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Improving Reproductive Health in the Philippines

Filipino women's lives are changing rapidly as a result of improvements in education, the spread of mass media, increases in the proportions of women working and growing acceptance of a larger role for women in society. While women continue to value their roles as wives and mothers, these developments have helped to redefine their childbearing goals.

The purpose of this report is to increase awareness of, and attention to, Filipino women's health care needs by highlighting key changes in their reproductive health and the factors that influence it—the socioeconomic context in which they live, their childbearing experience, their success in planning births and in achieving their family-size goals, and the extent of their use of contraception and abortion. This document is directed to policymakers, service providers, advocates and others concerned about improving the reproductive health of Filipino women.

To capture recent trends, the report presents information for two points in time, 1993 and 1998, years for which comparable national survey data on these issues are available. To address the need for information for specific areas of the country, it includes measures for regions.* Information at the regional level will help to inform decision-making on policies and programs, as well as on budget allocation for family planning programs, at the regional, provincial and local levels. (There has been a pressing need for data for subnational areas—provinces; municipalities; and *barangays,* the smallest administrative units, corresponding to villages—since 1991, when the central Philippine government transferred responsibility for the provision of basic services, including health care, to local administrative units. However, such detailed data are not available.)

The context of women's lives is changing.

With a population of 80 million in 2003, the Philippines is the 13th most populous country in the world.[1] It has one of the highest population growth rates in Asia (2.3% annually). The per capita gross national product of $3,971 (in 2000) places the Philippines between the poorer Asian countries, like India and Pakistan, and the more industrialized ones, like Malaysia and Thailand.[2]

Large socioeconomic changes have taken place over the past several decades. The circumstances in which families and women live today are quite different from those of the 1950s; even during the 1990s, many aspects of women's lives changed substantially. In the 30 years from 1970 to 2000, the proportion of women living in urban areas increased by 79% (from 33% to 59%)—a pace that is greater than the average worldwide (27%).[3] From 1993 to 1998, the proportion of women living in households with piped water increased from

*There were 14 regions in the Philippines in 1993; by 1998, after redefinition of administrative areas, this number had increased to 16.

Key Points

- **Substantial societal changes have improved Filipino women's lives and influenced their family-size goals. Fertility has fallen considerably, and women want even fewer children than they typically have.**
- **Almost half of recent births were either not wanted at all or not wanted at the time. At the national level, this situation has not improved over the last decade; in some regions, unplanned childbearing has increased.**
- **Nonuse of contraception and increasing use of traditional methods contribute to the high level of unplanned pregnancy. Half of married women do not want a child soon, or want no more children, but are not using a modern contraceptive.**
- **An estimated 400,000 women from all regions and backgrounds have illegal abortions each year; approximately 100,000 are hospitalized for related complications.**
- **Poor access to modern contraceptives, a reflection of a lack of social and political support, is a major obstacle to wider use. Increased government support and resources are needed at all levels to improve access to family planning services.**

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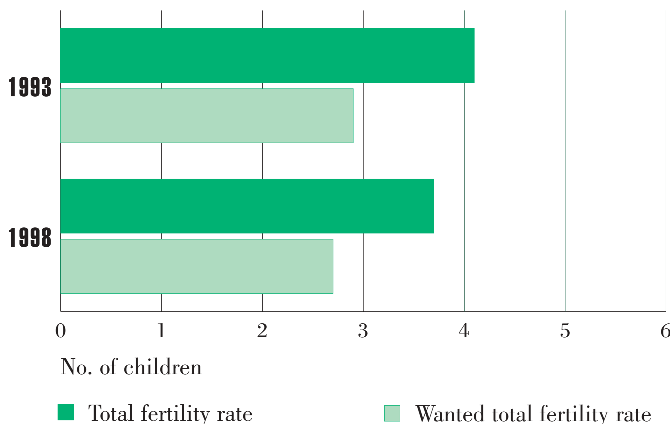
chart a

Total and Wanted Fertility

On average, Filipino women have one child more than they want.



33% to 42%; similar increases are seen in the proportions living in households with a flush toilet (from 58% to 64%) and living in households with a television (51% to 64%). Women's educational attainment has steadily risen, reaching a relatively high level by 1998: In that year, 82% of women aged 20–24 had had seven or more years of schooling, compared with 59% of women aged 40–44. The proportion of women currently working for pay increased from 43% to 55% over the period 1993–1998.[4] To find work, many families migrate either to more prosperous areas of the country; to other countries in the region, such as Hong Kong and Singapore; or to Europe, the United States or the oil-producing countries of the Middle East. A high proportion of Filipinos working abroad are women.[5]

These changes—especially the rising levels of educational attainment and exposure to media—are strongly associated with the diffusion of new ideas, including the advantages of a small family, the acceptability of women's working and gender equity. Far-reaching social and economic changes such as these are also likely to shape women's aspirations regarding their quality of life and the number and spacing of their children.

Despite significant overall advances, however, large economic inequalities remain within the Philippines—for example, between rural and urban areas, and across and within regions. Women living in less-affluent parts of the country have limited opportunities and options, and these variations are likely to be reflected in different patterns of reproductive behavior.

Filipino women want smaller families than they did before.

The average woman in the Philippines today has four children, whereas her counterpart 40 years ago had seven.[6] Modernization, the changing role of women, severe poverty in some regions, the rise in the value of educating children and an increased desire to improve the quality of life all have contributed to this reduction in fertility. However, women want even smaller families than they have (Chart A). The wanted total fertility rate was one child lower than the total fertility rate in 1998.* Although this gap had decreased somewhat since 1993 (when it was 1.2), the level of unwanted childbearing was very high: About one-quarter of the average woman's lifetime births were unwanted (that is, they occurred after she had decided that she wanted no more children or at a time when she specifically said that they were unwanted).

In 1998, the gap between wanted and achieved fertility was larger than average in Eastern Visayas, Bicol and Northern Mindanao, reaching almost two children. Women living in rural areas reported having 1.5 children more than they wanted.

At the national level and across rural and urban settings, the proportion of recent births that currently married women aged 15–49 reported in 1998 were unwanted or mistimed was roughly the same as the proportion in 1993—about 45% (Chart B). However, substantial changes occurred in some regions. The largest increases in unplanned childbearing were in Central Mindanao (57% of recent births in 1998, approximately twice the 29% in 1993), Cagayan Valley (41% vs. 23%, a 78% increase) and Metro Manila (47% vs. 31%, a 52% rise). Most other regions had relatively small changes, but in three, the level of unplanned childbearing was markedly lower in 1998 than in 1993: Southern Mindanao (a 30% reduction, from 47% to 33%), Eastern Visayas (a decline of 35%) and Bicol (a 21% drop).

Induced abortion is one method that Filipino women use to meet their reproductive goals.

Although abortion is illegal in the Philippines, and despite the potential harmful consequences of an unsafe abortion for women's health and life, many women resort to abortion to meet their family-size goals or to space births. Since the late 1970s, several studies have documented the occurrence of unsafe abortions and their negative impact on women's health.[7]

Nationally, the estimated annual abortion rate in the mid-1990s was 25 per 1,000 women aged 15–44; this rate

*Total fertility rates and wanted fertility rates are based on events during the three years before the survey.

Data Sources

Data presented in this report are derived mainly from the 1993 and 1998 Demographic and Health Surveys (DHS). These surveys are part of an international research effort conducted by Macro International in cooperation with national governments. The samples are nationally representative and are large enough to permit estimates for all of the country's regions (14 in 1993 and 16 in 1998). In 1993, the DHS interviewed 15,029 women aged 15–49; in the 1998 survey, 13,983 women were interviewed. Unmarried women were included in both surveys but were asked only selected questions.

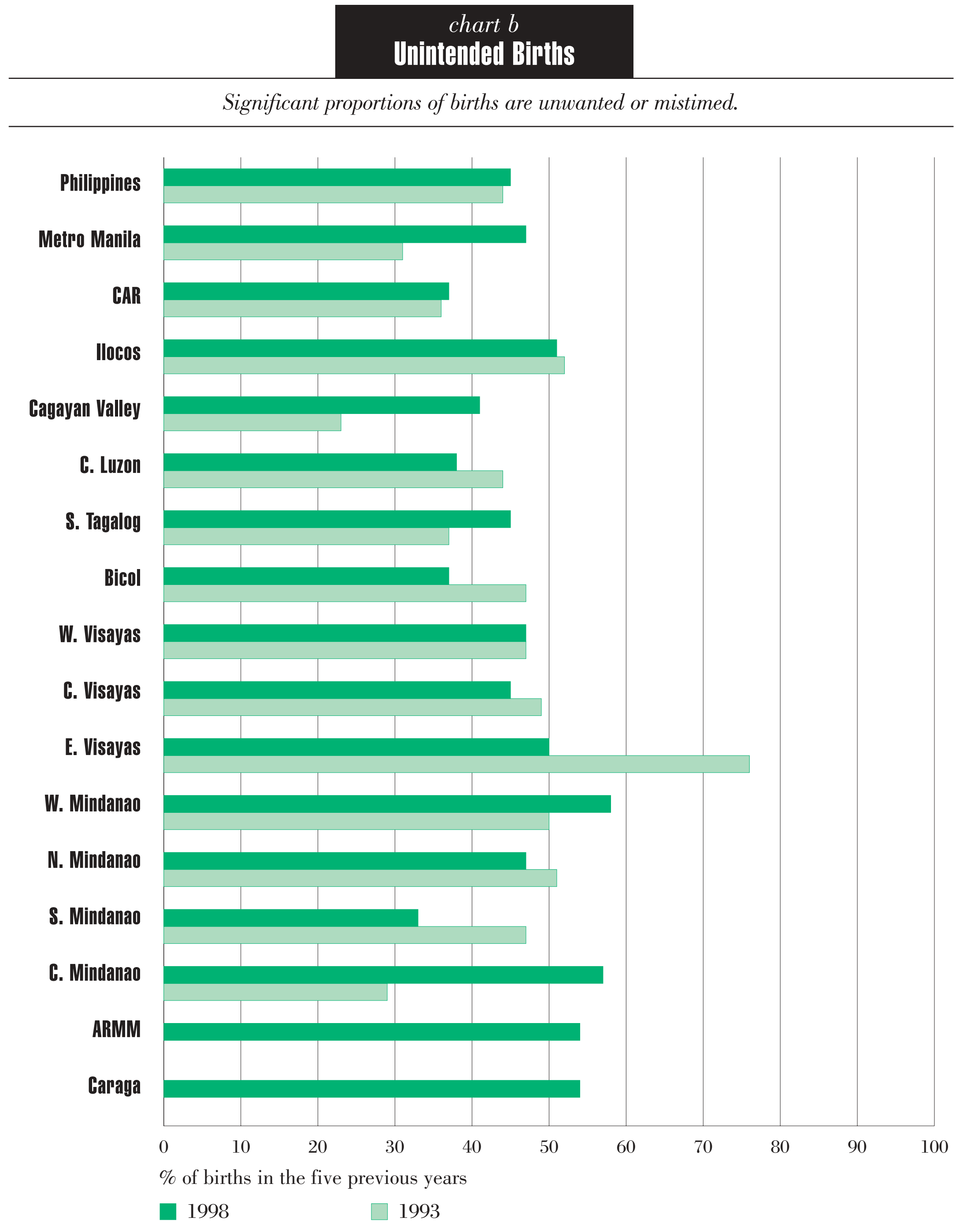


chart b

Unintended Births

Significant proportions of births are unwanted or mistimed.

Notes: CAR=Cordillera Administrative Region. ARMM=Autonomous Region of Muslim Mindanao.

corresponds to about 400,000 abortions each year. While women in every region had abortions, the rate varied considerably across regions (Chart C, page 4). Metro Manila had the highest rate—41 per 1,000, representing an estimated 105,000 abortions. Some regions, generally those in more rural parts of the country, had rates lower than 10 abortions per 1,000 women.

A 1994 survey in three large hospitals, each in a different region, showed that women of all social classes seek and obtain abortions. Compared with the general population, women who are in cohabiting (live-in) unions, those who are better educated and those from households with six or more children are overrepresented among women who are hospitalized for abortion complications.[8]

An estimated 100,000 women are hospitalized and treated each year in the Philippines for complications due to induced abortion.[9] A 1994 study showed that the most common medical complications are fever (accounting for 67% of hospitalizations for complications), abdominal pain (33%) and excessive bleeding (14%).[10]

Filipino women's abortion experiences cannot be isolated from their legal and sociocultural context. The country's constitution defines abortion as a criminal act for which both the woman undergoing the procedure and the provider who performs it may be prosecuted. Given these legal constraints, and the position taken by the Catholic Church that abortion is immoral and sinful, many women have little choice but to resort to an unsafe clandestine abortion when they are faced with an unwanted pregnancy. In addition, the overall negative climate of opinion on abortion influences the attitude of health care providers, some of whom show overtly judgmental behavior toward women they treat for abortion complications.[11]

About half of married women use contraceptives, and four in 10 users rely on traditional methods.

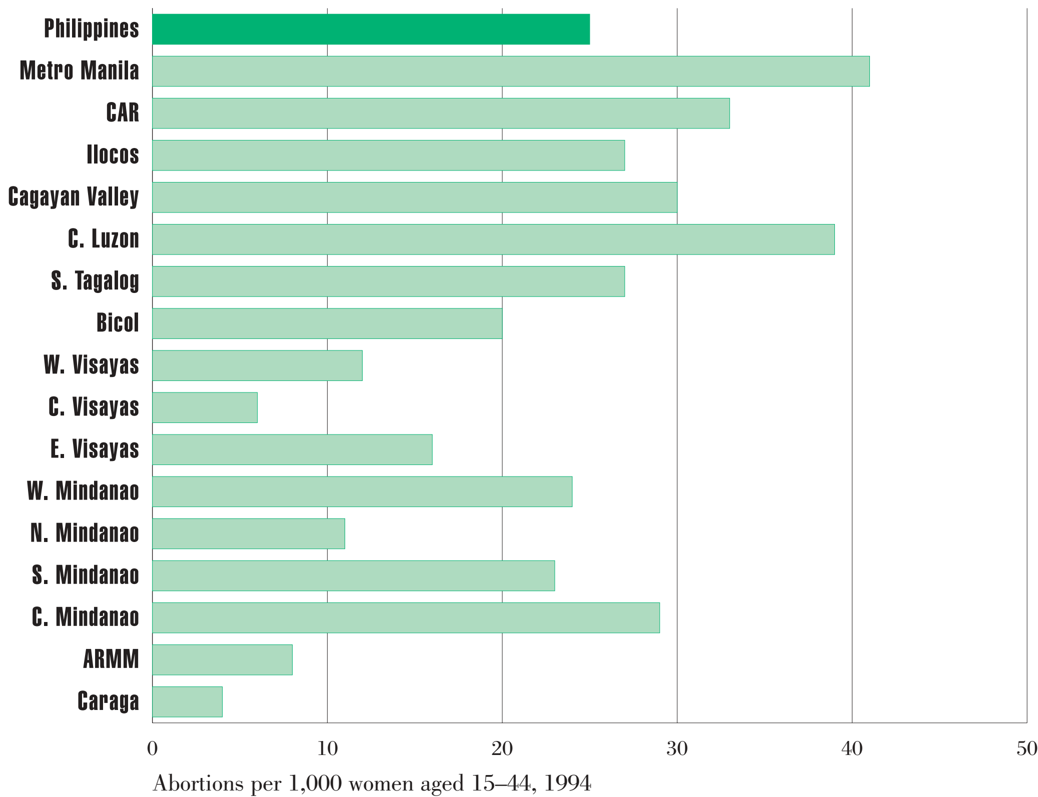
In 1998, 48% of married women of reproductive age used a method of family planning (Table 1, page 5). About 60% of these users relied on the pill, female sterilization or another modern method (the IUD, injectables, spermicides, barrier methods or male sterilization). However, four in 10 users depended on periodic abstinence, withdrawal or other traditional methods, which have high failure rates.

Women living in urban areas were more likely to practice

chart c

Abortion Rates

Abortion rates vary widely by region.



Notes: CAR=Cordillera Administrative Region. ARMM=Autonomous Region of Muslim Mindanao.

contraception (52%) than were rural residents (44%). Substantial proportions of women in both urban and rural areas used traditional methods: 21% and 19%, respectively.

The regions with the highest proportions of women using modern contraceptives in 1998 were Cagayan Valley (39%), Southern Mindanao (36%) and Central Luzon (35%). The regions with the highest proportions using traditional methods were Eastern Visayas (26%) and Central Visayas (23%).

Trends between 1993 and 1998 show great variations across regions. For example, in Cagayan Valley, a region characterized by a relatively high prevalence of overall use and of modern method use, reliance on modern contraceptives increased from 32% to 39%, and reliance on traditional methods remained low and almost unchanged (9–10%). Similarly, in Southern Mindanao, the overall prevalence of modern methods rose from 27% to 36%, and traditional method use was essentially stable (19–20%).

The picture is quite different elsewhere, showing increases in traditional method use and either no change or a decrease in the use of modern methods. In Metro Manila, the prevalence of modern method use remained almost unchanged between 1993 and 1998 (27–28%), while the use of traditional methods increased from 15% to 22%. A similar trend is observed for Eastern Visayas, where the prevalence of modern method use remained essentially unchanged (18% in 1993 and 16% in 1998), and use of traditional methods increased by eight percentage points (from 18% to 26%).

The general trend of contraceptive use in the Philippines is the opposite of what has been observed elsewhere in the developing world, where women living in the more modernized and urban areas of a country are more likely to use modern contraceptive methods, and less likely to use traditional methods, than women in the rural, less-developed areas. In nine regions of the Philippines, the use of traditional contraceptive methods has increased by three percentage points or more; in seven of these regions, the increase has been at least five points. It is particularly striking, and unexpected, that an increase has occurred in Metro Manila, the most urbanized area of the country.

Findings from recent research indicating that Philippine family planning services are deficient[12] suggest that this could be a factor in the increasing use of traditional methods. In a study focusing on the quality of family planning services for new mothers, carried out in 86 clinics in 28 provinces across the country, nearly all women wishing to postpone their next birth reported that providers gave them advice on contraception. However, a substantial proportion of women who wished to stop having children reported that clinics did not provide any advice on contraception (15% in 1994 and 23% in 1997). In addition, service providers misunderstood the duration of the protective role of breastfeeding and informed clients that the lactational amenorrhea method provides protection against pregnancy for a longer period than it actually does.[13]

A high proportion of Filipino women need, but are not using, modern contraceptives.

The proportion of currently married women with an unmet need for effective contraception declined slightly during the 1990s but still is extremely high: In 1998, 50% of women did not want a child soon, or did not want any more children, but were not using a modern method;

table 1

Percentage distribution of married women aged 15–49, by current contraceptive use, and percentages relying on the most commonly used methods, all according to region and residence, Philippines, 1993 and 1998

Region and residence	Any method		Modern*		Traditional†		No method		Total	
	1993	1998	1993	1998	1993	1998	1993	1998	1993	1998
All	**40**	**48**	**25**	**28**	**15**	**20**	**60**	**52**	**100**	**100**
Region										
Metro Manila	42	50	27	28	15	22	58	50	100	100
CAR	39	42	23	30	16	12	61	58	100	100
Ilocos	39	44	22	29	17	15	61	56	100	100
Cagayan Valley	41	48	32	39	9	10	59	52	100	100
C. Luzon	44	56	31	35	13	20	56	44	100	100
S. Tagalog	35	47	23	26	13	20	65	53	100	100
Bicol	36	40	16	19	20	22	64	60	100	100
W. Visayas	40	46	24	25	16	21	60	54	100	100
C. Visayas	46	51	29	28	17	23	54	49	100	100
E. Visayas	36	43	18	16	18	26	64	57	100	100
W. Mindanao	28	45	17	30	12	16	72	55	100	100
N. Mindanao	49	55	31	34	18	21	51	45	100	100
S. Mindanao	46	55	27	36	19	20	54	45	100	100
C. Mindanao	33	46	21	29	12	18	67	54	100	100
ARMM	na	19	na	9	na	10	na	81	100	100
Caraga	na	50	na	28	na	21	na	50	100	100
Residence										
Urban	43	52	28	31	15	21	57	48	100	100
Rural	37	44	22	25	15	19	63	56	100	100

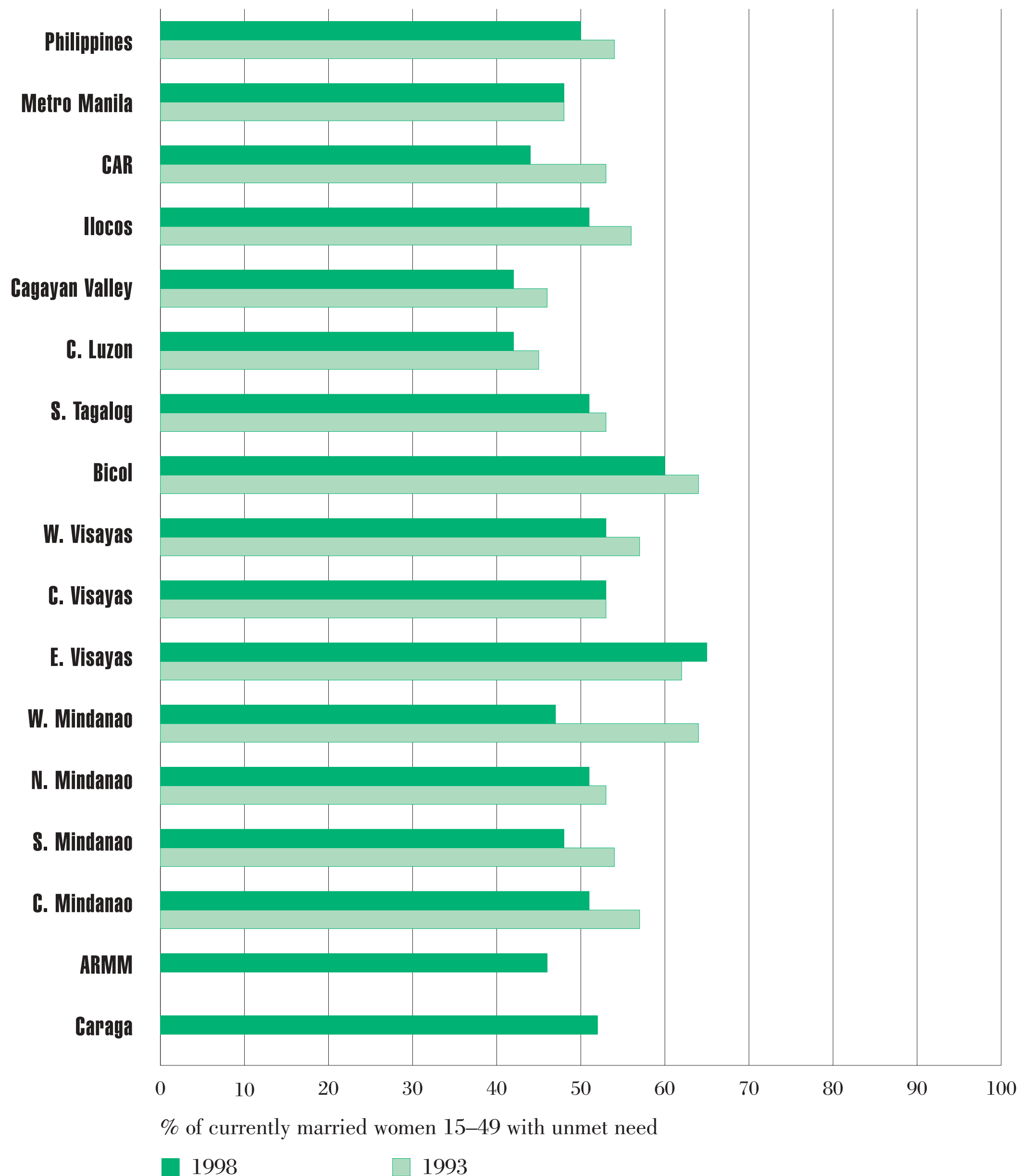
Region and residence	Most commonly used methods							
	Pill		Female sterilization		Period abstinence		Withdrawal	
	1993	1998	1993	1998	1993	1998	1993	1998
All	**8**	**10**	**12**	**10**	**7**	**9**	**7**	**9**
Region								
Metro Manila	9	11	15	12	7	10	8	10
CAR	3	7	16	15	7	4	8	7
Ilocos	7	10	13	13	6	3	11	11
Cagayan Valley	15	16	13	12	3	3	6	6
C. Luzon	9	12	19	19	3	6	10	13
S. Tagalog	6	8	12	12	5	6	8	12
Bicol	6	8	7	5	8	6	12	9
W. Visayas	10	8	10	9	10	12	6	7
C. Visayas	10	8	12	7	9	15	8	8
E. Visayas	6	4	10	7	10	10	7	10
W. Mindanao	9	16	6	4	7	10	3	3
N. Mindanao	12	14	8	5	13	13	4	7
S. Mindanao	8	14	11	7	11	13	7	6
C. Mindanao	7	8	6	9	8	10	3	6
ARMM	na	4	na	3	na	2	na	1
Caraga	na	9	na	8	na	13	na	6
Residence								
Urban	9	11	14	13	8	9	7	9
Rural	8	9	10	8	7	8	7	8

*The pill, IUD, injectable, spermicide, barrier methods, and male and female sterilization. †All forms of periodic abstinence (calendar, Billings, mucus, basal body temperature, symptothermal and lactational amenorrhea), withdrawal, breastfeeding and other, local methods. *Notes:* na=not applicable because the region was created after 1993. CAR=Cordillera Administrative Region. ARMM=Autonomous Region of Muslim Mindanao.

chart d

Unmet Need

About half of currently married women in all regions have an unmet need for effective contraception.



Notes: CAR=Cordillera Administrative Region. ARMM=Autonomous Region of Muslim Mindanao.

by comparison, the proportion was 54% in 1993. Urban and rural women had similar levels of unmet need, and similar patterns of change in unmet need, in the 1990s.

Variations in the level of unmet need across regions are large, but even the lowest levels are extremely high (Chart D). In 1998, the highest proportions of women with an unmet need for effective contraceptive methods were in Eastern Visayas (65%) and Bicol (60%), while the lowest proportions were in Cagayan Valley (42%) and Central Luzon (42%). The trend during the 1990s is not encouraging: Reductions in unmet need were very small in most regions. Metro Manila and Central Visayas showed no improvement from 1993 to 1998. Two regions registered fairly large reductions in unmet need: Western Mindanao (from 64% to 47%) and Cordillera (from 53% to 44%).

Helping women achieve their reproductive health and family-size goals will require action on many fronts.

The circumstances in which a Filipino woman today becomes a wife, a mother and a productive person in society are very different from those of the past. Though women's levels of education and participation in the country's development have increased, large gaps remain in their ability to achieve their reproductive goals. Recent trends in contraceptive use and the estimated level of abortion demonstrate that levels of unplanned pregnancy, unsafe abortion and unplanned childbearing are high, and depict an extremely unfavorable situation for women. At the same time, women's willingness to have an abortion despite the risks is evidence of the strength of their determination to control the size of their families and the timing of their births.

Filipino women's inability to achieve their desired family size and their great need for modern contraception can be understood only in the context of the social and political climate in which family planning services are delivered. In-depth studies have identified husbands' attitude toward family planning as a significant barrier to women's use of contraceptives.[14] They also have suggested that an important barrier is women's perception that the side effects of modern method use outweigh the benefits.[15]

The Catholic Church in the Philippines is also likely to have a strong influence on the provision of contraceptive services, given that it has been very proactive in oppos-

ing modern methods. The Church and other prolife advocates support only one method of contraception—natural family planning, or periodic abstinence.[16] They are critical of the Ramos administration, which governed from 1992 to 1998 and supported the use of modern birth control methods, and they have campaigned against politicians who support family planning. Under President Macapagal-Arroyo, the national population and reproductive health program has endorsed natural family planning, on the grounds that it promotes family values. President Arroyo has stated that the rhythm method brings spouses together, with the wife observing her body temperature, vaginal secretions and menstrual cycle, and her husband recording the information on a chart. According to the Church, natural family planning also helps teach patience, responsibility and self-control.[17]

These statements ignore evidence that husbands' attitudes and behavior often prevent women from using contraceptive methods to achieve their reproductive goals.[18] Furthermore, natural family planning methods typically have high failure rates. In an analysis using information from 18 developing countries (including the Philippines), the average failure rate was 22% for periodic abstinence and 15% for withdrawal, compared with 7% for the pill, 10% for the condom and IUD, and 2–3% for injectables.[19] Moreover, these rates were based only on contraceptive failures that resulted in live births; because abortions were not measured, these rates underestimate method failure.

Another important factor that may have negatively influenced the provision of family planning services in the 1990s is devolution, the transfer of power from the central government to local levels of administration that began in 1991. This has included the shifting of decision-making regarding the content of health care services and budget allocation for expenditures on health services, including family planning programs. Variation across local government units in the priority assigned to family planning (depending, for example, on whether the local mayor supports modern contraception) can have a marked impact on resources allocated to programs and on the quality and types of services offered to women. Variation at the local level in support for family planning services may explain some of the large declines in use of modern contraceptives, increases in use of traditional methods or increases in unmet need. In particular, reduced access to services and supplies of modern contraceptive methods may partly explain the unexpected finding that women living in Metro Manila, where family planning services would be expected to be fairly available and accessible, have a high level of unmet need for contraception and are increasingly using traditional methods.

In sum, the findings from national surveys and other sources suggest a number of key measures that must be taken if Filipino women's reproductive health needs are to be met: The great need for improved access to family planning services should be addressed by the government at the national and local levels, and by family planning providers. Additionally, providers need training to improve and update their knowledge of the efficacy, advantages and disadvantages of all methods. And couples need education about the advantages of using modern contraceptive methods to achieve their family-size goals—and about the disadvantages, including failure rates and potential side effects, so that they can make appropriate and informed choices. A national information campaign could help meet educational needs. Finally, husbands and partners may play an important role in influencing decisions about family size and contraception, and should therefore be included in the provision of family planning information and services.

Women's ability to achieve their childbearing goals hardly improved during the 1990s, and in many respects the reverse occurred. These circumstances strongly argue for increased attention by policymakers, service providers and advocates to identifying and implementing mechanisms for helping women to successfully plan their families, reduce unintended childbearing and thereby improve their health.

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Credits

Susheela Singh oversaw the development of this report, Fatima Juarez conducted research and analyses, and both contributed to writing the report. Erin Carbone provided valuable research assistance. We thank Josefina Cabigon, University of the Philippines Population Institute, Manila, for reviewing the draft and for her many contributions. We also thank Alexandrina Marcelo and the Reproductive Rights Resource Group (3RG) for comments on preliminary findings and for coordinating the printing. In addition, we acknowledge the guidance we received from Sara Seims, Beth Fredrick, Jacqueline E. Darroch, Patricia Donovan, Akinrinola Bankole and Jennifer Nadeau. Dore Hollander edited the report; Kathleen Randall, Michael Greelish and Judith Rothman produced the layout. We thank The David and Lucile Packard Foundation for supporting the research and publication of this report.

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