadvantaged groups the most. The following sources must be mobilized:

- a. Congress needs to allocate a significant budget to cover for commodities, the reestablishment of a centralized procurement, warehousing and distribution center in the DOH, and the cascaded training of enough FP providers.
 - b. PhilHealth needs to improve its system and make their benefits, particularly on IUD insertion and BTL, more accessible to local FP practitioners and RHU facilities.
 - c. Private companies must do their share of operating FP/RH clinics with functional services for their employees according to the Labor Law.
6. The Right to Family Planning, which is enshrined in international as well as national laws (e.g. the Philippine Constitution of 1987), must be actively wielded in defense of disadvantaged citizens and against the derogation by powerful institutions like the Catholic hierarchy. To insure the continued preservation of this human right, the following steps are necessary:
- a. The passage of a Reproductive Health Law, which has been stalled in the Philippine Congress for at least nine years now, institutionalizes the rights-based and integrated health approach to FP, including several FP provisions, e.g. delivery of all modern FP methods, subsidized provision of surgical sterilization for the poor, the integration of FP among other subjects in secondary schools, and the classification of contraceptives as “essential medicines” to ensure sustained procurement.
 - b. The continuing cultivation of a social movement on reproductive health with a strong focus on FP and which gathers together a broad base of constituents—RH practitioners and advocates; government, nongovernment and private sectors; professionals and grassroots communities is instrumental not only for advancing the RH bill but also for educating and empowering people to control their fertility and to enshrine this entitlement in the country's laws, policies and programs.

APPENDICES

References

Unless otherwise specified, the Philippine surveys commonly referred to as (*year*) *NDHS* in this report refer to the 1993, 1998, 2003 and 2008 (National) Demographic and Health Surveys jointly published by the National Statistics Office (Philippines) and Macro International/ORC Macro/ICF Macro of the DHS Measures Project. The full text of all four surveys are available for download, in pdf format, at http://www.measuredhs.com/countries/country_main.cfm?ctry_id=34&c=Philippines.

1993 NDHS. National Statistics Office (NSO) [Philippines] and Macro International Inc. (MI). 1994. *National Demographic Survey 1993*. Calverton, Maryland: NSO and MI.

1998 NDHS. National Statistics Office (NSO) [Philippines], Department of Health (DOH) [Philippines] and Macro International Inc. (MI). 1999. *National Demographic and Health Survey 1998*. Manila: NSO and MI.

2003 NDHS. National Statistics Office (NSO) [Philippines], and ORC Macro. 2004. *National Demographic and Health Survey 2003*. Calverton, Maryland: NSO and ORC Macro.

2008 NDHS. National Statistics Office (NSO) [Philippines], and ICF Macro. 2009. *National Demographic and Health Survey 2008*. Calverton, Maryland: National Statistics Office and ICF Macro.

Data on wealth quintiles for the 1993 and 1998 NDHS all come from this source:

Lamberte, Exaltacion E., Nanette R. Lee, and Desiree Concepcion U. Garganian. 2000. *Family Planning Service Utilization and Market Segmentation in the Philippines*. Calverton, Maryland: ORC Macro.

Data Tables

The figures (charts) in the main text and the tables shown below are correspond to each other through their numbers, e.g., Figure 1 gets its data from Table 1. All growth rates in these tables, unless otherwise specified, were calculated by authors from the published data.

Table 1. Trends in current use of modern methods compared to demand for FP

	1968	1978	1988	1993	1998	2003	2008
Current use of any modern method (%)	2.9	17.2	21.6	24.9	28.2	33.4	34.0
Average annual % growth rate in modern method use (<i>past 10 years for figures in italics; past 5 years for the rest</i>)	-	<i>19.48</i>	<i>2.30</i>	2.88	2.52	3.44	0.36
Total demand for family planning (spacing and limiting, %)	na	na	na	68.5	69.5	68.5	73.1
Total demand for family planning met by modern methods				36.4	40.6	48.8	46.5

Sources: *NDHS 1993, 1998, 2003 and 2008; the total demand met by modern methods was calculated by dividing the current use of any modern method with the total demand for FP*

Table 2. Use of modern methods by married women 15–49, by age group

Age Group	1993	1998	2003	2008	Ave. Annual Growth, 1993-2008
15-19	9.6%	11.4%	13.2%	14.3%	2.7%
20-24	18.9%	23.5%	30.1%	32.5%	3.7%
25-29	23.5%	29.3%	35.2%	35.6%	2.8%
30-34	29.0%	32.5%	38.0%	38.8%	2.0%
35-39	29.4%	31.6%	38.5%	39.5%	2.0%
40-44	27.0%	28.8%	31.5%	35.7%	1.9%
45-49	18.4%	21.5%	26.4%	22.4%	1.3%
Total	24.9%	28.2%	33.4%	34.0%	2.1%

Sources: NDHS 1993, 1998, 2003 and 2008

Table 3. Use of modern methods by married women 15–49, by number of living children

No. of Living Children	1993	1998	2003	2008	Ave. Annual Growth, 1993-2008
None	0.6%	0.9%	1.7%	1.4%	5.8%
1	13.9%	18.2%	24.2%	28.7%	5.0%
2	25.4%	30.3%	38.9%	39.2%	2.9%
3	35.5%	40.1%	47.2%	44.5%	1.5%
4+	27.4%	30.2%	34.6%	36.1%	1.9%
Total	24.9%	28.2%	33.4%	34.0%	2.1%

Sources: NDHS 1993, 1998, 2003 and 2008

Table 4. Percentage distribution of all women 15-49 employed 12 months preceding survey, by occupation and number of living children (NDHS 2008)

No. of Living Children	Clerical	Unskilled manual	Skilled manual	Domestic service	Prof./technical/managerial	Sales and services	Agriculture	Missing
None	11.5	4.0	7.1	20.9	17.8	33.2	5.3	0.2
1-2	7.2	4.0	7.0	9.2	30.8	31.0	10.4	0.3
3-4	3.8	3.2	6.2	10.5	30.8	27.0	18.3	0.2
5+	1.4	3.9	6.9	13.6	16.1	25.6	32.5	-
Total	7.0	3.8	6.9	14.0	24.4	30.0	13.7	0.2

Source: NDHS 2008

Table 5. Use of modern methods by married women 15–49, by wealth quintile

Wealth Quintile	1993	1998	2003	2008	Ave. Annual Growth, 1993-2008
Lowest	14.5%	19.6%	23.8%	25.9%	3.9%
Second	23.3%	26.2%	33.8%	35.7%	2.9%
Middle	26.9%	33.0%	35.7%	36.6%	2.1%
Fourth	30.8%	33.0%	37.9%	38.5%	1.5%
Highest	30.7%	29.4%	35.2%	33.1%	0.5%
Total	25.0%	28.2%	33.4%	34.0%	2.1%

Sources: NDHS 1993, 1998, 2003 and 2008

Table 6. Share of each method to total modern method use, married women 15-49

Method (ranked by 2008 % share)	% Share				Trend	
	1993	1998	2003	2008	1993 – 2008 CPR	Trend
1. Pill	34.1	35.1	39.5	46.2	8.5 – 15.7	85% ↑
2. Female sterilization	47.8	36.5	31.4	27.1	11.9 – 9.2	(23%) ↓
3. IUD	12.0	13.1	12.3	10.9	3.0 – 3.7	23% ↑
4. Injections	0.4	8.5	9.3	7.6	2.4* – 2.6	8% ↑
5. Male condom	4.0	5.7	5.7	6.8	1.6 – 2.3	130% ↑
6. Modern NFP	0.0	0.7	1.5	1.5	0.2 – 0.5	
7. Male sterilization	1.6	0.4	0.3	0.0	0.1 – 0	
	100.0	100.0	100.0	100.0	28.2 – 34.0	37% ↑

Sources: Base data from NDHS 1993, 1998, 2003 and 2008; percentage shares calculated by dividing the percentage use of each method to the percentage use of any modern method

Table 7. Traditional method use, 1998-2008

Current use (%) by married women 15-49	1988	1993	1998	2003	2008
Current use of any traditional method by married women 15-49 (%)	14.5	15.1	19.3	14.9	16.3
Average annual % growth rate (past 5 years)	2.05%	0.81%	5.03%	-5.04%	1.81%
Current use (%) by married women 15-49 of:					
Withdrawal	n.a.	7.4	8.9	8.2	9.8
Periodic abstinence	n.a.	7.3	8.7	6.7	6.4
Periodic abstinence users who know that the fertile period is at middle of cycle (%)		33.7	25.7	43.3	48.4

Sources: NDHS 1993, 1998, 2003 and 2008

Table 8. Unmet need for modern methods and the total demand for family planning

Year	A Modern method user	B Currently pregnant/ amenorrhic while using any method	C Traditional method user	D Unmet need (no method used)	(A+B+C+D) Total current demand for family planning	No current demand for FP (pregnant & wanted, want to get pregnant soon, infecund)	(A+B) Unmet need for modern method
1993	24.9	2.3	15.1	26.2	68.5	31.5	41.3
1998	28.2	3.2	19.3	18.8	69.5	30.5	38.1
2003	33.4	2.9	14.9	17.3	68.5	31.5	32.2
2008	34.0	0.5	16.3	22.3	73.1	26.9	38.6

Sources: NDHS 1993, 1998, 2003 and 2008; column B was calculated by deducting unmet need and met need from the total demand for family planning, as described in NDHS 2003: "Nonusers who are pregnant or amenorrhic and women whose pregnancy was the result of a contraceptive failure are not included in the category of unmet need, but are included in total demand for contraception (since they would have been using had their method not failed)"

Table 9. Estimated number of married women with unmet need for modern methods

Year	Married Women 15-49 (M)	(A) With Unmet Need		(B) Using Traditional Method		(A+B) Unmet Need for Modern Methods	
		%	No. (M)	%	No. (M)	%	No. (M)
1995	9.98	26.2	2.61	15.1	1.51	41.3	4.12

* The injectable DMPA was re-introduced into the family planning program only in 1994; the 2.4% use shown here was recorded in the 1998 survey.

2000	11.33	18.8	2.13	19.3	2.19	38.1	4.32
2005	12.84	17.3	2.22	14.9	1.91	32.2	4.13
2010	14.31	22.3	3.19	16.3	2.33	38.6	5.52

Sources: The total number of women aged 15-49 was taken from "[Table 4. Projected Populations by Five-Year Age Group and Sex, by Region and Province, and by Five-Calendar Years: 2000-2040 \(Medium Series\)](#)" by the National Statistics Office and Inter-Agency Working Group on Population Projections (8 December 2006), from the 2000 Census-based Population Projection, retrieved 13 November 2010. The term "married women" include those in informal unions to be consistent with NDHS data on unmet need and contraceptive use. The percentage used to calculate the number of married women was 58.2%, taken from "[Special Release No. 161, Women 15 to 49 Years Old \(Results from the 2000 Census Population and Housing\)](#)" by the National Statistics Office (19 April 2005). This proportion is slightly lower than the proportion of married women in NDHS 1993, 1998, 2003 and 2008 which had figures of 59.6%, 59.6%, 63.6% and 61.9% respectively, which makes the estimates in this table lean on the conservative side. All other data are from NDHS 1993, 1998, 2003 and 2008.

Table 10. Intended future non-use among married women not using any method, top-15 countries with 2000–2005 DHS, compared with % use of modern methods

Country	Year	Intended Non-use in the Future		Using Any Modern Method	
		%	Rank	%	Rank
Mauritania	2000	79	1	5	35
Eritrea	2002	71	2	7	30
Nigeria	2003	64	3	8	29
Philippines	2003	55	4	33	15
Ethiopia	2000	53	5	6	33
Gabon	2000	50	6	13	26
Mali	2001	50	6	7	30
Egypt	2003	50	6	57	5
Mozambique	2003	48	9	21	21
Madagascar	2003-04	47	10	18	24
Armenia	2000	47	10	22	20
Cameroon	2004	46	12	13	26
Cambodia	2000	45	13	19	22
Indonesia	2002-03	42	14	57	5
Ghana	2003	41	15	19	22

Source: Khan, Shane, Vinod Mishra, Fred Arnold, and Nouredine Abderrahim (2007). "[Contraceptive Trends in Developing Countries](#)", pp. 27-28 & 59-60. DHS Comparative Reports No. 16. Calverton, Maryland, USA: Macro International Inc. The rank in the use of any modern method was based on the full list of 34 countries in the comparative report (not shown here for brevity).

Table 11. Reason for not intending to use contraception, by major groupings

Reason	1993	1998	2003	2008
WITH UNMET NEED				
Safety	31.6%	31.2%	28.5%	34.8%
Health concerns	10.0%	13.8%	14.3%	20.9%
Fear of side effects	21.6%	17.4%	14.2%	13.9%
Low fecundity (real or perceived)	18.6%	8.2%	16.8%	19.6%
Infrequent sex	18.6%	4.8%	5.3%	9.8%
Subfecund, infecund		3.4%	11.5%	9.8%
Opposed to FP	8.0%	15.3%	19.7%	9.0%
Religious prohibition	4.8%	4.8%	6.2%	2.9%

Reason	1993	1998	2003	2008
Spouse opposed	3.2%	5.5%	3.7%	3.2%
Respondent opposed		4.8%	8.8%	2.8%
Others opposed		0.2%	0.1%	0.1%
Other opposition to use		0.0%	0.9%	0.0%
Access & info.	6.8%	2.1%	3.6%	3.2%
Cost too much	0.4%	0.4%	1.8%	2.2%
Lack of access	0.4%	0.2%	0.4%	0.4%
Knows no method	6.0%	1.3%	1.1%	0.4%
Knows no source		0.2%	0.3%	0.2%
Other issues	4.2%	8.4%	5.4%	3.1%
Inconvenient to use	2.1%	1.0%	1.1%	1.2%
Interfere with body	0.0%	1.0%	0.7%	0.6%
Other	0.9%	5.8%	2.3%	0.6%
Don't know	0.4%	0.4%	1.0%	0.6%
Missing	0.1%	0.3%	0.1%	0.1%
Not married	0.3%	0.0%	0.2%	0.1%
Fatalistic	0.4%	0.0%	0.0%	0.0%
WANTS TO GET PREGNANT OR CANNOT GET PREGNANT ANYMORE				
Wants more children	20.1%	20.3%	14.5%	15.5%
Menopausal, hysterectomized	10.7%	14.4%	11.6%	14.8%
TOTAL	100%	100%	100%	100%

Sources: NDHS 1993, 1998, 2003 and 2008; the classification into major categories such as "Safety", etc. are from the authors

Table 12. Comparison of inequities in maternal care and family planning

Inequity based on	Demand for FP Met through Modern Contraception (%)	Skilled Professionals at Birth (%)
Residence		
Urban	47.4	77.5
Rural	45.6	47.7
Inequity gap	4% better for urban dwellers	62% better for urban dwellers
Wealth		
Highest quintile	47.0	94.4
Lowest quintile	37.5	25.7
Inequity gap	25% better for the highest quintile	267% better for the highest quintile
Education		
College	49.2	87.0
No education	18.5	10.9
Inequity gap	166% better for college level	698% better for college level
Region		
Region with highest level	62.3 [*]	86.8 [†]
Region with lowest level	20.7 [*]	19.2 [†]

^{*} Region II, Cagayan Valley

[†] National Capital Region (Metro Manila)

Inequity based on	Demand for FP Met through Modern Contraception (%)	Skilled Professionals at Birth (%)
Inequity gap	201% better highest region	352% better for highest region

Source: NDHS 2008

Table 13. Inequities in unwanted fertility, and possible contributing factors

Wealth Quintile	Total Fertility	Unwanted Fertility	Unwanted Fertility as % of Total Fertility	Unmet Need for Modern Contraception (%)	% Have Begun Childbearing at 15-24	% of Those Who Want No More Children Able to Get Sterilized
Lowest	5.2	1.9	36.5	43.0	44.1	6.6
Second	4.2	1.3	31.0	39.6	34.6	13.5
Middle	3.3	0.9	27.3	38.4	27.3	14.7
Fourth	2.7	0.5	18.5	36.8	22.9	19.5
Highest	1.9	0.3	15.8	37.4	13.1	19.6
Total	3.3	0.9	27.3	39.0	26.1	14.7

Source: NDHS 2008; the last column was calculated by dividing the percentage use of female sterilization (p. 56) by the percentage of married women who do not want any more children (p. 84)

Table 14. Percentage able to get sterilized among married women who do not want any more children

Wealth Quintiles	Percentage of those Who Want No More Children Able to Get Sterilized		
	1998	2003	2008
Lowest	6.3%	6.4%	6.6%
Second	12.4%	12.1%	13.5%
Middle	17.4%	18.2%	14.7%
Fourth	22.5%	22.5%	19.5%
Highest	26.9%	27.3%	19.6%
Total	16.6%	17.2%	14.7%
Ratio (Highest/Lowest)	4.27	4.27	2.97

Sources: Base data from NDHS 1998, 2003 and 2008; percentages was calculated by dividing the percentage use of female sterilization by the percentage of married women who do not want any more children

Table 15. Sexual behavior, pregnancy and marriage among young women, NDHS 2008

	15-19 (%)	20-24 (%)	25-49 (%)
Had intercourse within past 4 weeks	8.1	39.6	55.6 – 65.7
Had intercourse within past 1 year (excludes those with sex in past 4 weeks)	4.5	11.7	17.0 – 21.7
Had intercourse one or more years ago	1.0	5.1	7.7 – 18.5
Never had sexual intercourse	86.4	43.7	8.8
Never married	88.8	50.9	5.0 – 22.5
Married (formal)	2.9	26.8	58.3 – 77.3
Living together (informal union)	7.4	19.8	6.7 – 15.7
Separated, divorced or widowed	0.9	2.6	3.4 – 11.8
Married or living together, ever use of modern contraception	26.3	51.7	55.1 – 69.0
Married or living together, current use of modern contraception	14.3	32.5	22.5 – 39.5
Married or living together, current use of traditional method	11.6	13.8	14.0 – 20.3

* ARMM - Autonomous Region of Muslim Mindanao

† ARMM - Autonomous Region of Muslim Mindanao

	15-19 (%)	20-24 (%)	25-49 (%)
Married or living together, unmet need	35.8	24.6	17.6 – 25.8
Never been pregnant	90.1	53.2	
% of births in past 5 years that are wanted	69.2 [*]	65.0	46.8 – 65.0
% of births in past 5 years that are mistimed	24.1 [†]	26.7	8.6 – 20.2
% of births in past 5 years that are unwanted	6.5 [†]	7.9	14.3 – 44.0
Mean ideal number of children	2.4	2.5	2.7 – 3.3

Sources: NDHS 1993, 1998, 2003 and 2008; "never been pregnant" was calculated by deducting the percentage that "have begun childbearing" from 100%

Table 16. Public sector share, most recent source of pills and condoms

	1993	1998	2003	2008
Pills	73.4%	76.4%	56.6%	22.2%
Condoms	55.6%	41.4%	27.0%	6.7%

Sources: NDHS 1993, 1998, 2003 and 2008

Table 17. Source of funds of all health expenditures

	National Government	Local Government	Social Health Insurance	Out of Pocket	Other Private Sources
1991	32.8	3.7	9.1	45.8	8.6
1992	30.0	4.1	9.5	47.0	9.3
1993	21.3	12.6	9.8	47.9	8.4
1994	18.8	15.8	10.1	46.8	8.6
1995	17.7	15.7	9.2	49.4	8.2
1996	19.6	16.1	8.5	47.7	8.1
1997	21.1	17.5	7.2	46.3	7.9
1999	20.7	18.5	5.0	43.3	11.2
2000	21.2	19.3	7.0	40.5	10.7
2001	17.1	19.1	7.9	43.9	10.6
2002	15.8	15.2	9.0	46.8	13.3
2003	16.7	17.5	9.5	44.0	11.3
2004	15.7	15.0	9.6	46.9	11.6
2005	15.3	14.1	9.8	49.2	10.5
2006	12.5	14.1	8.8	52.3	10.3
2007	13.0	13.3	8.5	54.4	10.5

Sources: For the years 1991-1997: UPEcon (1991-1994) and NSCB (1995-1997) as cited in Magno Cielo (2001). "The devolution of agricultural and health services", p. 38, in 2001 Report – Social Watch Philippines, retrieved 15 November 2010. For the years 1999-2003: Department of Health (2005). [National Objectives for Health 2005-2010](#), p. 54, retrieved 30 October 2010. For 2004: National Statistical Coordination Board (February 2008). [2005 Philippine National Health Accounts](#), retrieved 15 November 2010. For the years 2005-2007: National Statistical Coordination Board (August 2010). [2005 to 2007 Philippine National Health Accounts](#), retrieved 15 November 2010.

Table 18. Population and Average Annual Growth Rate, Census Years 1903–2007

Year	Census Population	Average annual rate of increase (%)
1903	7,635,426	2.87
1918	10,314,310	2.03
1939	16,000,303	2.11

* All mothers less than 20.

Year	Census Population	Average annual rate of increase (%)
1948	19,234,182	2.07
1960	27,087,685	2.89
1970	36,684,486	3.08
1975	42,070,660	2.78
1980	48,098,460	2.71
1990	60,703,206	2.35
1995	68,616,536	2.32
2000	76,504,077	2.36
2007	88,574,614	2.04

Source: National Statistical Coordination Board. [Population of the Philippines Census Years 1799 to 2007](#). Retrieved 15 November 2010.

Table 19. World's 15 Most Populated Countries, 2010 and 2050 Projection

Rank	Country	Mid 2010 Pop. (M)	Rank	Country	Mid 2050 Projected Pop. (M)
1	China	1,338	1	India	1,748
2	India	1,189	2	China	1,437
3	United States	310	3	United States	423
4	Indonesia	236	4	Pakistan	335
5	Brazil	193	5	Nigeria	326
6	Pakistan	185	6	Indonesia	309
7	Bangladesh	164	7	Bangladesh	223
8	Nigeria	158	8	Brazil	215
9	Russia	142	9	Ethiopia	174
10	Japan	127	10	Congo, Dem. Rep. of	166
11	Mexico	111	11	Philippines	141
12	Philippines	94	12	Egypt	138
13	Vietnam	89	13	Mexico	129
14	Ethiopia	85	14	Russia	127
15	Germany	82	15	Vietnam	114

Sources: PRB 2010 World Population Data Sheet;

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