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Meeting Women's Contraceptive Needs in the Philippines

The ability to practice contraception is essential to protecting Filipino women's health and rights. Yet low levels of use have led to high levels of unintended pregnancy in the Philippines, for which women and society pay dearly—in lives, family well-being and public funds.

The desire to have children and raise them well leads many women and families to plan the timing and number of their births. Many women and couples, however, do not have the knowledge, tools and assistance they need to maintain their sexual and reproductive health and form the family they desire. Currently, more than half of all pregnancies in the Philippines are unintended—that is, they occur too soon, too close together or after a couple already has as many children as they want (Table 1, page 2). Consequently, many women give birth to more children than they want or can care for, and others turn to unsafe abortion. Maternal and infant mortality are unacceptably high, especially among disadvantaged women—those who are poor, live in rural areas or have little education.[1,2]

Reproductive health care—including quality contraceptive services—enables women and couples to make choices about pregnancy, have healthy babies and care for their families. Full access to reproductive health care is crucial to fulfilling the Philippine government's commitment to attaining the Millennium Development Goals, including improving maternal health, eradicating extreme poverty and hunger, improving educational attainment, reducing child mortality, and promoting women's empowerment and gender equality.[3] Expanding contraceptive use also saves money that can be used to promote economic development and improve health.

This issue brief aims to help policymakers chart a course toward better health and family well-being in the Philippines by highlighting the benefits of allocating resources to improving contraceptive services. Building on prior work[4] and using national data to provide estimates for 2008 (see box, page 3), it uses women's own reports of their childbearing goals to estimate the numbers of women in the Philippines who need contraceptive services and supplies. It also describes women's current patterns of contraceptive use and the personal and financial costs that result from unmet need for contraception. The report then models alternative scenarios of contraceptive use to quantify the net benefits—to women and society—that could result from meeting the contraceptive needs of all women and couples at risk for unintended pregnancy in the Philippines.

Key Points

- Without contraceptive use in the Philippines, there would be 1.3 million more unplanned births, 0.9 million more induced abortions and 3,500 more maternal deaths each year.
- More than half of all pregnancies in the Philippines are unintended, with the highest proportions in the Cordillera Administrative Region, Central and Eastern Visayas, and Caraga.
- Three in 10 Filipino women at risk for unintended pregnancy do not practice contraception. These women account for nearly seven in 10 unintended pregnancies.
- Poor women are especially likely to need assistance in preventing unintended pregnancy. The 35% of women aged 15–49 who are poor account for 53% of unmet need for contraception.
- Investing in increased access to the full range of modern contraceptive methods and services to support effective use would reap savings on medical care for pregnant women and newborns. Reducing unintended pregnancy would help women have the number of children they desire and would save money that could be directed toward improving and expanding other needed services.
- All levels of the Philippine government, the private sector and the international community should increase their investment in modern contraception—for poor Filipino women in particular—to save women's lives and support healthy families.

Table 1

Unintended Pregnancies and Their Outcomes

Poverty, risk for unintended pregnancy and pregnancy outcomes among women aged 15–49, by region, 2008

	Women aged 15–49		Women at risk for unintended pregnancy†			Percentage distribution of pregnancies, by outcome						
	No. (000s)	% who are poor*	No. (000s)	% of women with unmet need‡	% of women with unmet need who are poor	No. (000s)	Intended pregnancies§	Unintended pregnancies				Total
								Total**	Mistimed births††	Unwanted births‡‡	Induced abortions	
TOTAL	22,923	35	10,210	29	53	3,371	46	54	16	14	17	100
NATIONAL CAPITAL REGION	3,479	10	1,331	26	18	514	40	60	11	10	32	100
REST OF LUZON	9,793	26	4,458	28	41	1,417	49	51	15	12	17	100
CAR	388	35	178	32	57	63	36	64	27	9	19	100
Ilocos	1,146	27	504	24	46	183	45	55	17	9	22	100
Cagayan Valley	759	41	393	22	66	116	53	47	11	9	20	100
Central Luzon	2,575	17	1,232	24	22	348	51	49	15	9	18	100
CALABARZON	3,085	12	1,267	28	25	422	51	49	13	14	14	100
MIMAROPA	673	60	320	33	79	92	51	49	13	14	14	100
Bicol	1,166	46	564	36	62	193	42	58	18	18	14	100
VISAYAS	4,173	50	1,900	33	68	614	41	59	20	20	10	100
Western Visayas	1,688	53	737	33	73	230	47	53	18	21	7	100
Central Visayas	1,612	41	751	29	54	236	36	64	20	20	15	100
Eastern Visayas	874	59	412	40	78	147	39	61	23	19	9	100
MINDANAO	5,479	56	2,521	32	73	826	47	53	19	14	11	100
Zamboanga Peninsula	799	62	388	36	78	123	46	54	18	19	8	100
Northern Mindanao	988	42	481	27	64	148	49	51	13	16	15	100
Davao	1,068	38	537	22	59	134	40	60	19	17	14	100
SOCCSKSARGEN	977	56	482	27	65	165	53	47	12	14	14	100
Caraga	539	50	283	28	75	84	32	68	28	21	7	100
ARMM	1,108	85	352	60	87	173	55	45	28	5	4	100

Notes: Data were calculated using a range of sources. See details at <www.guttmacher.org/pubs/MWCNPmethodology.pdf>. CAR=Cordillera Administrative Region. ARMM=Autonomous Region of Muslim Mindanao. *Women are considered poor if their household assets place them in one of the two lowest wealth quintiles, or the bottom 40% of the population. †Women are at risk for unintended pregnancy if they are married or if they are unmarried and sexually active (within the past three months), are able to become pregnant, and do not want any more children or do not want a child in the next two years. ‡Women who are at risk for unintended pregnancy and are using no contraceptive method. §Includes births and miscarriages from intended pregnancies; miscarriages are estimated at 17% of pregnancies that end in birth or miscarriage. **Total includes miscarriages. ††A birth is considered mistimed if the woman did not wish to have a child for at least two years when she became pregnant. ‡‡A birth is considered unwanted if the woman wanted no more children when she became pregnant.

Health risks for both women and infants accompany pregnancy. Pregnancy is a risky time for women and infants, especially when pregnancies come close together and when women and infants do not receive adequate medical care and advice.[1] In the Philippines, an estimated 200 women die from pregnancy-related causes (such as infection, obstructed labor, severe bleeding, hypertensive disorders and other complications of births, abortions or miscarriages) for every 100,000 live births.[5] In 2008, births and miscarriages resulted in about 3,700 women's deaths. Some 1,600 of these women had not wanted to become pregnant.

Because abortion is illegal in the Philippines, the procedure is almost always clandestine and often unsafe.[6] Projections based on data from 2000 indicate that about 1,000 women in the Philippines died as a result of abortion in 2008; as many as 90,000 were hospitalized for complications.

Pregnancy-related deaths and hospitalizations keep women out of the workforce and away from their families, and have countless other effects on women's and society's well-being. The DALY (disability-adjusted life year) is an internationally used measure of the years of productive life lost to death and disability from disease and other health conditions. In 2008, Filipino women lost an estimated 311,000 productive years of their lives due to conditions related to pregnancy and birth—167,000 DALYs were due to intended pregnancies and 144,000 were related to unintended pregnancies. This loss of productive years of life is greater than the annual loss among Filipino men and women from traffic accidents or diabetes.[7]

Birth also entails health risks for the infant. In 2008, an estimated 52,000 babies in the Philippines (22 out of every 1,000 born alive) died before their first birthday; 30,000 of them died within a month of being born. Spacing births helps babies survive: Those born at least two years after a previous birth have the best chance of survival.[2] However, 33% of births to Filipino women who already have at least one child occur less than two years after a prior birth.[8]

Newborns suffering from conditions such as birth asphyxia and trauma, premature birth, low birth weight and infections accounted for one million DALYs in 2008. This loss of productive years of life among Filipino children accounts for nearly twice the

DALYs related to tuberculosis, more than twice those due to diarrhea and triple those due to measles, pertussis and tetanus combined.[7]

Poor women face a host of obstacles to having healthy pregnancies and births. The poorer women are, the less likely they are to have prenatal care, give birth in a health facility or have a skilled attendant at delivery—factors that lower the risk for maternal death.[1,2] Poor women also tend to have shorter intervals between births compared with better-off women.[2] The consequences can be dire for their babies: The death rate among infants whose mothers received no prenatal or delivery care is 3.6 times the rate among infants whose mothers did receive such care.[2] Meanwhile, women in the poorest fifth of the Philippines population have nearly three times as many births as those in the wealthiest fifth (Figure 1, page 4).[2,8]

Contraceptive use promotes health and saves lives.

Contraceptive use is crucial to preventing unintended pregnancies. Accurate and complete knowledge about contraceptive methods and pregnancy risks, better access to quality services, and mutually respectful decision-making between men and women about planning pregnancies would improve the ability of women and their partners to have safe pregnancies, give birth to healthy babies, and form a family of the size they want and at the pace they choose.

Comparing numbers of unintended pregnancies and other adverse health effects to the numbers that would occur if women used no contraceptive methods illustrates the huge positive impact contraception is having on reproductive health in the Philippines. An estimated 7.2 million Filipino women currently practice contraception, and 3.4 million pregnancies occur each year. With no contraceptive use, there would be 5.9 million pregnancies annually (Figure 2, page 4). By averting 2.5 million pregnancies each year, women in the Philippines prevent an estimated 1.3 million unplanned births, 0.3 million miscarriages and 0.9 million induced abortions. The current level of contraceptive use also prevents 3,500 maternal deaths and 180,000 DALYs among women. Use of modern contraceptive methods* accounts for 78% of these benefits, while the use of traditional methods accounts for the remaining 22%.†

Women are having more children and pregnancies than they plan for.

While current levels of contraceptive use help millions of women prevent unintended pregnancies, women still have an average of one more child than they want.[2] Total fertility rates fell from 5.1 births per woman in 1983 to 4.1 in 1993 and 3.5 in 2003, but have not kept pace with women's increasing desire for smaller families: Filipino women wanted an average of 2.7 children in 1998 and only 2.5 in 2003.

Poor women have an especially hard time achieving the family size they desire. Although poor women want more children on average than better-off women do, they experience a much larger gap between the number of children they want and the number they actually have.[2,8] For instance, women in the poorest two-fifths of households have 1.5–2.1 more children than they desire, while better-off women experience a gap of less than one child.

The high level of unplanned childbearing in the Philippines reflects a high level of unintended pregnancy. In 2008, an estimated 3.4 million Filipino women became pregnant, and 54% of them—some 1.9 million women—did not want to have a child so soon or at all. Among those who carried their pregnancy to term, 55% gave birth two or more years sooner

Methods

The 2008 estimates in this report are based on the most recent available data. Unless otherwise noted, the data were calculated using the following methods. Sources and more details on methodology are available online at <www.guttmacher.org/pubs/MWCNPmethodology.pdf> or from the lead author.

- The numbers of women in each region by marital status, risk for unintended pregnancy and contraceptive method use in 2008 were estimated from the 2003 Philippines Demographic and Health Survey (DHS) and regional estimates of the number of women aged 15–49 from the national census and population projections from the Philippines National Statistical Office. Recent Family Planning Surveys confirm that levels of contraceptive use have changed little since 2003.
- The numbers of unintended pregnancies in 2008 under current contraceptive use patterns and alternative scenarios were based on contraceptive use–failure rates and pregnancy rates for nonusers from the Philippines DHS and other sources, adjusted to the estimated number of unintended pregnancies in each region in 2008.
- Pregnancies by intention and outcome were estimated from regional data from the 2003 DHS, regional estimates of induced abortion rates in 2000 and estimates of the number of miscarriages.
- Pregnancy-related deaths among women were estimated using national-level maternal mortality estimates from the World Health Organization for 2000 and 2000 estimates of mortality from induced abortion. Regional infant death rates were estimated from the 2003 DHS.
- National-level estimates of pregnancy-related disability-adjusted life years (DALYs) among women and infants in 2002 and 2004 estimates of abortion-related DALYs in low-and middle-income countries in the Western Pacific Region formed the basis for rates used to estimate pregnancy-related DALYs in 2008.
- Estimates of the costs of providing contraceptive and pregnancy-related care are based on public-sector costs. Costs for female and male sterilization, normal delivery, cesarean-section deliveries and normal newborn care are current 2008 reimbursement levels in the national health insurance program, PhilHealth. The lowest current prices for pills, IUDs, injectables and condoms from Philippines pharmaceutical suppliers were used to estimate commodity costs for these methods. Related delivery and infrastructure costs were estimated at 30% of these commodity costs, but this is a very rough estimate. Modern NFP service costs were estimated from the DOH Commission on Population 2009 proposed budget. Costs of long-term methods were annualized, assuming 10 years of contraceptive coverage for sterilization and 3.5 years for the IUD. Average duration of modern NFP methods was assumed to be one year. For other methods, the cost estimates are based on supplying 13 cycles of oral contraceptives, 96 condoms or four injections per year.

*Modern methods used in the Philippines include female and male sterilization, IUD, contraceptive injection, oral contraceptive pills, condoms and modern natural family planning (NFP) methods. Modern NFP includes the mucus or Billings Ovulation, Standard Days, symptothermal, basal body temperature and lactational amenorrhea methods.

†Traditional methods include mainly withdrawal and periodic abstinence methods other than modern NFP.

Figure 1

Childbearing and Poverty

Filipino women are having more children than they want, especially if they are poor.

Note: The Demographic and Health Survey ranks individuals according to their household assets and divides the population into five groups of equal size (quintiles) to capture relative differences in wealth. *Sources:* References 2 and 8.

than they had wanted (i.e., they experienced a mistimed birth), and 45% had not wanted a baby at all at the time of conception (i.e., they experienced an unwanted birth). Pregnant women who had not wanted a baby at all were especially likely to have an induced abortion: Some 41% obtained abortions, compared with 17% of those whose pregnancies were mistimed.

Fewer than two in five pregnancies were intended in the Cordillera Administrative Region (CAR), Central and Eastern Visayas, and Caraga, while 55% of pregnancies were intended in the Autonomous Region in Muslim Mindanao (ARMM; Table 1), one of the most impoverished areas in the Philippines in terms of wealth, education and health.[9] The proportion of pregnancies that ended in induced abortion varied greatly, from 4% in the ARMM to 32% in the National Capital Region. The breakdown of unintended births between women who would have preferred to postpone the event and those who wanted no more children also varied across regions. More than five times as many births were mistimed as unwanted in the ARMM, whereas unwanted births outnumbered mistimed births in six other regions.

Current contraceptive use in the Philippines is inadequate.

Despite the health benefits of contraception, use is far below the apparent demand. Based on women's reports about their fertility preferences and related behaviors in a nationally representative survey, 10.2 million women in the Philippines were at risk for unintended pregnancy in 2008. Women are considered to be at risk for unintended pregnancy if they are sexually active and able to become pregnant, but do not want to become pregnant within the next two years or at all.

Almost all of the women at risk for unintended pregnancy—a full 10 million—were currently married. (An estimated 200,000 unmarried women were similarly at risk, but this figure may be low because of underreporting due to the social stigma attached to sexual activity outside of marriage.) The majority (62–77%) of married women aged 15–49 wanted to delay or stop childbearing, except in the ARMM where the proportion was 47%.

Despite being at risk for unintended pregnancy, fewer than half of women were using contraceptive methods with high effectiveness rates, i.e., modern contraceptive methods (Table 2). The most commonly used methods were the pill and female sterilization, accounting for more than two-thirds of all contraceptive use in the Philippines. Modern natural family planning (NFP) methods and vasectomy were the least-used methods.

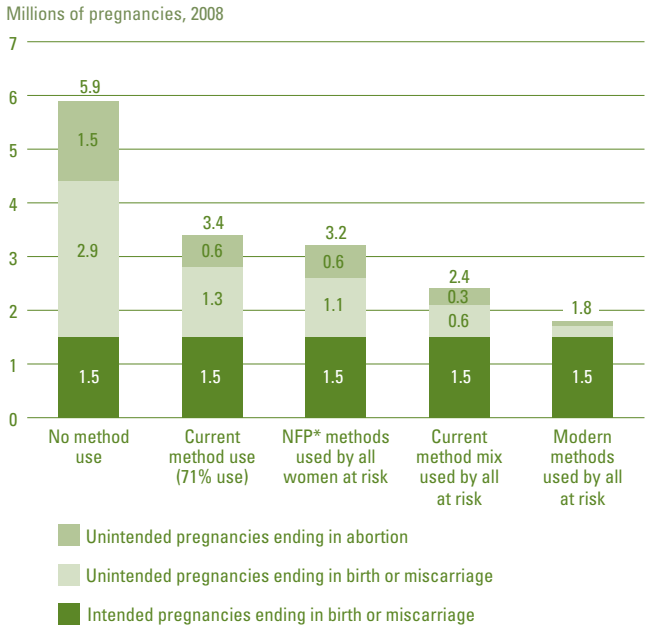
Another 22% of women at risk—2.3 million women—were using a traditional method (mostly withdrawal or periodic abstinence), and 29% (three million women) were using no contraceptive method at all—that is, they experienced an unmet need for contraception.

In the ARMM, women who want to delay or stop childbearing appear to have greater difficulty obtaining methods and practicing contraception, compared with their counterparts elsewhere in the Philippines. As a result, the proportion of women

Figure 2

Impacts of Contraceptive Use

Use of contraception, especially modern methods, reduces abortions and unplanned births.



Note: Data were calculated using a range of sources. See details at <www.guttmacher.org/pubs/MWCNPmethodology.pdf>. *NFP=natural family planning.

with an unmet need for contraceptives was highest in the ARMM (60%; Table 1). Use of modern contraceptives was lowest in the ARMM (25% among women at risk for unintended pregnancy) and highest in Cagayan Valley (72%; data not shown). At 31%, Bicol had the greatest proportion of women at risk for unintended pregnancy using traditional methods.

One-third of women at risk did not want to become pregnant within the next two years, while the remaining two-thirds did not want any more children. Women who wanted to delay a birth were more likely than those who wanted to end childbearing to be using no method and therefore to have an unmet need for contraception (42% and 23%, respectively).

Poor women make up a disproportionate share of women with unmet need: In 2008, they accounted for 35% of women aged 15–49 but 53% of those with unmet need. In the ARMM, Eastern Visayas, MIMAROPA and the Zamboanga Peninsula, more than three-quarters of women with unmet need are poor.

Nonusers account for the vast majority of unintended pregnancies.

The risk of experiencing an unintended pregnancy varies greatly depending on which, if any, contraceptive method a woman and her partner use and how correctly and consistently they use it. The chance of becoming pregnant is highest when no contraceptive is used and lowest when women or their partners use methods that have high efficacy and that do not require user action.[10] Pregnancy rates are lowest among women using permanent sterilization or the IUD. Among methods that require user action, the most effective is the injectable, followed by the pill. Pregnancy rates are higher for condoms and higher still for modern NFP, other periodic abstinence methods and withdrawal.

In 2008, more than two-thirds of unintended pregnancies (1.3 million) in the Philippines occurred among the 29% of women not using any contraceptive method (Figure 3, page 6). Meanwhile, only about 8% of pregnancies occurred among the 49% of women practicing modern contraception, reflecting the relatively high effectiveness of these methods. Traditional method users (22% of all women at risk for unintended pregnancy) accounted for almost one-quarter of unintended pregnancies.

Addressing contraceptive needs, especially those of poor women, is crucial.

Nine in 10 unintended pregnancies in the Philippines occur among women at risk for unintended pregnancy who are using either no method or traditional methods, which have relatively high failure rates. Figure 2 demonstrates the benefits of contraceptive use by presenting different scenarios in which the types of methods and levels of use differ, while other characteristics of the women are held constant.

In one scenario, all Filipino women at risk for unintended pregnancy use modern NFP methods. Those currently using no method would have fewer unintended pregnancies because pregnancy rates are high among nonusers. However, because modern NFP methods have higher failure rates in typical use than other modern methods, unintended pregnancies among women who currently use other modern methods would increase. The net result would be an annual total of 3.2 million pregnancies, 1.7 million of which would be unintended.

Figure 2 also shows a scenario in which all women at risk who do not practice contraception adopt the method mix of current contraceptive users, including both modern (67%) and traditional (33%) methods. Total pregnancies would decrease to 2.4 million because both modern and traditional methods have lower pregnancy rates than using nothing.

A final scenario estimates the potential outcomes should all women at risk for unintended pregnancy use the same mix of modern methods as women who currently practice modern contraception. Because methods that are much more effective than modern NFP and traditional methods would make up 99% of use, unintended pregnancies would be lower than in either the modern NFP–only or the current method mix scenarios. With full use of modern methods, there would be 1.8 million pregnancies each year, only 0.3 million of which would be unintended. Compared with the current situation, this scenario would result in more than 0.8 million fewer unplanned births, 0.5 million fewer induced abortions and 0.2 million fewer miscarriages. Expanding modern contraceptive use to all women at risk for unintended pregnancy would also prevent 2,100 maternal deaths and 120,000 DALYs among women.

Fulfilling demand for contraceptives could benefit disadvantaged women in particular, given that poor Filipino women experience disproportionately high levels of unmet need and unintended pregnancy.

Table 2

Contraceptive Use Among Women at Risk

Percentage distribution of women at risk for unintended pregnancy, according to pregnancy intention; and estimated annual pregnancy rate (pregnancies per 100 users), all by method, 2008

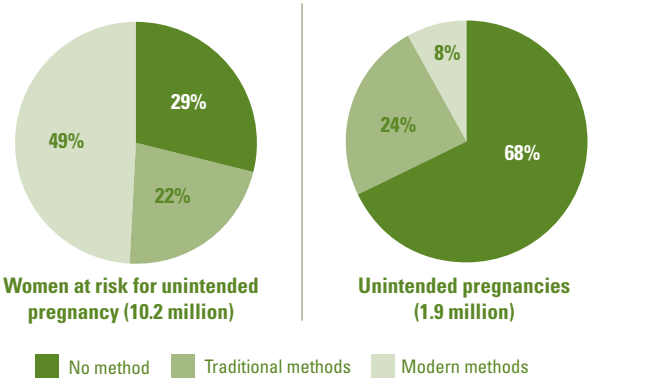
Method	Total	Want to delay births	Want no more births	Pregnancy rate under typical use
Modern	**49**	**36**	**55**	na
Pill	19	22	18	4.6
Sterilization*	16	0	24	0.5
IUD	6	5	6	0.9
Injectable	4	5	4	1.6
Condom	3	3	3	8.2
NFP†	1	1	0	15.5
Traditional	**22**	**22**	**22**	na
Withdrawal	12	12	11	19.8
Periodic abstinence	9	9	10	15.5
Other	1	1	1	17.5
No method	**29**	**42**	**23**	**40**
Total	**100**	**100**	**100**	na

Notes: Data were calculated using a range of sources. See details at <www.guttmacher.org/pubs/MWCNPmethodology/pdf>. na=not applicable. *Pregnancy rate is for (female) tubal ligation, since it accounts for 99% of all sterilizations in the Philippines. †NFP=natural family planning. Includes mucus or Billings Ovulation, Standard Days, symptothermal, basal body temperature and lactational amenorrhea methods.

Figure 3

Contraceptive Use and Unintended Pregnancy

Nonuse and traditional methods accounted for nine in 10 unintended pregnancies in 2008.



Note: Data were calculated using a range of sources. See details at <www.guttmacher.org/pubs/MWCNPmethodology/pdf>.

Currently, the poorest third of women are twice as likely as wealthier women to cite lack of access as a reason for not using contraceptives.[11] Problems obtaining contraceptive services and health care in general in the Philippines are common among women who live in rural areas, have no education, have five or more children, and live in the regions of Mindanao, Caraga and ARMM.[2] Addressing disadvantaged women's needs for services, supplies, information and counseling is both a challenge and an opportunity to make great strides toward improving reproductive health in the Philippines.

Improving reproductive health will require greater financial commitments.

Increasing contraceptive use will require increased investments in contraceptive supplies and services, both from international donors and from the Philippine government at all levels. For many years, funds for family planning services and commodities came mostly from households (45% in 2000) and from donors, technical assistance agencies and NGOs (24%). Local and national government covered smaller shares of the cost—22% and 8%, respectively.[12] Until 2006, most contraceptive commodities were donated by the U.S. Agency for International Development (USAID).[13]

The end of USAID's large-scale provision of contraceptives has presented a significant challenge for ensuring the availability of supplies. In 2004, the Philippines Department of Health (DOH) devised a plan for managing the remaining donated commodities.[14] This "contraceptive self-reliance strategy" encourages local government units (LGUs) to give the poor priority access to the remaining donated contraceptives and to fund future supplies for poor clients. It also promotes shifting better-off users to commercial or partially subsidized sources of supplies, to be made available via LGU outlets. However, a recent survey of the 122 LGU chief executives (representing 76 provinces and 46 cities) found that in 2007, only 64 provinces and cities used funds from local budgets to purchase oral contraceptive pills.[15] Another three LGUs procured pills with income from user or laboratory fees.

For the first time, in 2007, the Philippines annual national budget included a specific line item for family planning funding. The General Appropriations Act of 2007 allocated P180 million to the DOH for operational costs associated with providing contraceptive services—P30 million for the routine functions of DOH in support of family planning and, through congressional initiative, another P150 million to be suballocated to LGUs for purchasing reproductive health commodities and conducting family planning seminars. In May 2008, regional centers for health development were informed of their share of the P150 million and issued guidelines for distributing funds to eligible LGUs within their region.[16] The guidelines required LGUs to provide a full range of reproductive health services to poor clients and to use local funding for reproductive commodities, education and counseling. As of the end of 2008, less than one-third of the budgeted funds had been released to regional centers for distribution to LGUs.[17] P1.2 billion was budgeted in 2008, again through congressional initiative, for the DOH to allocate to LGUs for procuring reproductive health commodities for free distribution to the poor, but it is not yet clear how much of this funding has reached LGUs or how it has been spent.

The cost of contraceptive services in the Philippines is at least P1.9 billion, a rough estimate incorporating data on the lowest available prices for contraceptives, the costs of services for methods requiring supplies and the reimbursement rates for sterilization under the PhilHealth national insurance system. While modern NFP methods do not require supplies, the Philippines DOH Commission on Population budget for 2009 includes P164 million to reach 580,000 couples with Responsible Parenthood and Natural Family Planning classes.[18] Based on these costs of P283 per couple, and assuming that all couples attending classes would subsequently use a modern NFP method, service costs to shift all 10.2 million women at risk for unintended pregnancy to modern NFP methods would be at least P2.9 billion.

The cost of providing modern contraceptive supplies and services to all women who are currently at risk for unintended pregnancy would vary depending on the mix of methods used: P2.7 billion for full use of the current method mix to P4.0 billion for full use of modern methods. These costs, and the financial savings discussed below, underestimate the total financial impact of contraceptive services because they do not include the substantial portion of medical care paid for by Filipinos out-of-pocket (48% of health care–related spending in 2005).[19]

Contraceptive use saves money.
Although providing contraception to all who need it may seem costly, the expenses associated with unintended pregnancies are even higher. Medical costs for all women experiencing an unintended pregnancy in 2008 (at PhilHealth rates for normal and cesarean births, newborn care and treatment of abortion complications) were at least P3.5 billion. Maternal and newborn care related to intended pregnancies cost an additional P3.9 billion. Thus, expenditures on pregnancy-related services, plus the current cost of contraceptive services (P1.9 billion), total at least P9.3 billion (Figure 4). In contrast, without current contraceptive use, the cost of medical care for pregnant women would be at least P12.1 billion.

If all women at risk for unintended pregnancy used only modern NFP methods, total costs would rise from the current P9.3 billion to P10.0 billion, because spending on family planning would increase without a large reduction in medical care for unintended pregnancies.

However, increasing funding to enable all women at risk to use either the current mix of contraceptives or modern methods only would *reduce* net spending. In a scenario using the current mix of modern and traditional methods, spending on family planning would increase from P1.9 billion to P2.7 billion, but medical costs for unintended pregnancies would fall from P3.5 billion to P1.6 billion—a net savings of P1.1 billion. If all women at risk used modern contraceptive methods, including a small proportion using modern NFP methods, spending on family planning would increase from P1.9 billion to P4.0 billion, but medical costs for unintended pregnancies would fall from P3.5 billion to P0.6 billion. Total costs would drop from P9.3 billion to P8.5 billion—a net savings of P0.8 billion.

Only 38% of women in the Philippines deliver their babies in a health facility, and levels are especially low in ARMM (11%), MIMAROPA (16%) and Zamboanga (16%; data not shown). Reducing unintended pregnancies would make the goal of having all pregnant women receive skilled, facility-based care during pregnancy and delivery more attainable. Providing facility-based care for all pregnant women today would roughly double the annual costs of their medical care from the current minimum of P7.4 billion to P15.9 billion. Increasing the ability of women and their partners to use contraceptives, however, would reduce the costs of medical care for all pregnant women. The cost of medical care would decline slightly from P15.9 billion to P14.9 billion if all women at risk used modern NFP methods, to P11.7 billion if they used the current mix of contraceptive methods, and to only P9.6 billion if they used modern methods in the same proportions as today's users.

Reducing unintended pregnancies by meeting women's need for contraception, especially by providing highly effective methods, also reduces stress on education, health care and other social services.[4,20,21] Savings in these areas, as well as in pregnancy-related medical care, can be used to improve and expand a range of public services, making it easier for the Philippines to achieve the Millennium Development Goals and other development objectives.

The case for additional funding is compelling.
Contraceptive use promotes the health and welfare of women and infants, their families and Filipino society. Without it, there would be about 5.9 million pregnancies each year, compared with the current level of 3.4 million, more than half of which would be unintended. However, there could be as few as 0.3 million unintended pregnancies annually if all couples who have an unmet need for contraceptive services, or who use traditional methods, were given the opportunity to obtain and use modern contraceptive methods. Moreover, if current users of modern methods received the information, counseling and ready access to supplies that they need to use their methods consistently and correctly, they would achieve even greater success at preventing unintended pregnancies.

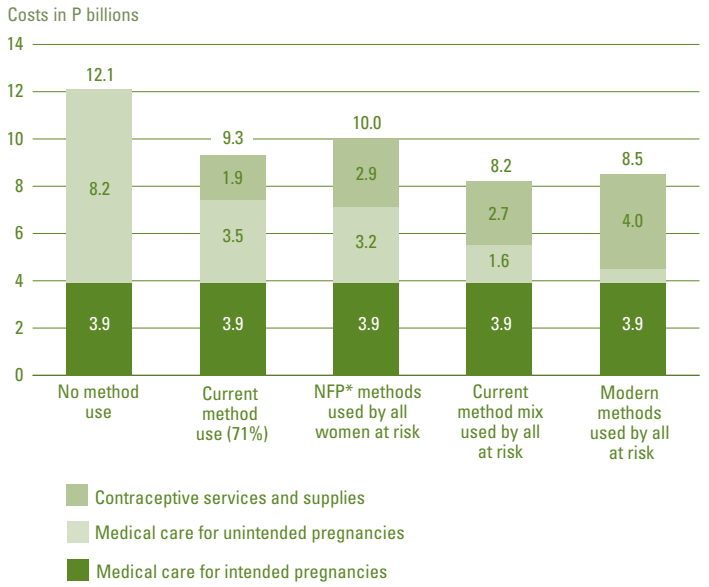
Increasing publicly funded contraceptive services is especially important to improve the sexual and reproductive health of poor women, who experience disproportionately high levels of unmet need, unintended pregnancy and pregnancy-related health risks. Meeting the needs of these women and their families will require developing services and outreach efforts, and directing resources to areas of the country where poverty is greatest.

Investing in contraceptive services not only protects

Figure 4

Costs of Contraceptive Use

Investing in contraception could greatly reduce costs associated with unintended pregnancy.



Note: Data were calculated using a range of sources. See details at <www.guttmacher.org/pubs/MWCNPmethodology/pdf>. *NFP=natural family planning

women and families, it also saves money. By taking on the cost of providing contraception, the Philippines government could avoid much greater expenses down the road, including those for maternal and newborn services, treatment for pregnancy-related complications and life-long services for millions of additional people. The savings could be invested toward improving public services and encouraging economic development.

REFERENCES

1. Ronsmans C and Graham WJ, Maternal mortality: who, when, where, and why, *Lancet*, 2006, 368(9542):1189–1200.

2. National Statistics Office (NSO) and ORC Macro, *National Demographic and Health Survey 2003,* Manila, Philippines: NSO; and Calverton, MD, USA: ORC Macro, 2004.

3. United Nations Millennium Project, *Preparing National Strategies to Achieve the Millennium Development Goals: A Handbook*, New York: United Nations Development Programme (UNDP), 2005.

4. Singh S et al., *Adding It Up: The Benefits of Investing in Sexual and Reproductive Health Care*, New York: The Alan Guttmacher Institute (AGI) and United Nations Population Fund, 2003.

5. World Health Organization (WHO), *Maternal Mortality in 2000: Estimates Developed by WHO, UNICEF and UNFPA,* Geneva: WHO, 2004.

6. Singh S et al., *Unintended Pregnancy and Induced Abortion in the Philippines: Causes and Consequences,* New York: Guttmacher Institute, 2006.

7. WHO, Mortality and burden of disease estimates for WHO member states in 2002, 2004, <http://www.who.int/healthinfo/statistics/bodgbddeathdalyestimates.xls>, accessed Nov. 23, 2008.

8. MEASURE DHS, STATcompiler, 2008, <http://www.statcompiler.com/>, accessed Nov. 19, 2009.

9. De La Paz CG and Colson L, *Population, Health, and Environment Issues in the Philippines: A Profile of the Autonomous Region in Muslim Mindanao (ARMM),* Washington, DC: Population Reference Bureau, 2008, <http://www.prb.org/pdf08/pheregionalprofiles_armm.pdf>, accessed Feb. 3, 2009.

10. Trussell J, Contraceptive efficacy, in: Hatcher RA et al., eds., *Contraceptive Technology*, 19th ed., New York: Ardent Media, 2007.

11. Sedgh G et al., Women with an unmet need for contraception in developing countries and their reasons for not using a method, *Occasional Report*, New York: Guttmacher Institute, 2007, No. 37.

12. Racelis RH and Herrin AN, *Philippine Population Management Program Expenditure Accounts, 1998 and 2000,* Manila, Philippines: Department of Health Commission on Population (POPCOM), Apr. 30, 2003, <http://www3.pids.gov.ph/ris/seminars/2004_pptpop-com430_herrinracelis.pdf>, accessed Nov. 29, 2008.

13. Aquino VM, *Completing the Family Planning Equation to Achieve Contraceptive Self-Reliance,* Manila, Philippines: Philippine Legislator's Committee on Population and Development Foundation, 2008.

14. Office of the Secretary, Department of Health, Administrative Order 158, July 9, 2004, <http://www.doh.gov.ph/files/ao158-04.pdf>, accessed Feb. 10, 2009.

15. Cabigon JV, Contraceptive self-reliance and local governments' responses to family planning commodity phase-out: technical report on the results of the CSR rapid assessment, Manila, Philippines: Health Policy Development Program and Foundation for the Advancement of Clinical Epidemiology, 2009.

16. Office of the Secretary, Department of Health, Department memorandum 2008-0100, May 7, 2008, <http://home.doh.gov.ph/dm/dm2008-0100.pdf>, accessed Feb. 10, 2009.

17. Office of the Secretary, Department of Health, Department memorandum 2008-0272, Dec. 16, 2008, <http://home.doh.gov.ph/dm/dm2008-0272.pdf>, accessed Feb. 10, 2009.

18. POPCOM, Proposed budget FY 2009, Manila, Philippines: POPCOM, 2008.

19. National Statistical Coordination Board, 2005 Philippines national health accounts: sources of funds for health, 2008, <http://www.nscb.gov.ph/stats/pnha/2005/sources.asp>, accessed Jan. 29, 2009.

20. Moreland S and Talbird S, *Achieving the Millennium Development Goals: The Contribution of Fulfilling the Unmet Need for Family Planning*, Washington, DC: POLICY Project, Futures Group, 2006

21. United Nations Millennium Project, *Public Choices, Private Decisions: Sexual and Reproductive Health and the Millennium Development Goals*, New York: UNDP, 2006.

CREDITS

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