

PHILIPPINES

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EXECUTIVE SUMMARY

The 1994 International Conference on Population and Development (ICPD) marked an important moment in the history of women's reproductive health and rights the world over, as well as the further recognition that women's empowerment and full participation in political, social and economic life were necessary conditions for development and progress to take place. Indeed with the Philippines' participation in and acceptance of the ICPD Programme of Action (PoA), a paradigm shift from the population control programme to the broader human rights-based population and development framework began to take place. The Philippines embraced reproductive health as a health approach, going beyond a mere focus on family planning (FP) and population reduction. Policies and programmes in reproductive health began to be introduced and implemented although, over time, inconsistencies began to show up in the understanding of both the goals and the actual implementation of programmes. When this happened, there was considerable external pressure to revert to the population control framework.

This study assesses progress made in achieving ICPD goals since 1994 and compares its findings and analysis with government reports and their findings. It focusses on three important and contentious themes of reproductive health and rights in the Philippines: maternal health, family planning/contraception, and abortion, it uses real stories and accounts of women's experiences to reflect the reproductive rights violations that continue to happen. Quantitative data from other Likhaan studies are also used and analysed. In addition the study critiques government reports on policies and programmes that are supposedly geared towards improving the health and situation of women.

The Philippines has seen several changes in government since the seventies when the first Population Act was passed. From the time of the Marcos regime (1972-1986) when the policy on sexual and reproductive health and rights was boldly anti-poverty through population control to the time of Macapagal-Arroyo (2002-current) which has questioned the concept of reproductive health and pushed for Church-approved methods, women's reproductive health and rights have been subject to the pull of these two opposing forces.

The Church gained ground with its major role in placing the Catholic widow, Aquino, in power in 1986. With a protestant president in place, from 1992-1998 (the period that covers ICPD), for a brief period the reproductive health concept with its cafeteria approach to family planning came to acquire some importance. In 1998, a more aggressive Family Planning Programme explicitly geared towards reducing the population growth according to a set target replaced this approach. With the Estrada administration's tenure cut short by another "people's power" revolt, we now have the Macapagal-Arroyo administration which, while presenting itself as being in favour of informed choice, has placed all FP resources into promoting only natural family planning (NFP).

While the Government reports progress in reaching ICPD goals, particularly through policies and programmes developed since 1994, Likhaan's report, based on in-depth interviews with poor women of Metro Manila reflects otherwise. There is a strong possibility that the maternal mortality rate (MMR) has been significantly underestimated by field reports. An assessment of emergency obstetrical care (EmOC) points to its inaccessibility even in urban centres where hospitals abound. Abortion, however, despite its illegality in the Philippines, continues to be pervasive and attended by life-threatening complications, yet is largely ignored. Although the Prevention and Management of Abortion Complications (PMAC) Programme was formulated and piloted from 2000-2002, access to post-abortion

care continues to be difficult in public hospitals and there has been pressure to rename the campaign, 'Prevention of Abortion and Management of Post-abortion Complications'. This study by Likhaan does not include deaths from abortion; but it does include accounts of medical maltreatment that could serve to alienate women from health facilities.

Where family planning is concerned, as has been mentioned earlier, there are two kinds of threats to reproductive rights. The current Government has foisted NFP as the method of choice on women despite their preferring modern methods in surveys. The Department of Health (DOH) itself has banned the emergency contraceptive, Postinor, and supports Pro Lif¹ allegations that the IUD is abortifacient. Also, the Government has not provided a budget for artificial contraceptives in the face of the US Agency for International Development's (USAID) scheduled pullout starting this year. At the same time, there are accounts of women who deliver in public hospitals not being allowed to go home without a long acting contraceptive – both types of coercion are very disempowering for women.

Today, we can identify certain issues and events that have facilitated or hindered the attainment of women's reproductive health and rights in the Philippines. Almost on a continuing basis since 1986, the tremendously powerful Catholic Church has influenced government policies and programmes and has virtually paralysed politicians despite the constitutional principle of separation of Church and State. The irony is that this has happened on the two occasions when women were Heads of State. This lack of political will then triggered off other hindering factors such as budgetary allocations, a refusal to accept real gender equality; and health system failures aggravating the effects of health sector reforms. The lack of appropriate reproductive health services for women is therefore exacerbated by the fragmented and increasingly expensive health care services. Partly, these negative developments are offset by the activities of women's groups and other civil society actors who have assumed larger shares of responsibility in IEC (information education and communication) and service provision towards reproductive health and rights. Such groups have also collaborated with the Government and donor agencies to keep the debate and public discussion on reproductive health issues alive and current.

The findings of this report suggest the following recommendations to improve the sexual and reproductive health and rights of women in the Philippines:

- To address the issue of maternal mortality,
- To strengthen and expand health facilities and systems, such as the emergency obstetrical care and post-abortion care in order to reduce reproductive mortality and morbidity.
- To mobilise financial resources by government at the national and local levels and to ensure that women continue to organise and mobilise to respond to their own needs while urging the Government to fulfil their obligations.

Recommendations in the area of abortion are: to strengthen and expand PMAC; and ensure public information so that women can be equipped to take control of their fertility needs. Beyond what is currently legal, it is important to stress the public health implications of the situation and to initiate the call to review the current law towards legalising abortion. For family planning, it is recommended that access to all FP methods is broadened and that FP services are made available at the primary health care level. Also, it is recommended that a rights-based, unmet need-driven approach be adopted as motivation to increase the contraceptive prevalence rate (CPR) and pursue for legislation that will guarantee

Church-State divide on FP policies and funding. This report calls on both non-government and government organisations and other civil society groups and funding agencies to strengthen the rights policy framework, strengthen pro-poor and pro women's reproductive health strategies, and expand the reproductive rights constituency to include grassroots communities.

Introduction and Objectives

Since the Philippines' participation in the ICPD in 1994, the expected changes in women's and Filipino people's reproductive health and rights have not taken place. The country has had three administrations since 1994. The continuing focus on population reduction and the strong opposition of the Catholic Church to reproductive health and rights, have ensured that programmes and policies implemented since have been erratic and ineffective.

Before ICPD, there was no official Government concept of reproductive health, much less a concept of the "reproductive health approach" in the country. The Population Act of the Philippines, instituted in the early seventies (under RA 6365) was a population and policy programme that included a Family Planning Programme meant to address the growing population of the country.

The Philippine participation in the ICPD prompted the Government to adopt the reproductive health approach, a paradigm shift from a number-conscious population control concept to the broader human rights-based population and development framework. The ten elements of reproductive health were adopted by the Department of Health, and specific programmes were initiated that included family planning, safe motherhood, and prevention and management of abortion complications, among others.

However, even as these programmes were being implemented, and the Philippine Government participated in a number of international conferences, at the official level, there continued to be a lack of clarity on what the paradigm shift meant even when the Government expressed its agreement with ICPD concepts and commitments. This is most clearly manifested in the Commission on Population's (PopCom) continuing adherence to the population, resource and environment (PRE) framework where the management and/reduction of the population is necessary to create a balance with the country's resources and environment. Towards this end, the reproductive and sexual health and rights of women are often violated.

The discourse on reproductive and sexual health and rights in the Philippines includes the participation of government technocrats particularly the Commission on Population and the National Economic and Development Authority (NEDA) that have always been predisposed to the population control approach. The Catholic Church with its clear stand that family planning methods - aside from natural family planning - are against Church teachings has also been a strong supporter of this approach. After the Edsa revolution (the overthrow of the Marcos regime led by Archbishop Cardinal Sin) of 1986, the Church's stand on this has become stronger. Non-government organisations, on the other hand, have an approach that often lies somewhere in between, with groups like Likhaan being critical of both perspectives.

This study is framed by Likhaan's definition of reproductive rights and its perception of the state of the health care system in the Philippines.

Likhaan's Definition of Reproductive Rights

Likhaan's definition of reproductive rights is located within a feminist and formal human rights frame. Feminists define women's intimate bodies as an arena of political contention, where women's decisions, well-being and personhood are often subordinated to, or controlled and appropriated by, others. Feminist discourse decries body violations such as rape, sexual abuse, forced pregnancy, forced contraception and forced abortion. As a corollary, however, it affirms sexual and reproductive freedom, including the right to sexual expression and enjoyment, the right to both pregnancy and fertility control, the latter through either contraception, abortion or both.

The formal human rights frame² – although more cautiously worded – basically affirms the political nature or power dynamics of sexuality and reproduction. It also assigns the State the responsibility of 'respecting,' 'protecting' and 'fulfilling' reproductive rights – explicitly interpreted as the right to make decisions on reproduction free from discrimination, coercion and violence and the right to accessible, affordable and quality reproductive health care. 'Respecting' basically means allowing people to exercise their rights; 'protecting' means disallowing third parties from usurping these rights; and 'fulfilling' refers to the State's concrete actions to enable people to realise their rights.

Reproductive and sexual rights are often taken together as a conjoined concept because the political issues refer to the same body and involve similar political influences and constraints. The development of AIDS and gay politics on the one hand, and assisted reproduction on the other, have been associated with a 'separated' or 'disjoined' approach that focusses on specific nuances of each aspect. Likhaan believes both 'conjoined' and 'disjoined' frames are equally useful. For the purposes of this study, however, the focus is strictly on reproductive rights as defined by the ICPD PoA.

The Objectives of the Report are:

1. To assess the extent to which the paradigm shift to reproductive health as a human rights-based and human development-centred approach has been achieved, focussing on maternal mortality, family planning and abortion, the three core issues of reproductive health;³
2. To identify facilitating and hindering factors; and
3. To identify concrete steps for government and non-government actors to carry the paradigm shift forward.

The assessment relates to specific commitments made in the Programme of Action (PoA) of the 1994 ICPD as well as the key actions identified during the ICPD +5:

ICPD Definition of Reproductive Rights

ICPD documents define reproductive rights in the following ways:

1. The right to attain the highest standards of sexual and reproductive health

(ICPD 7.3)

where RH implies -

- The right to access FP methods of choice and other methods of fertility regulation not contrary to law
 - The right to access health services to enable women to go safely through pregnancy and childbirth...with the best chance of having healthy infants
- (ICPD 7.2)
2. The right to make decisions concerning reproduction free of discrimination, coercion and violence (ICPD 7.3)

Maternal Health Targets

1. Reduction of maternal mortality (MM) by half from 1990 levels by the year 2000, and by half from 2000 levels by 20 (ICPD 8.21)
2. Maternal health care to include assistance by trained personnel and provision for obstetric emergencies (ICPD 8.22) by 2005, 80 percent of all births to be assisted by skilled attendants (ICPD + 5 goals)

Abortion Targets

1. Expanded and improved family planning services to lessen the instance of unsafe abortions.
2. Women with unwanted pregnancies should have access to reliable information and counselling
3. In all cases (whether legal or not), women should have access to quality care for the complications of abortion (ICPD 8.25)

Family Planning Targets

1. Universal access to the full range of FP methods and related RH services not contrary to law by 2005 (ICPD 7.16)
2. User-centred services to control abuses by FP managers and providers and ensure continuing improvement in quality care (ICPD 7.17)
3. Programmes to remove legal, medical, clinical and regulatory barriers to information and access (ICPD 7.19, 7.20)

Methodology

This study focusses on the three important and most contentious themes of reproductive health and rights in the Philippines: one, maternal health – the right to go through safe pregnancies and deliveries; two, family planning/contraceptives – the right to fertility regulation of one’s choice; and three, abortion – the right to humane care from complications of abortion. Using identified specific relevant indicators within these themes, the study acknowledges some critical issues such as women’s death and disability from pregnancy and childbirth, unwanted pregnancy, induced abortion, Government services for pregnant women and birthing/delivery, Government FP services including emergency contraceptive

care, and Government post abortion care, especially issues of quality and access including patients' rights.

The major findings are based on Likhaan's recent research on maternal mortality and abortion as well as examples of reproductive rights violations from real stories and accounts of women's experiences.

The research methodology included the use of primary and secondary sources. Primary sources for the study consisted of:

1. Interviews and consultations with two key people in government: a representative from the Commission on Population and a champion legislator of the Reproductive Health Care Bill. Interviews were also conducted with a total of 13 doctors, nurses and midwives, residents of five hospitals. Four focus group discussions (FGDs) with 5-10 participants in each group were held with 21 traditional birth attendants and 18 midwives. The Reproductive Health Advocacy Network (RHAN) was consulted and meetings were held with six of its member organisations. Two other people's organisations, one being a youth organisation, were also consulted. In the gathering of stories/accounts of women's reproductive health experiences 30 community women and leaders were interviewed from four people's organisations. (see Annexures II and III)
2. Policy-dialogue based on the findings
The preliminary findings of the study were presented to policymakers from five areas. They included the Commission on Population, Women's Commission, Health, Human Rights and the UNFPA; their responses are included in this study.

Secondary sources included the following:

1. Literature review and policy and data analysis of government, non-government and international agency reports and administrative and executive orders.
2. Likhaan reports and documents:
 - 'Investigating Responses to Emergency Obstetric Complications Among Urban Poor Women in Malabon', a qualitative study covering the period end 1999 – 2002, employing FGDs with birth attendants and in-depth interviews with 18 women survivors and surviving kin/friends of 12 women who died: a project with the Averting Maternal Death and Disability (AMDD) programme of Columbia University.
 - 'Women's Accounts of Abortion' – in-depth interviews with 30 women from different urban poor communities, stories spanning the period from the sixties to 2002: a project by Likhaan to determine its abortion rights strategies funded by the David and Lucile Packard Foundation.

History of Reproductive Health in the Philippines

Introduction of Family Planning (Marcos Period 1967-1986)

The 1973 Constitution clearly stated the Government's commitment to population control... 'It shall be the responsibility of the State to achieve and maintain population levels conducive to the national welfare.' Thus, the Government's adoption of the Family Planning programme was purely for population reduction towards the alleviation of poverty. The Government met with strong opposition from both women's groups and Catholic-affiliated groups claiming the programme to be coercive and methods imposed unsafe. Massive resources were made available to the programme and funding support was received from USAID.

Within a decade the average family size was halved, and the programme was considered successful.⁴ However, the goal of poverty alleviation and redistribution of income was not met.

Ascendancy of the Catholic Church (Aquino Period 1986-1992)

The major role of the Catholic Church in the 'people's power' revolt⁵ of 1986 that placed Cory Aquino in the president's chair, encouraged Cardinal Sin, Archbishop of Manila, to assert greater influence over the population programme. A Constitutional amendment mandating the State to 'protect the life of the unborn from conception'⁶ was inserted by the conservative members of the Constitutional Commission. Fortunately, feminist commissioners were still able to attach the phrase 'equal to the life of the mother'⁷ for some semblance of balance. Family planning was rejected as a fertility control scheme and attempts were made to abolish the programme. The Population Commission Chair, Mita Pardo de Tavera, a member of the Opus Dei (a powerful Catholic-affiliated religious sect), wanted to abolish the family planning programme altogether, claiming it to be a failure. Eventually, in 1988, local pressure as well international pressure from foreign donors resulted in transferring the family planning programme from the Department of Social Welfare, where it was not moving at all, to the Department of Health.⁸

Paradigm Shift to RH approach (Ramos Period 1992-1998)

Aside from the ICPD, between 1992 and 1996, the Philippines participated in other international conferences on population and development. Such participation, particularly as signatory to the commitments made in the Cairo conference, led to the adoption of the reproductive health (RH) approach as opposed to the previous population control framework. The Secretary of Health, Dr Juan Flavier, was a staunch advocate of family planning and the fight against AIDS. Clashing with the opposition of the Catholic Church, during his term, Dr Flavier set aside money to purchase contraceptives and launched an anti-AIDS campaigns that put considerable stress on the use of condoms.⁹ Succeeding him as Health Secretary in 1994, Dr Carmencita Reodica, who participated in the Cairo and Beijing conferences, was responsible for the creation of an Integrated Reproductive Health Programme within the Department of Health. A signal of its favoured position, the RH programme was directly attached to the office of the Secretary of Health. The RH approach was elaborated in considerable detail during this time. However, the attention was short lived and by 1998, with the change of administration the programme was abolished¹⁰ as a separate programme at the national level and relegated to agreements with Local Government Units (LGU).

Family Planning to Meet Fertility Targets (Estrada Period 1998-2002)

Similarly, during the Estrada administration the Health Secretary Dr Alberto Romualdez was an advocate of family planning and more so of population management. Dr Romualdez set a target to reduce fertility rate from 3.7 to 2.1 by 2004, a rate recommended by demographers towards zero population growth and despite the country's desired fertility rate of 2.7.¹¹ Contrary to the principles of the RH approach, this Government seems to have adopted Herrin's¹² critique that, 'the free exercise of fertility was not consistent with the common good.'¹³ Thus government intervention was necessary in the fertility decisions of couples

through the promotion of family planning. To respond to the USAID plan to scale down and eventually cease its contraceptive donation to the Philippines, this administration committed to purchase P70 million worth of contraceptives. But the effort led nowhere since President Estrada was ousted before the contract was signed.

Erasing the Concept of RH and RR (Arroyo Period 2002-Current)

Recent years have seen a return to favouring the Catholic hierarchy in government policy and pronouncements regarding reproductive health. Initial efforts made by the previous governments towards the expansion of the family planning programme were limited but even this partial progress saw a backward slide during this administration.

The allocated funds intended for the purchase of contraceptives were diverted to other health expenses, on grounds that the Government has a policy against purchasing contraceptives.¹⁵ Yet, P50 million was given to the Couples for Christ, a Catholic lay organisation, to promote and teach natural family planning.¹⁶

The effective banning of the emergency contraceptive pill, Postinor in 2001 (shortly after it was made legal in 2000), was the result of a petition filed by ultra conservative Catholic groups claiming it to be abortifacient.¹⁷ Health and women's NGOs rallied and protested that the decision was based on the opinion of only one sector of society; that women and service providers were not consulted; and that it was a violation of women's reproductive rights. Yet, to this date, after a series of public meetings where reproductive health groups clashed with Pro Life groups, Postinor remains banned.

Moreover, clearly President Arroyo shares the view of the Catholic Church that the Reproductive Health Care Bill is a pro-abortion bill and accordingly, she announced in her second State of the Nation Address, that she would veto it. Ironically, during the international women's day celebration she announced that her new population policy was based on the principles of responsible parenthood, respect for life, birth spacing, and informed choice.¹⁸ These are the very same principles on which the Reproductive Health Care Bill is founded.

Reproductive Health Care Bill

Filed in 2001, the Reproductive Health Care Bill has instigated intense debate and heightened public awareness on issues of reproductive health. The strong antagonistic position of the Catholic Church was confronted with the formidable force of women, reproductive health and population NGOs and other sectoral organisations, from which the Reproductive Health Advocacy Network (RHAN) developed. Arenas of battle included congressional public hearings, television talk shows, discussion fora, and numerous other venues and events, nationwide. At the same time many government agencies – such as the Department of Health, the Commission on Human Rights (CHR) and the National Commission on the Role of Filipino Women (NCRFW) – have expressed strong support for the Reproductive Health Care Bill.

In spite of this popular support, the President ordered the NCRFW to scrap any reference to reproductive rights from the medium term programme for Filipino women.¹⁹ However, according to Ms. Miya Versoza, executive director of NCRFW,

during a National Dialogue²⁰ they replaced the term ‘reproductive health and rights’ which was unacceptable to the President with the term ‘comprehensive women’s health services’. Part of the elaboration of this new terminology included ‘the right of women to determine the size [of the family] and the spacing of their children’ and the notion of ‘humane and compassionate treatment of women who have undergone abortion.’ With this, NCRFW rationalised the endorsement necessary to implement their framework.

Assessing Progress in Achieving Cairo Goals and Objectives

Maternal Mortality

ICPD Objectives	NGO Country Assessment	Comparison with Government Report
<ul style="list-style-type: none"> Reduction of maternal mortality (MM) by ½ from 1990 levels by 2000 and by ½ again from 2000 levels until 2015 (ICPD 8.21) Maternal health services to include assistance by trained personnel and provision for obstetric emergencies (ICPD 8.22) By 2005, 80 percent of all births to be assisted by skilled attendants (ICPD + 5 goals) 	<p>Basing it on both the Likhaan study and government reports such as the NDHS, it is estimated that the MMR reduction is slow, possibly tapering and definitely short of ICPD target:</p> <ul style="list-style-type: none"> MMR field estimates probably lower than actual – NDHS 1998, WHO, UNFPA, UNICEF Likhaan count of death in 3 barangays (villages) alone (comprising 12 percent of total Malabon population): 3 per year from 1999 – 2002 compared to 1 per year official incidence report for all of Malabon for 2001 and 2002. <p>Significant percentage of deliveries continue to be handled by Traditional Birth Attendants (TBA) despite Malabon’s urban location and proximity to government tertiary facilities. TBA deliveries were associated with increased risks:</p> <ul style="list-style-type: none"> Of 12 deaths investigated, 9 were handled by TBAs. On the other hand, they handled only five of surviving cases that they referred early enough. Of these 12 deaths, 4 were women below the age of 25. In 2 of the 4, it was their first pregnancy. 	<p>The National Demographic Survey (NDS)/National Demographic Health Survey (NDHS) results are often interpreted to suggest a reducing trend in MMR from 209 in 1993 to 172 in 1998.</p> <p>The national surveys revealed that health professionals attend only to about half of women delivering. Within the last 10 years the increase has been very small from 53 percent in 1993 to 56 percent in 1998.²² Moreover, the use of government facilities is less than 50 percent.²³</p> <p>More women in urban areas consult with a doctor, while more women in rural areas consult with a hilot or a TBA. For example, while in Metro Manila 51 percent consult with doctors for postnatal care; 59 percent consult with TBAs in ARMM.²⁴</p>

ICPD Objectives	NGO Country Assessment	Comparison with Government Report
	<ul style="list-style-type: none"> • Urban TBAs' concept of obstetrical complications is folk belief based; yet they are aggressive in managing difficult labour cases. Their dangerous practices include injecting oxytocics (agents that make the uterus contract), forceful extraction of foetus in prolonged labour, performing IE without gloves, no attention to immediate post-abortion period (during which severe bleeding usually takes place), etc. • Some TBAs use DOH and other training certificates to "market" their expertise and charge higher fees, sometimes at par or even higher than private midwives' rates. <p>Government tertiary referral centres (Tondo General, Jose Reyes, Fabella and PGH) were decisive in many of the surviving cases:</p> <ul style="list-style-type: none"> • Of the 18 survivors, 15 reached and were managed in government facilities while two were in private, secondary facilities. • Some of the survivors got shunted from one government facility to another for various reasons – including the lack of beds, supplies, equipment and expertise. The survivors were characterised by their aggressiveness, resourcefulness and perseverance in the face of the above admission barriers. 	<p>National data show more than 1/3 or 36 percent of young Filipino women aged between 15-24 conceive before marriage.²⁵</p> <p>Recognising the high MMR, according to the PopCom country report for the APPC in 2002 - the high incidence of high-risk births, inadequate pre-natal care, and lack of information and means to manage complications in difficult pregnancies account for much of the increased risks of dying during pregnancy and childbirth.</p> <p>About 17% of pregnant women aged 13-20 have iodine deficiency.²⁶</p> <p>According to official reports in 2000, out of 10.43 million married women, 7.2 million (more than half) are regarded as high-risk pregnancy and from the approximate 2.4 million women that become pregnant each year, 300,000 experience major obstetric complications requiring hospitalisation.²⁷ Yet, the hospital system lacks the appropriate number of public facilities - less than 800 nationwide - while private facilities are overwhelming with over 1,000.</p>

ICPD Objectives	NGO Country Assessment	Comparison with Government Report
	<ul style="list-style-type: none"> • On the other hand, most of the women who died were those who delivered at home or were transported to the hospital too late e.g., expiring at a facility within two hours of arriving. <p>Other skilled primary and secondary level attendants – notably midwives (both public and private) – were “out of the picture” at the instance women encountered emergency obstetrical complications: suggesting a critical under-utilisation of vital personnel.</p> <ul style="list-style-type: none"> • Of the 30 women investigated, none of them was ever handled by either a public or a private midwife. • FGDs with midwives suggest that public midwives in public facilities hardly handle deliveries because they have been relegated to clerical work or assisting doctors. The few who do are very careful about handling “normal cases only.” Private midwives, on the other hand, are resorting to other sources of livelihood since they are losing their clients to TBAs. Whether public or private, all are keenly aware and careful that the law allows them to handle normal cases only. <p>(Source: Likhaan Study)²¹</p>	

The results of the National Demographic Survey (NDS)/National Demographic Health Survey (NDHS) are often interpreted to suggest a reducing trend in MMR from 209 in 1993 to 172 in 1998, a figure that falls short of the ICPD goal of 104 in 2000.

The reliability of this data is also questionable. Since the two surveys actually measure data from as much as 5-7 years before the survey date and since they overlap, it is difficult to ascertain the trend. Further, the margin of error is so large – i.e. plus/minus 30 percent - that it is impossible to map the trend with any certainty. It could be declining, yet it could also be flattening out or even rising. In a dialogue organised by Likhaan where these findings were presented, the Executive Director of PopCom, Tom Osias, agreed that the data were unreliable. And he announced that the MMR has been excluded in the latest NDS/NDHS. Instead, questions of MMR will be included in the census to ensure a more reliable figure. It is important to remember, however, that the MMR is only a rough guide and is useful if taken 10 years apart. But it needs to be complemented by process indicators, such as those proposed by the AMDD consortium.

Consistent with Likhaan findings, official reports show that the number of deliveries being attended by health professionals is still too low as well as merely a minimal use of government health facilities. However, while Likhaan's research shows that a significant number of women are resorting to TBAs even within Metro Manila, government reports show that in Metro Manila the majority of births are attended by doctors and the high number of TBA consultations and delivery attendants occur only in rural areas like the Autonomous Region of Muslim Mindanao (ARMM), where there is armed conflict. Since the study is confined to one city, it is not certain how other cities behave or whether the phenomenon of TBAs attending births is recent and is due mainly to increasing economic difficulties. Interviews with OB-Gyn residents and consultants in Malabon affirm that while women consult before delivery, there is a marked drop in the number that return for birthing/delivery.

Official reports reflect the tendency of the Government to focus on prenatal risk assessment rather than providing skilled attendants who can respond to emergency obstetrical situations. Yet, as the Likhaan study shows, contrary to the ICPD goal, trained personnel such as midwives rarely attend to birthing patients at least in Malabon. At the same time, there is little chance that ICPD goals of 80 percent of deliveries being attended by skilled attendants by 2005, will be met since according to official reports, skilled attendants during delivery increased by a mere 3 percent within a span of five years from 1993. Government reports have also failed to identify the place of death of women during pregnancy and childbirth, which is the home. Yet, based on Likhaan findings, many women die during delivery or shortly after, even in instances where they live 30 minutes away from the nearest hospital.

Abortion

ICPD Objectives	NGO Country Assessment	Comparison with Government Report
<ul style="list-style-type: none"> All should deal with the health impact of unsafe abortion as a major public health concern and to reduce recourse through expanded and improved FP Women with unwanted pregnancies should have access to reliable information and counselling In all cases (whether legal or not), women should have access to quality care for the complications of abortion 	<p>Abortion is an individual response to a complex situation – i.e. no stereotypes, no predictable behaviour. As such, it may be very difficult to “eradicate”, even with perfect contraception.</p> <ul style="list-style-type: none"> The 30 women had a total of 66 abortion attempts and 51 successful terminations. The women had their abortion at age 15 to 39 years. Of 66 abortion cases, 49 cases occurred when women were between the ages of 15-29 (7 women were between 15-19 years and 42 were between 20-29 years). Some women had single reasons (20/66) specifically: for FP, economic, gender, health, etc. but more had simultaneous compound reasons (46/66) including above reasons. The desire for FP figured in 38 cases, poverty in 34 cases and gender issues in 26 cases. Among young women, 3 feared parents’ discovering their pregnancy, two were unmarried and bothered by teenage pregnancy and two were raped. Some women had one abortion, others had more than one, including one who had five; women who had repeat abortions had different reasons per abortion. One had four abortions before she turned 24 and another had three abortions before she turned 20. 	<p>Most government reports say little about abortion. In a superficial way, they recognise that abortion is a public health issue:</p> <ul style="list-style-type: none"> Approximately 400,000 cases of abortion each year; It is the third leading cause of discharge in DOH hospitals (DOH, 1994-1998); 12 percent of maternal deaths were due to abortion, making it the fourth leading cause of maternal deaths in the country; and Poor women are the most vulnerable.²⁹ <p>Government reports also tend to focus on abortion cases among young women reporting that young mothers account for 17 percent of induced abortion (YAFS II, 2002).</p> <p>National data show more than 1/3 or 36 percent of young Filipino women aged between 15-24 conceive before marriage.³⁰</p> <p>Early or teenage pregnancies, while being still below 10 percent, are on the increase. This incidence is higher still in the rural areas and among the less educated.³¹</p>

ICPD Objectives	NGO Country Assessment	Comparison with Government Report
	<ul style="list-style-type: none"> • Of the 51 successful inductions, over half were associated with the use of scientifically acceptable methods – D&C, MVA, cytotec – singly or in combination; while about 1/5 of these inductions (11) developed life-threatening complications (bleeding and infection) for which all but one required hospitalisation. • Four of the ten hospitalised reported traumatic treatment by medical personnel, e.g., being refused admission to hospital, being scolded or shamed in public – including being told that one’s soul was already burning in hell; being subjected to D&C for infection without anaesthetic; being “abandoned” by medical personnel after treatment. • Without correlation to the stated religion, age of gestation and experience of traumatic treatment, many of the women (17) had positive attitudes towards their abortion experience while a minority (3) continued to be remorseful and bothered. Ten demonstrated changing attitudes – from negative to positive (6), from positive to negative (3) and positive to negative to positive suggesting malleability to external influences. In those firmly positive or negative, the influential factors were women’s concepts of morality, the nature of their God and the personification of the foetus. <p>(Source: Likhaan study)²⁸</p>	<p>Government reports have highlighted the initiated policy and programme, the Prevention and Management of Abortion Complications (PMAC), piloted by Engender Health in ten facilities for 2001-2002. PMAC services include clinical services, counselling, and the linking of PMAC to other reproductive health services.</p> <p>PMAC assessment in 2002 focussed on the increase in the number of post-abortion (PA) patients, PA patients who had counselling, and PA patients who accepted FP methods. It also reported that, with the discrepancies in the number of PA patients for counselling and FP use, it concluded that not all PA patients receive counselling and that very few decide to use FP.³²</p>

ICPD Objectives	NGO Country Assessment	Comparison with Government Report
	<p>Despite the PMAC (2001) and the 2-year (2001-2002) Engender Health Project of Training Providers in Post-Abortion Care Using the MVA, health service providers continue to be insensitive to and downright discriminatory to women who are hospitalised for abortion complications. Key admitting personnel in three government tertiary hospitals admitted that induced abortion is one of the top reasons for Ob-Gynae admission. In these facilities, it is standard treatment for women to be scolded upon admission “so they will repent their errors.” A medical doctor shared that some of his colleagues would prick the women with suture needles to show their disapproval.</p> <p>There is a tendency among government policymakers to give their moral position on abortion instead of flagging it as an issue that requires public concern. Most legislative or executive policymakers are quick to issue statements expressing “vehement” disfavour against abortion. These statements not only ignore the dangers of unsafe abortion to women’s well being, they also deny abortion as a reality and discriminate against women’s reproductive decision-making. Yet allowing discussions on the public health impact of abortion and advocating post-abortion care are neutral positions that do not imply agreement with legislation.</p>	<p>However, the Government has yet to come up with an order mandating PMAC in all – not just pilot – hospitals. There are also mechanisms in place to stop hospital personnel from being rude or maltreating patients with post-abortion complications.</p>

According to Government reports since 2000 the PMAC programme has been implemented in a number of public and private hospitals, including some local government hospitals. However, while the PMAC assessment focussed on statistical conditions such as the number of facilities that have PMAC in place, or the number of post-abortion (PA) clients, how many are receiving counselling, and how many are using FP; the Likhaan assessed PMAC as experienced by PA women and focussed on the effects on their dignity and well-being. Likhaan's research also establishes that there are various socio-economic reasons for women choosing to terminate their pregnancies and that these vary from individual to individual. Government reports tend to gloss over these complexities by listing the reasons and then zeroing in on the economic ones as the most important.³³

Critical analysis of government reports, however, reveals that the causes of abortion are often linked to unwanted pregnancies and these, in turn, are linked to the lack of FP. The proposed solution to abortion thus is simply FP, which is fundamentally a technical solution and one that ignores the social context of unwanted pregnancies and women's differential attitude to FP. The Likhaan study establishes that things are not so simple: abortion is an individual response to a complex situation and even with perfect contraception the eradication of abortion may not follow. Thus, to address the numerous cases of unwanted pregnancy that may or may not lead to abortion or maternal mortality, there must be a range of options from a wide spectrum of contraceptives, including both emergency contraception and the legalisation of abortion. At any rate, the Government's current response shows that an expansion and improvement of even just FP towards reducing recourse to abortion as stated in the ICPD PoA, is not a priority. Rather, artificial FP is being attacked as abortifacient.

More importantly, PMAC offered the possibility for the Government to provide this much needed care, yet the inhumane treatment of women availing the service reflects deep-rooted resistance from the providers themselves. Upon its discontinuation in 2002, it is not certain whether the government hospitals will continue to take it up. Not only is the ICPD goal of providing women with access to quality care for treatment of abortion complications not being met, but the existence of any service that could legally attend to abortion complications is now threatened.

Family Planning

ICPD Objectives	NGO Country Assessment	Comparison with Government Report
<ul style="list-style-type: none"> • Universal access to full range of FP methods and related RH services not contrary to law by 2005 (ICPD 7.16) • User-centred services to control abuses by FP managers and providers and ensure continuing improvement in quality care (ICPD 7.17) • Programmes and Government to remove legal, medical, clinical and regulatory barriers to information and access (ICPD 7.19, 7.20) 	<p>Likhaan continuously monitors national and local government changes in policies and programmes affecting reproductive health.</p> <p>The recent GMA administration has outrightly exhibited violations of FP as a right:</p> <ul style="list-style-type: none"> • Continued banning of artificial contraceptives in some LGUs – e.g. Manila, Laguna, and Palawan; • Banning of Postinor (i.e. a “fertility regulating method that has not been proven contrary to law”) since 2001 on grounds that it is abortifacient; • Depriving people of basic FP services by the diversion of budget intended for contraceptives to NFP only – supplies are already scarce in Government health centres with the USAID withdrawal of contraceptive donations but Government response is merely to use FP budget for NFP only; • Discrimination against users of artificial contraceptives by pushing only for NFP; and • Allowing 3rd parties like the Catholic Church to run government programmes (e.g. Couples For Christ teaching Sexuality or facilitating housing programmes) or to coerce people (e.g. Catholic doctor’s removing women’s IUD without informed consent in Bukidnon, based on interview with Congressman Nereus Acosta of District Bukidnon). <p>Government policies and programmes reflect a backsliding on rights-based and unmet need approach to FP:</p> <ul style="list-style-type: none"> • A. Herrin’s paper, challenging RH and RR and advocating strongman tactics to achieve population growth rate reduction is often used as reference by many government reports (Herrin is also a consultant of PopCom); 	<p>Official reports reflecting...</p> <ul style="list-style-type: none"> • an increasing trend of CPR - 40 percent in 1993 and 47 percent in 2000 (FP Survey 2000); • a decreasing trend in unmet need – 26 percent in 1993 and 20 percent in 1998 (NDHS 1998); and • a decreasing trend in TFR - 4.09 in 1993 and 3.73 in 1998 and an estimated 3.2 for the year 2002 (NDS/NDHS 1998) <p>may account for the Government’s complacency towards FP issues. Furthermore, NDHS has claimed that there is almost universal knowledge of FP in the Philippines.</p> <p>According to the 2000 FP Survey, usage of modern methods has increased from 28.2 percent in 1998 to 32.3 percent in 2000, while the use of traditional method has decreased from 18.3 percent in 1998 to 16.9 percent in 1999 and to 14.7 percent in 2000.</p> <p>However, on a regional level, there are nine regions including Metro Manila where the use of traditional methods has increased, 15 percent in 1993 to 22 percent in 1998; and Eastern Visayas, 18 percent in 1993 to 26 percent in 1998.</p> <p>The Government reports that while the desired fertility rate is at 2.7, the standing TFR is 3.7. It laments that the decline in TFR is a mere 10 percent from the 1990-1992 TFR of 4.1 and stresses that even with a lesser estimated TFR of 3.2 in 2002, it is still one child away from the replacement level.</p>

ICPD Objectives	NGO Country Assessment	Comparison with Government Report
	<ul style="list-style-type: none"> • DOH's adoption of PGR targets instead of unmet need (1998); • RH ceased to be a central programme at the national level and was relegated to LGUs in 1998; • Many RH NGOs cut off from UNFPA support in 2000-2004 following an evaluation that trivialised NGO contribution to Family Planning/CPR (1%) • Increasing usage of the pre-Cairo "population bomb"/ "volcano" framework instead of unmet need <p>Continuing tendency to disregard people's actual needs for FP:</p> <ul style="list-style-type: none"> • NDHS 1998 found that among women not using FP and not planning to use FP, 52 percent cited as their main reason the desire to have more children, worries about the side effects and other health concerns; yet no approach responds to the above preferences/worries • Many women in the abortion study admitted not using protection (27/66) or were using unreliable methods (18/66); some were on reliable methods (12/66) but stopped because they experienced discomfort with the method; many women had no or incorrect information about when they were fertile, how they got pregnant, how contraceptives work or how to use them properly. • Yet, there is no focused attention to these unmet needs, which can be expanded to include women who are using traditional /ineffective methods. These also include the need for correct information on a range of topics related to fertility and fertility management. 	<p>There is little discussion in government reports regarding issues behind unmet need. The PopCom ICPD assessment report even claims that couples and individuals have access to information and service necessary for them to plan their families, whereas other less recent reports forward as challenges the improvement of accessibility and affordability for RH and FP services especially among the poor and rural women.</p> <p>Adolescent RH services are limited to IEC and call for sexual responsibility or delaying sex, while sex education is confined to basic anatomy and physiology and responsible parenthood.</p>

ICPD Objectives	NGO Country Assessment	Comparison with Government Report
	<ul style="list-style-type: none"> • Tendency to disregard the poor quality health care – (including FP) at the primary health facilities that is crucial in “sustaining and broadening contraceptive usage” (ICPD section on FP, consistent with Quality FP Care concepts of Jain/Bruce). • Lack of attention to the role of erratic FP supplies and increasing cost, especially in the face of impending “fee for commodity/ services.” 	

Government officials deny that they are favouring natural family planning methods over artificial ones. They insist that their programmes are consistent with the four pillars of the new population policy introduced by the Gloria Macapagal-Arroyo (GMA) administration, which are: respect for life, informed choice, birth spacing and responsible parenthood. They claim that prioritising NFP is merely to ‘balance’ the promotion of FP that had previously concentrated only on artificial methods. However, the PopCom report that explains ‘respect for life’, based on a mechanical interpretation of the 1987 Constitution, seems to insinuate as well that all artificial FP methods are abortifacient, hence the hesitation to promote or fund artificial FP programmes. Clearly, such actions are a total overthrow of the ICPD goal of universal access to the full range of FP methods.

Further, as assessed in the Likhaan report, the banning of artificial contraceptives by some local government executives can be viewed as a failing on the part of the national government to protect people’s reproductive rights. Again this reflects lack of government will to meet the ICPD goals.

There are other areas in which differences between the two approaches – that of Government and of NGOs, more specifically Likhaan, are evident. For example, government reports speak of a lack of consensus on population growth and fertility reduction. They critique the shift in objectives towards ‘fertility reduction, upholding of reproductive rights, and promotion of maternal health’, as being confused, and leading to a policy inertia that resulted in the slowing down of fertility transition. This lack of a uniform and pointed policy on population growth rate reduction is being attributed to people’s sluggish acceptance of modern contraceptives, and no attention is being paid to their actual choices and access to basic FP, including the quality of care. Likhaan’s study shows that there is a pervasive under valuation of fertility control, as well as a misunderstanding of how the technology works and its place in women’s lives. Many of the women’s fears about the methods are unacknowledged and unexplained. Instead of recognising and responding to this complex situation the Government is withdrawing its contraceptive subsidy and leaving contraceptive supplies to market forces. Foisting FP or PER (population, environment and resource) targets while privatising FP is a formula that seems destined for failure.

At most, government reporting regarding FP revolves around contraceptive prevalence rates (CPR), unmet need and total fertility rate (TFR). And while issues of access, availability, affordability, quality of care and information are discussed,

other issues that NGOs regard as major hindrances to women's access to FP are not given any attention. Or, if such issues are mentioned in government reports it is almost as if they were non-issues. For example, the issue of NFP priority; the banning of artificial FP in some LGUs (never mentioned or regarded as a concern in government reports); changing policies regarding FP and RH every time there is a change in administration, etc.

Hindering And Facilitating Factors

Hindering Factors

Catholic Opposition

For the bishops and priests who have been outspoken against reproductive health, any form of family planning that is not natural or based on abstinence is abortifacient and therefore immoral. In their mission to abolish this concept and right, church leaders have used Catholic influence and clout to its utmost capacity to strengthen their case. They have denounced reproductive health and all efforts towards attaining it, not hesitating to use the pulpit for doing so and discrediting and threatening, 'champions' of reproductive health. Fear has been used as a tool, reprimands have been brought in as well, and threats of prohibition from receiving communion or confession are used against artificial family planning users.⁴⁰ The most recent Catholic Church policy proclaimed by the Catholic Bishops Conference of the Philippines (CBCP) sanctions against and excommunicates those who have had abortions, on the basis that abortion is a 'reserved sin'.⁴¹ The sense of wrongdoing is taken one step further by the church's authorising selected priests to absolve the 'sin of abortion' and to receive confessions about abortion.⁴² The intense advocacy of the Catholic Church against reproductive health and rights has reduced reproductive health to family planning and reproductive rights to abortion rights.

Government's Continuing Obsession with PGR

The Government continues to uphold the framework that an increasing population 'retards' a country's economic growth,⁴³ aggravates poverty and hinders efforts towards sustainable development. Thus the PRE framework was developed where fertility reduction works towards creating a balance 'between and among population level, resources and the environment'.⁴⁴ Further, the promotion of family planning within the context of reproductive health as stated in government economic and development policies merely becomes a tool towards stumping the growing population which, in turn, is assumed to work towards alleviating poverty. The promotion of maternal and child health then become mere strategies to persuade women and couples to limit the number of their children. The poor are blamed for their impoverished plight and their reproductive and sexual behaviour becomes the target of the Government's population programmes.

Fragmenting a Politicised and Increasingly Privatised Health Care System

The structure of the Philippine health system was set up during the US occupation of the Philippines that officially ended on July 4, 1947. By 1967, this system was described as a 'mixed system' where 50 percent of health services were delivered by the Government and 50 percent by private practitioners.⁴⁵ Since that time,

changes, both in the internal management by the Department of Health (DOH) and influences outside it, have created the health system that exists today. Among the significant external influences are:

- The devolution law of 1991 (Local Government Code) that transferred authority and functions of most government agencies including health from the national to the local level, specifically the provinces, cities and municipalities. By this law, all local government units (LGUs) as mentioned above – numbering over 1,600 – were deemed autonomous and entitled to set internal revenue allocations (IRA). The devolution law was pushed by well-meaning politicians, especially from the south, who did not want a repeat of the authoritarian rule from 1972 to 1986 and aimed to redistribute authority from the centre of Manila to the central and southern provinces. Although services that were deemed vital, like education and the police, were exempt from devolution, health care was not.
- The National Health Insurance Law of 1995 that merged the health insurance systems covering government and private employees. Unknown to many, this law included a ‘rider’ (i.e. a provision not part of the bill that was discussed but inserted during the final deliberation) that allowed public facilities and doctors to charge ‘user fees’ purportedly for the purpose of maintaining the facilities and to augment personal salaries. This law also allowed government physicians to have their own private practice outside of official hours.
- The reproductive health programme that is subject to the dispositions and whims of the national executive. In 1998, with impetus from the ICPD and Beijing conferences, the first woman secretary of the DOH laid down the foundation of the Reproductive Health Programme through a department administrative order.⁴⁶ This AO created some new service lines – e.g. Adolescent Reproductive Health (ARH), Prevention and Management of Abortion Complications (PMAC), Sexuality Education, Male Involvement and others -- and integrated these with existing vertical programmes – e.g. Mother and Child Health, Family Planning – to form the integrated, 10-element Reproductive Health Programme. The development of this programme is discussed further in the section on Reproductive Health Policies and Programmes.

The above influences have brought about a health system that can be described as ‘fragmented,’ ‘privatised’ and thoroughly unfriendly to women. Devolution has resulted in over 1,600 fiefdoms where health services are often neglected except during elections to win votes. Though LGUs receive significant IRAs, there is nothing to indicate that they are spending a proportionate part of this budget for health. A World Bank study in 1999,⁴⁷ points to the fact that people are, in fact, bypassing government primary health care facilities where the quality of care is perceived to be very low. The same study says that people are scheduled to be fully ‘corporatised’ in the near future.

The total health expenditure profile shows that 55 percent of the burden is shouldered either by private out-of-pocket or other private sources while government expenditure (national and local) accounts for only 35 percent of total health spending.⁴⁸ Of the total health spending, 68 percent goes to the pharmaceutical industry, which is totally unregulated in the Philippines.⁴⁹ The monopoly on drug pricing by the pharmaceutical industry makes Philippine drugs among the most expensive in Southeast Asia.⁵⁰

To correct the gross inequities perpetuated by the fragmented and privatised system, Health Sector Reform Agenda (HSRA) proponents look to health

insurance as the key corrective mechanism, with LGUs encouraged to subsidise their 25 percent indigents. Unfortunately the current insurance support value is very much less than the 70 percent intended and the local governments as well as the poor are lukewarm about enrolling.

The specific effects of the health system on women relate to the neglect of much-needed reproductive health services detailed in the other sections.

A Situation of Increasing Poverty

The Philippines is among those Southeast Asian countries whose economy has not demonstrated any meaningful expansion since the 1970s. It is also the country with the biggest Gini coefficient, indicating the biggest disparity between the richest and poorest population deciles. At present, poverty is estimated at 40 percent or affecting over 5 million people. Instead of charting an independent economic course, Philippine economic technocrats easily subscribe to the latest neo-liberal formulas. Instead of investing to develop the vast human resources of the country, the current economic approach tends to fault 'population' while being content with 'safety' nets.

Token Gender Equality

In 1992, a law promoting gender equality was passed. By addressing gender issues and eliminating gender biases in government policies and programmes, this law was meant to ensure women's complete participation in development and nation building.⁵¹ There is also the Philippine Plan for Gender Responsive Development for 1995-2025, managed by the NCRFW. Specifically, a framework was developed 'for analysing gender-responsive population policies with the RH perspective'.⁵² Yet much of women's needs specific to RH have remained unmet. As this study has shown, services to ensure 'safe motherhood' - EmOC, FP, post-abortion care - have not been effective. Further, the 2002 National Statistical Coordination Board (NSCB) reported 9,903 cases handled by the Philippine National Police Women's Desk and the NSCB records show a constant increase in reported rape cases from 1995 to 1999. There is also a lack of shelters for women survivors of violence; a lack of breastfeeding and childcare facilities; and some hospitals continue to require authorisations from husbands for women to have litigation.

Lack of Budget for RH

The low priority the Government places on health, and more particularly on reproductive health is manifested not only in the declining budget for health but also in the lack of it for certain reproductive health programmes. From 1991 to 2003, the national health budget fell from 3.7 percent to 1.3 percent⁵³ because the budget for local government units was increased and it was assumed that LGUs would spend for social revenues including health. The split of the national health budget from the local government health budget makes it difficult to estimate the total health budget although it can be assumed that it is less than defence and debt service appropriations. What is known, however, is that the national Government's support to DOH-retained secondary and tertiary facilities is declining while these facilities are undergoing 'corporatisation' that is required to be self-sustaining. This means more and more government beds are being assigned to paying patients.

In the meantime, funds allocated for contraceptive supplies during the Estrada administration were diverted to other uses by the Macapagal-Arroyo administration. Such funds were said to have been used as seed money for a project of medicine importation and for hospital and drug augmentation as well as other family programmes such as woman and child protection programme, safe motherhood, PMAC, etc.⁵⁴ Funds were also put into natural family planning but nothing was available for artificial family planning. During the House of Representatives' appropriation hearing on the reproductive health bill in February 2004, the Department of Budget and Management (DBM) refused to release the budget for the implementation of a reproductive health policy and programme. Health care expenses have historically been low especially for reproductive health, and the future seems set to continue in the same way.

Donor's Play on RH

USAID, which has been a consistent partner of the Philippine Government through the provisions of funds, has always focussed on family planning rather than the holistic reproductive health and reproductive rights-based approach. USAID-funded strategies are consistent with the framework of population reduction as a strategy towards poverty alleviation. Thus, they have been providing 80 percent of the free contraceptives supplied at government health centres⁵⁵ with little impact on contraceptive usage. In 1999, when USAID announced its withdrawal of free contraceptive supplies to the country, it chose to strengthen private sector provision of FP through Friendly Care Foundation, an NGO working closely with Phil Health.⁵⁶ The Government did not step in to fill in the contraceptive need. With three out of four or 73 percent of women obtaining contraceptives from the public sector,⁵⁷ the dwindling contraceptive supply serves as a threat to women's access to FP. This gap plus the Government's increased reliance on NFP, could well spell a dramatic increase in unwanted pregnancy and abortion in the years to come.

Facilitating Factors

Influence of the Women's Movement

The women's movement in the Philippines is of dual origin. Part of it developed autonomously possibly through the efforts of a females intelligentsia – such as the 'feministas' celebrating their 100th year this year and the 'suffragettes' who pushed for women's right to vote in the 1940s. A bigger and more politically significant part sprang from the broad social movement advancing class and national liberation from the 1960s onward. This women's movement reached its peak in 1995, which was also the moment when resistance against the Marcos dictatorship was at its height. Composed of both an underground and legal component, the 'revolutionary movement' included many women cadres and activists who subsumed gender issues to the general, political struggle.

One of the broadest and most successful women's coalitions fighting the dictatorship at the time was GABRIELA, which was set up in 1995. At its peak, Gabriela had about 45,000 members nationwide, many belonging to the poorest sectors. It also developed service arms called 'commissions' that laid down the framework and strategies for approaching key women's concerns: development, children and family, violence against women and women's health and reproductive rights, among others. The Commission on Women's Health and Reproductive Rights, established in 1989, elaborated a comprehensive women's health programme with a strong reproductive rights content and approach. Likhaan grew from this beginning in 1995.

From a class framework, the women's movement branched out into other issues and other methods of struggle. It embraced Violence Against Women and Sexual and Reproductive Rights issues; from the streets and confrontational methods it worked to set up alternative programmes, spread into the academe and even went into government offices. Parts of the women's movement combined with AIDS and Family Planning groups to resist the increasing intrusion of the Catholic Church into national policies begun from the first woman Catholic president, Corazon Aquino, in 1986. This alliance is at the core of the Reproductive Health movement that is trying to institutionalise the rights-based reproductive health approach through legislative measures and programme modelling. Part of the movement problematises other sources of reproductive rights infringement including the continuing efforts of economic technocrats to foist demographically driven 'population management policies'.

The Philippine women's movement is heterogeneous in its content, its analytical framework and methods of struggle. Some women's groups have spoken out about abortion, which is highly stigmatised, and yet increasingly being used. Reproductive health, too, is considered contentious and divisive among women's groups so used to prioritising class issues.

Friendly UNFPA-DOH Regimes for 1998

The years between 1994 and 1998 marked a shift from the population control/reduction framework to the human rights-based reproductive health approach. Both Government and NGOs showed a great deal of enthusiasm towards fulfilling the commitments of the Cairo conference. The Department of Health appointed its first woman Health Secretary, Dr Carmencita Reodica, a Catholic and a reproductive health and rights advocate who also participated in the Beijing and Cairo conferences. She was instrumental in defining the 'womb to tomb' and the 10 RH elements framework through the establishment of an integrated reproductive health programme that was directly under her supervision. Simultaneously NGO participation was actively solicited: feminist activists were included in a task group within the DOH that attended to all women's issues and participated in the policy-making of the Department. Meantime, UNFPA, in 1995-1998, with a progressive director and consultants who carried the rights-based framework, opened funding opportunities to NGOs to support reproductive health programmes, through its PO7 project involving 16 NGOs. In all this time the Cairo momentum reflected the collaboration of the DOH, NGOs and UNFPA towards achieving reproductive health and rights.⁵⁸

Major Issues and Conclusion

In the Philippines the most threatened reproductive rights are the right to safe pregnancy and delivery; the right to fertility regulation of one's choice; the right to humane and quality treatment even just for post-abortion care; and the overarching right to one's reproduction, free of discrimination, coercion and violence particularly for poor women and young people. The fluctuations in political direction and will are important but more so is the lack of a human rights/social justice approach in the area of health, including reproductive health care. Women's well-being and agency are severely compromised by government 'omissions' and 'commissions'.⁵⁹ Omissions include: the failure to check Catholic Church intervention, the failure to check Government health personnel's pervasive violation of patients' rights, especially those with post

abortion service and the failure to set the infrastructures – including budget and affordable quality reproductive health programmes – that would enable women to attain ‘the highest possible level of reproductive health’. Commissions would include the push towards privatised health care and the institutional refusal to liberalise abortion laws if only to save women’s lives.

To conclude, three major concerns are highlighted:

Right to Safe Motherhood eludes the Poor

The ‘right to safe motherhood’ eludes many Filipino women, especially the poor.

There is a general complacency about the level of maternal deaths among policymakers, service providers and even among women themselves. At the policy level, this may be because of the supposed intermediate level of MMR and the apparent decline. Actual levels are probably high—as the Malabon study shows—even in the national urban centre where the health care system is supposed to be most functional.

Government and donor approach to maternal mortality continues to be focussed on Risk Assessment (e.g. the categorisation of pregnancies into High Risk and Low Risk) and Prenatal Care with token attention to safe delivery and access to EmOC, despite WHO’s admonition since 1998 that the traditional approaches of prenatal screening and TBA deliveries were ineffective in bringing down MMR. In fact, the Likhaan study concludes that TBA delivery can be dangerous for women. The Averting Maternal Death and Disability programme proposes a multi-pronged approach that includes FP, Safe Abortion and EmOC. Together with UNFPA, UNICEF and their other partners, they propose the use of process indicators to monitor the maternal death level which include:

- The availability of adequate number of EmOC facilities (specifically four basic EmOC facilities and one comprehensive facility for a population of 500,000). A basic facility is able to put in an IV line, infuse life-saving medications such as anti-hypertensives, anticonvulsants, oxytocics, and antibiotics directly into the bloodstream, do manual removal of retained placenta and placental fragments and perform assisted delivery. A comprehensive facility does all PLUS blood transfusion and Caesarean section.
- Utilisation of these facilities by at least 15 percent of women—where 15 percent is the likelihood of emergency obstetric complications—but especially (100 percent) by those who actually develop complications.
- Percentage of Caesarean section not less than 5 percent but not higher than 15 percent (ensuring necessary surgery but avoiding ‘excessive’, risky surgery).
- Case fatality rate of less than one percent.

Women themselves tend to be complacent or fatalistic about complications and would rather deliver at home. Some are not able to distinguish trained birth attendants and don’t put much premium to their being there. Some have experienced trauma in hospitals, which they do not want to repeat.

Unsafe abortion is a cause of women’s mortality and morbidity. Abortion, like EmOC is also a neglected issue. This is so despite persistent demonstrations of the life-saving role of safe abortion and the relative safety of abortion as compared with all contraceptives or going through pregnancy and childbirth. The ethical committee

of the International Federation of Gynaecologists and Obstetricians (FIGO) in 1999 recommended an approach to abortion that is protective of women's health and life and autonomy.

In the Philippines, the taboo on abortion works to gag even neutral discussions of the issue that affects hundreds of thousands of women every year and through them, their families. It also inhibits doctors from undertaking essential, ethical, life-saving post abortion care. There is therefore a huge need to develop strategies to address these obstacles squarely and effectively.

Safe motherhood requires a functional and pro-poor women's health system.

Reversing the Development of a Rights Framework

The development of a rights framework that was started from 1994 to 1998 and sustained to 2000 has been reversed and continues to be challenged. After an auspicious start from 1994 to 2000 -- when there was a health-centred and 10-element Reproductive Health approach with attention being given to the 'sensitive areas' of adolescent reproductive health, and to emergency contraception for rape victims, post abortion care and strong GO-NGO-donor collaboration -- there have been significant reversals from 2000 up to now.

The reversals and threats mainly came from the increased Catholic Church influence and intervention in national and local Government policies and programmes. But there is also an emerging threat to revert to pre-Cairo population control.

Women's bodies are the site of contestation between two powerful entities: the Catholic Church which looks at women's wombs as mere vessels for reproduction and demographers who look at women's wombs as the cause of countries' underdevelopment and environmental despoliation. Both seek to regulate women's reproduction for utilitarian purposes, based on ideologies that do not take into account women as autonomous agents.

With the increasing Malthusian rhetoric being pushed by demographers and economic technocrats, it is important to reiterate the perspectives of the ICPD PoA, Chapter III: that the relationship between poverty and population growth is plural – i.e., that there are 'interrelationships and these are not causal; that inequity is a big factor in poverty, including inequitable consumption/use of resources; that population 'stabilisation' is necessary to buy time for economic strategies to work, but not as one key economic strategy.

The same reasoning applies to the environmental damage and population growth linkage.

Faulting population growth—in essence, poor people and women's reproductive behaviour—for the country's maldevelopment is not only erroneous but also discriminatory of the poor and of women. Victim blaming will alienate the ultimate stakeholders in development and will prevent the Government from getting even to the point of 'population stabilisation'.

To illustrate - income and expenditure surveys in the Philippines consistently show that the richest 10 percent of families earn and consume more than the poorest 60 percent, (FIES 1994, 1997, 2000 & APIS 1998, 1999).

RR Policy, Grassroots and NGO Perspectives

Grassroots women's and RH NGO's perspectives, although growing, have not really influenced RR policy in a big way. Grassroots women's groups continue to function in a dispersed manner and are focussed on economic issues. Thus, a task still lies ahead for RH NGOs to further transform their client base into advocates/RR constituency.

There is a need to develop broader organisations and alliances together with developing effective policy advocacy methods, including the use of media.

Recommendations

Maternal Mortality

1. Strengthening EOC/EmOC as key MMR reduction strategy:
 - Strengthening the policy framework
 - Adoption of UN process indicators
 - Public discussion on the advantage of liberalising the abortion law
2. Defining personnel roles, training and development:
 - Training, including that of primary care physicians in basic EmOC ,
 - Rationalising appropriate roles and accountability of TBAs
 - Discussions/review of Midwifery Law to expand the role of midwives including Basic EmOC
3. Strengthening the health system to cope with EmOC:
 - Strengthening EmOC capacity of Primary and Secondary public hospitals; strengthening the district health care delivery system, which will require substantive adjustments in health systems organisations
 - Local and national budgetary appropriation for EmOC facility and capability-building
 - Support for indigent patients, e.g. including EmOC in Phil Health package;
4. Education of women regarding EmOC, organising/mobilising them to care for themselves and assist other women while advocating for EmOC among policymakers.

Abortion

1. Strengthening the PMAC, by requiring it in all public facilities:
 - Expanding the scope of PMAC, including penalising negligent/abusive personnel
 - Clarification of the medical ethics of abortion and post abortion care
2. Vigorous abortion-reduction measures—including broadening access to FP and EC:
 - Addressing gender and economic reasons for abortion
3. More public information regarding why women resort to abortion, the risk to their lives and the cost to their families/society.
4. Capability building and empowerment of women towards making decisions to decide and act on fertility needs.
5. Liberalisation of the abortion law starting with the protection of women's lives and health.

Family Planning

1. Clarify a rights-based, unmet need-driven approach to FP which can potentially raise CPR to 82 percent (data from NDHS '98):
 - Discuss the HR implications of a PGR-focussed approach and challenges to PGR reduction-driven economic strategies.
 - Review and reiterate ICPD wording of population poverty linkages.
2. Strengthen quality FP care at the primary level by improving over-all quality care:
 - Strengthen local government's spending/accountability for PHC/FP including providing budget for personnel and commodities.
 - Strengthen and sustain personnel capacity to provide basic quality PHC-FP care on a sustainable basis.
3. Legislation to guarantee Church-State divide on FP and government funding for FP.

General Recommendations

Strengthen the Rights Policy Framework

- Clarify maternal mortality as an expression of discrimination against women and the need for RH services appropriate to women's needs and respectful of their preferences
- Clarify the rights approach vis-à-vis opposing claims of Church and technocrats
- Strengthen the role of UN/UNFPA in clarifying, promoting and defending RR
- Develop a user-friendly scheme for measuring and monitoring RR status and violations

Strengthen Government's Pro-poor Women RH Programmes

- Broad 'safe motherhood' package that includes safe delivery, EmOC, PAC, quality FP
- Quality reproductive health care and respect for patients'/clients' rights
- Continuing education and training of health personnel
- Health system reforms to address fragmentation and politicisation, strengthening of PHC/district level while maintaining the Government's secondary and tertiary facilities
- Address health care financing schemes that cause barriers to access—such as user fees—and increase national and local Government appropriation, including Phil Health support

Strengthening Grassroots and NGO Involvement in RH-RR

- Continue to build, consolidate and expand RR constituency
- Develop skills/capacity for effective policy advocacy including media advocacy
- Develop alternative models and perspectives
- Continue exchanges and engagements with Government towards rights-based governance

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Abbreviations / Acronyms

AMDD	Averting Maternal Death and Disability
AO	Administrative Order
APPC	Asia Pacific Population Conference
ARH	Adolescent Reproductive Health
ARMM	Autonomous Region of Muslim Mindanao
CBCP	Catholic Bishops Conference of the Philippines
CEDAW	Convention on the Elimination of All Forms of Discrimination against Women
CHR	Commission on Human Rights
CPR	Contraceptive Prevalence Rate
D & C	Dilation and Curettage
DBM	Department of Budget and Management
DOH	Department of Health
EmOC	Emergency Obstetrical Care
FGD	Focus Group Discussion
FIGO	International Federation of Gynaecologists and Obstetricians
FP	Family Planning
GO	Government Organisations
ICPD	International Conference on Population and Development
IE	Internal Examination
IEC	Information, Education & Communication
IUD	Intrauterine Device
LGU	Local Government Units
MMR	Maternal Mortality Rate
MVA	Manual Vacuum Aspiration
NCRFW	National Commission on the Role of Filipino Women
NDHS	National Demographic Health Survey
NDS	National Demographic Survey
NEDA	National Economic and Development Agency
NFP	Natural Family Planning
NGO	Non-government Organisations
NSO	National Statistics Office
NSCB	National Statistical Coordination Board
PA	Post-abortion
PAC	Post-abortion Care
PHC	Public Health Centres
Philhealth	Philippine Health Insurance
PGH	Philippine General Hospital
PGR	Population Growth Rate
PMAC	Prevention and Management of Abortion Complications
PoA	Programme of Action
PopCom	Commission on Population
PPMP	Philippine Population Management Plan
PRE	Population, Resource & Environment
RH	Reproductive Health
RHAN	Reproductive Health Advocacy Network
RR	Reproductive Rights
TBA	Traditional Birth Attendant
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
USAID	US Agency for International Development
WHO	World Health Organisation

ANNEXURES

Interviews were conducted with:

1. Mia C. Ventura
Deputy Executive Director
Commission on Population
2. Nereus Acosta
Congressman of District , Bukidnon
House of Representatives
3. Junice D. Melgar
Executive Director
Likhaan

NGO partners consulted:

Reproductive Health Advocacy Network (RHAN) and specifically with the following organizations within RHAN:

- Women's Health Care Foundation
- Family Planning Organization of Philippines
- WomenLead
- Kalakasan
- Mothers Clinic
- PILAKK

AMDD Project

Consultations were conducted with the following organizations:

- Mothers
- Catmon Women's Organisation
- 3 K Para sa Kabataan (youth organisation of Letre, Malabon)

Interviewed doctors, midwives and nurses (totaling to 13 informants) from the following hospitals:

- Pagamutang Bayan ng Malabon (PBM)
- Tondo Medical Center (TMC)
- Jose Reyes Memorial Medical Center (JRMMC)
- Jose Fabella Memorial Hospital (JFMH)
- Philippine General Hospital (PGH)

Focus group discussions (FGD) were held with:

- 11 Traditional Birth Attendants (TBA) from Tonsuya
- 10 TBAs from Catmon
- 4 midwives from PBM (hospital)
- 7 midwives from Government Health Centers
- 7 midwives from private clinic

Abortion Rights Advocacy (ARA) Project

Interviews were conducted by 30 women from the following organizations:

- Mothers
- Bukal
- Zoto
- Kakampi

NOTES

- ¹ Catholic Church affiliated international organisation.
- ² General Comment No. 14 (2000), 'The right to the highest attainable standard of health,' article 12 of the International Covenant on Economic, Social and Cultural Rights (ICESCR).
- ³ according to Dr. Nicholas Dodd of UNFPA, 1999.
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- ⁵ The 'people power' revolt or the EDSA revolution in 1986 was when people went into the streets to place Corazon Aquino in power as president despite the official results of the snap election that reflected Ferdinand Marcos as the elected president. Jaime Cardinal Sin, Archbishop of Manila along with the Catholic Church, led this mass movement.
- ⁶ Section 12, State Policies, Article II, 1987 Philippine Constitution
- ⁷ *Ibid.*
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- ⁴⁰ Based on interview with Congressman Nereus Acosta, District of Bukidnon, where the incidence of IUD removals by a Catholic doctor occurred upon the persuasion of the Parish Priest by claiming such sanctions as prohibitions from taking communion or confessions for IUD users; April 2004.
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