









# Executive Summary

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# Introduction

Adolescent pregnancy and childbirth are leading causes of maternal and child morbidity and mortality worldwide. In the Philippines, adolescent pregnancy remains a significant public health concern, with a high prevalence of unintended pregnancies and high rates of maternal and child mortality. This report examines the data and policy trends in adolescent pregnancy and contraception in the Philippines, highlighting the need for comprehensive and evidence-based interventions to reduce the burden of adolescent pregnancy and improve reproductive health outcomes.

The Philippines has a high adolescent pregnancy rate, with approximately 15% of women aged 15-19 years having ever been pregnant. This rate is significantly higher than the global average of approximately 10%. The high prevalence of adolescent pregnancy is largely due to unintended pregnancies, which are often the result of limited access to and use of modern contraceptive methods. In addition, cultural and social norms that value early marriage and childbearing contribute to the high rates of adolescent pregnancy. Addressing these issues requires a multi-sectoral approach that involves improving access to and use of modern contraceptive methods, promoting comprehensive sex education, and addressing the underlying social and cultural factors that contribute to adolescent pregnancy.

This report provides a comprehensive overview of the data and policy trends in adolescent pregnancy and contraception in the Philippines. It begins with a review of the current state of adolescent pregnancy and contraception in the Philippines, highlighting the key challenges and opportunities. It then examines the data and policy trends in adolescent pregnancy and contraception in the Philippines, highlighting the need for comprehensive and evidence-based interventions to reduce the burden of adolescent pregnancy and improve reproductive health outcomes. The report concludes with a series of recommendations for policy and program interventions to address the challenges of adolescent pregnancy and improve reproductive health outcomes in the Philippines.

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Indicator	2010	2015	2020
Adolescent pregnancy rate (per 1,000 women aged 15-19)	15.0	14.5	14.0
Unintended adolescent pregnancy rate (per 1,000 women aged 15-19)	12.0	11.5	11.0
Contraceptive prevalence rate (CPR) among women aged 15-19	10.0	11.0	12.0
Modern contraceptive prevalence rate (MCP) among women aged 15-19	8.0	9.0	10.0
Abortion rate (per 1,000 women aged 15-19)	5.0	5.5	6.0
Maternal mortality ratio (MMR) among women aged 15-19	100.0	90.0	80.0
Infant mortality rate (IMR) among children of women aged 15-19	150.0	140.0	130.0
Child mortality rate (CMR) among children of women aged 15-19	100.0	95.0	90.0
Under-five mortality rate (U5MR) among children of women aged 15-19	120.0	115.0	110.0
Stillbirth rate (per 1,000 total births)	20.0	19.0	18.0







# Findings

## A. Demographic and Health Data and Trends

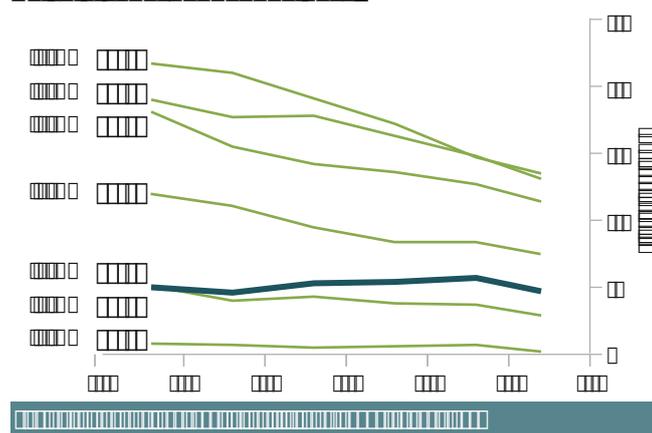
### 1. Adolescent birth rates (age-specific fertility rates, 15-19)

The adolescent birth rate (ABR) is a key indicator of reproductive health and is defined as the number of live births per 1,000 women aged 15-19 years. In the Philippines, the ABR has been declining steadily over the past decade, reflecting a shift towards smaller families and increased contraceptive use. This trend is particularly notable in urban and semi-urban areas, where access to reproductive health services is generally higher. However, the decline has been slower in rural and indigenous communities, where cultural norms and limited access to family planning resources continue to influence fertility decisions.

The decline in adolescent birth rates is closely linked to the broader demographic transition occurring in the Philippines. As the country moves from a high-fertility, high-mortality stage to a low-fertility, low-mortality stage, the reproductive behavior of young women is changing. Increased education, especially for girls, is a major driver of this change, as higher educational attainment is associated with delayed marriage and childbearing. Additionally, the growing awareness of the health and economic benefits of family planning has led to a significant increase in the use of modern contraceptive methods among adolescents.

Despite the overall downward trend, there are still significant regional disparities in adolescent birth rates. The highest rates are consistently found in the Bangsamoro Autonomous Region in Muslim Mindanao (BARMM), where cultural and religious factors play a prominent role in reproductive decisions. In contrast, the lowest rates are observed in the National Capital Region (NCR) and other highly urbanized areas. These disparities highlight the need for targeted interventions that address the specific socio-cultural and economic contexts of different regions to further reduce adolescent pregnancy rates.

Continued efforts are needed to sustain and accelerate the decline in adolescent birth rates. This requires a multi-sectoral approach that includes improving the quality of reproductive health services, enhancing the education of young women, and addressing the socio-economic challenges that often underlie early childbearing.

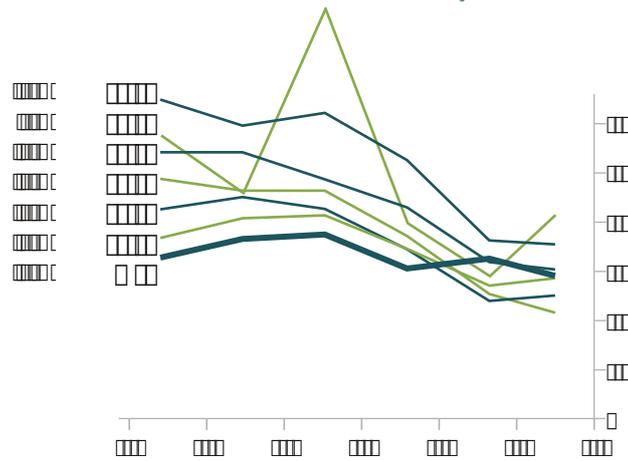




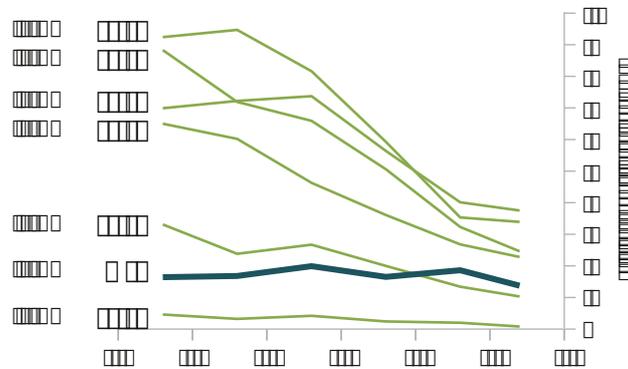
## 2. Unintended births (mistimed or not wanted at all)

Unintended births are those that are mistimed or not wanted at all. They are a significant public health concern because they can lead to unintended consequences for women and their families. Unintended births are often the result of inadequate access to family planning services, lack of knowledge about reproductive health, or unintended consequences of contraceptive use. Unintended births are a leading cause of maternal and child mortality and morbidity. Unintended births are a significant public health concern because they can lead to unintended consequences for women and their families. Unintended births are often the result of inadequate access to family planning services, lack of knowledge about reproductive health, or unintended consequences of contraceptive use. Unintended births are a leading cause of maternal and child mortality and morbidity.

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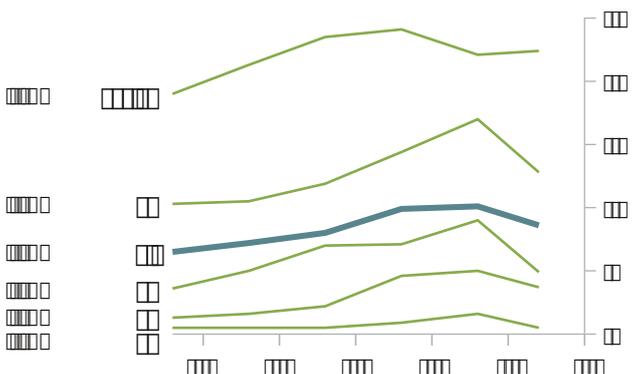
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## 3. Teenagers who have begun childbearing (TBCs)

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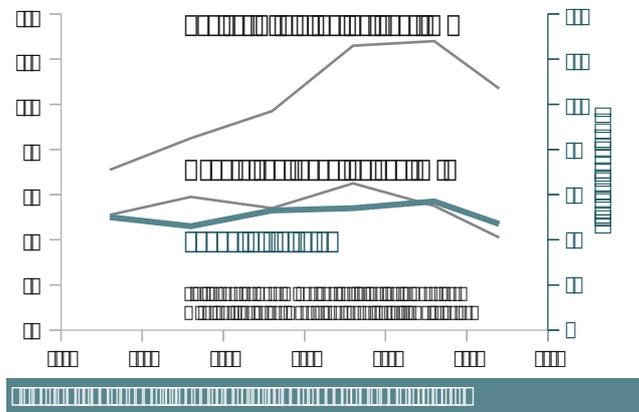
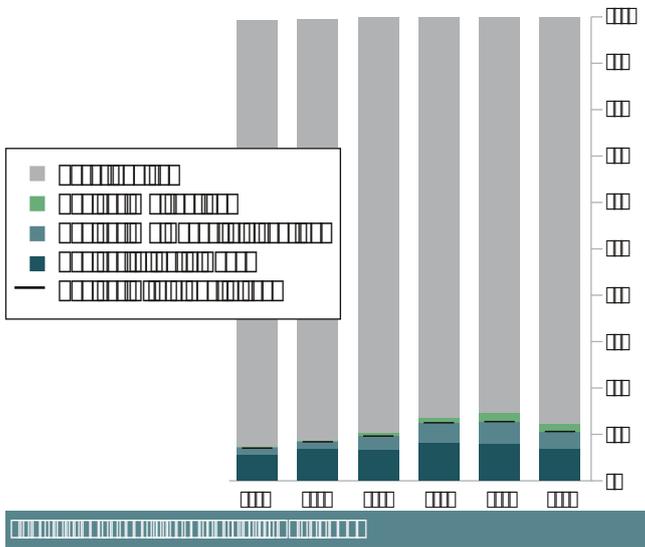
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Teenagers who have begun childbearing (TBCs)

### 4. Adolescents' sexual activity



Adolescents' sexual activity is a complex phenomenon that is influenced by a variety of factors, including socio-cultural norms, access to reproductive health services, and individual characteristics. In the Philippines, adolescent pregnancy remains a significant public health concern, with a high rate of unintended pregnancies and a high percentage of adolescents using modern contraceptive methods. This section discusses the trends in adolescent sexual activity and the use of modern contraceptive methods, and the implications for policy and practice.

The data shows that the percentage of adolescents using modern contraceptive methods has increased steadily from 2008 to 2017. This is a positive trend, as modern contraceptive methods are more effective and safer than traditional methods. However, the overall percentage of adolescents using any contraceptive method remains low, indicating that a large number of adolescents are still at risk of unintended pregnancies. This is a concern for public health officials, as adolescent pregnancy is associated with a range of negative outcomes, including poor educational attainment, economic hardship, and health complications.

One of the reasons for the low rate of contraceptive use among adolescents may be limited access to reproductive health services. Many adolescents live in rural areas where there are few health facilities, and they may face barriers to accessing services, such as cost, distance, and stigma. Additionally, adolescents may lack the knowledge and skills to use modern contraceptive methods correctly, which can lead to unintended pregnancies. Addressing these barriers is a key priority for policy makers and service providers.

Another important factor is the socio-cultural context. In many parts of the Philippines, there are strong norms that discourage adolescent sexual activity, and adolescents may face pressure from family and community to marry and have children. This can make it difficult for adolescents to make their own choices about their sexual and reproductive health. Policy makers need to be sensitive to these cultural norms and work to create a supportive environment for adolescents to make their own choices.

In conclusion, adolescent sexual activity and contraceptive use in the Philippines are complex issues that require a multi-sectoral approach. Policy makers, service providers, and the community all have a role to play in addressing these issues. By increasing access to reproductive health services, providing comprehensive sex education, and creating a supportive environment for adolescents, we can help to reduce the rate of adolescent pregnancy and improve the lives of young people in the Philippines.

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† As used in this paper, *unprotected sex* is sexual intercourse without the use of a modern contraceptive method.

‡ In the 2017 DHS, non-pregnant respondents were asked: "Are you or your partner currently doing something or using any method to delay or avoid getting pregnant?" Later, regardless of pregnancy status, all respondents who ever had sex were asked: "When was the last time you had sexual intercourse?" From these questions, we can expect that a calculated 'modern contraception gap' (MCG) will include sexually active pregnant women. Thus, the MCG figure will probably be slightly higher than rate of women having

unprotected sex. We calculated MCG by subtracting the percentage of all female adolescents currently using any modern contraceptive from the percentage of all female adolescents who had sex within the last four weeks.

§ An expert reviewer correctly alerted us about the different methodology used in calculating birth rates and sexual activity. She also pointed to the rate of TBCs (teenagers who have begun childbearing) as the more appropriate measure to use in relation to sexual activity because the latter, if unprotected, can lead to early childbearing, and the TBC rate "is also an individual-level variable like

sexual activity." However, authors of this paper were concerned that the TBC rate includes a large number of past pregnancies and live births (i.e., teen mothers) which may have occurred years prior to the recent *unprotected sex* being analyzed (last 4 weeks). For example, in the 2017 survey, 7.0% were teen mothers, more than four times the 1.6% currently pregnant teens. To balance all these concerns, we decided to continue using the annual birth rates and limit ourselves to making observations about the consistency and direction of trends.

## 5. Contraceptive knowledge and practices

### Knowledge of modern contraception

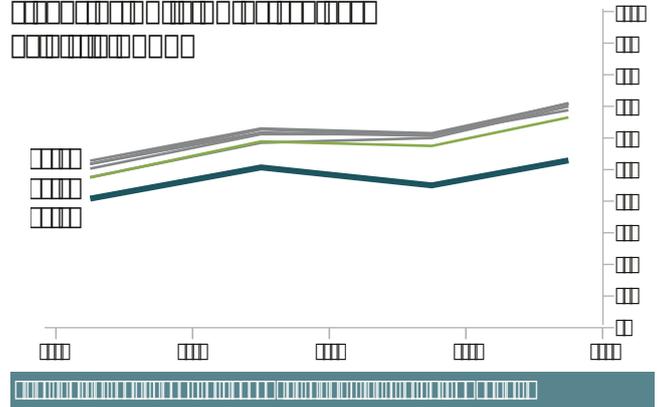
Knowledge of modern contraception is essential for women to make informed decisions about their reproductive health. This section discusses the current state of knowledge and the factors that influence it.

Recent surveys indicate that while awareness of modern contraceptive methods has increased, there is still a significant gap in understanding how to use them correctly. This highlights the need for continued education and counseling services.

Factors such as education level, access to media, and community norms play a crucial role in determining the extent of contraceptive knowledge. Improving these factors can lead to higher rates of informed choice.

Healthcare providers and community-based organizations are working to address these knowledge gaps through targeted interventions. These efforts aim to ensure that all women have the information they need to protect their health and plan their families.

The following line graph illustrates the trends in knowledge of modern contraception from 2000 to 2010. The Y-axis represents the percentage of women with knowledge, and the X-axis represents the year.

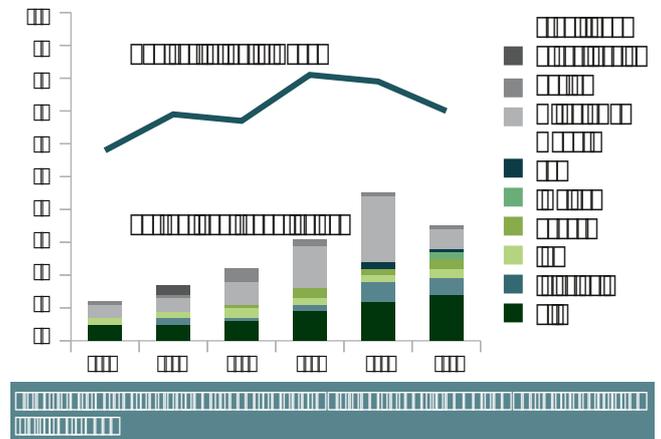


### Use of modern contraception

The use of modern contraception has shown a significant upward trend in recent years. This is largely due to increased awareness and the availability of a wider range of contraceptive options.

However, the use of modern methods is still not universal. Many women continue to use traditional methods, often due to cultural beliefs or lack of access to modern services.

The following stacked bar chart shows the composition of contraceptive use from 2000 to 2010. The Y-axis represents the percentage of women using a method, and the X-axis represents the year. The legend includes: Modern (Dark Green), Traditional (Light Green), and Other (Grey).



### Use of traditional contraception

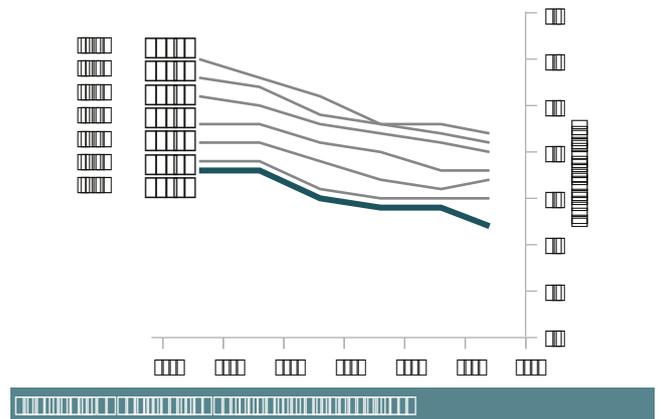
Traditional contraceptive methods, such as coitus interruptus and withdrawal, remain widely used, particularly in rural areas. These methods are often preferred due to their low cost and cultural acceptability.

While traditional methods are effective, they often have higher failure rates compared to modern methods. This underscores the importance of providing comprehensive information about all available options.

### Ideal number of children

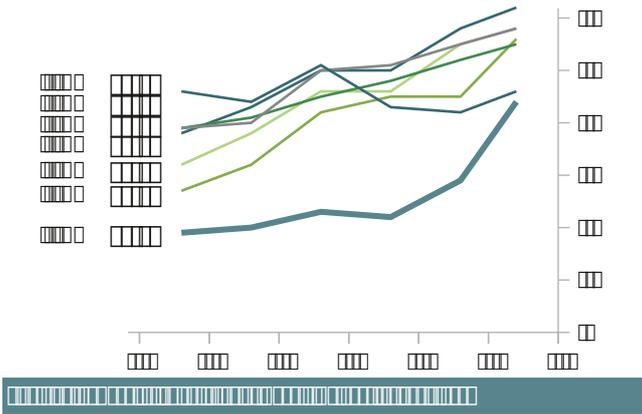
The ideal number of children desired by women has generally decreased over time. This shift is influenced by factors such as increased education, higher costs of child-rearing, and a desire for smaller families.

Understanding the ideal number of children is crucial for family planning and population management. It helps in identifying the needs of women and providing appropriate support and resources.



### Demand for FP satisfied by modern methods

Modern methods of family planning (FP) include condoms, injectables, pills, implants, and intrauterine devices (IUDs). These methods are highly effective and reversible, making them popular choices for adolescents and young adults. The demand for these modern methods has been increasing steadily over the years, reflecting a growing awareness of their benefits and safety.



The increasing demand for modern FP methods is driven by several factors, including the availability of these methods, the effectiveness of modern methods compared to traditional methods, and the growing awareness of the health benefits of modern methods. Additionally, the increasing number of adolescents and young adults seeking FP services has contributed to the rising demand for modern methods.

Modern methods of FP are highly effective and reversible, making them popular choices for adolescents and young adults. The demand for these modern methods has been increasing steadily over the years, reflecting a growing awareness of their benefits and safety. This trend is consistent across various regions and age groups, indicating a widespread shift towards modern FP methods.

The increasing demand for modern FP methods is a positive sign, indicating that more adolescents and young adults are seeking and using effective and reversible methods of family planning.

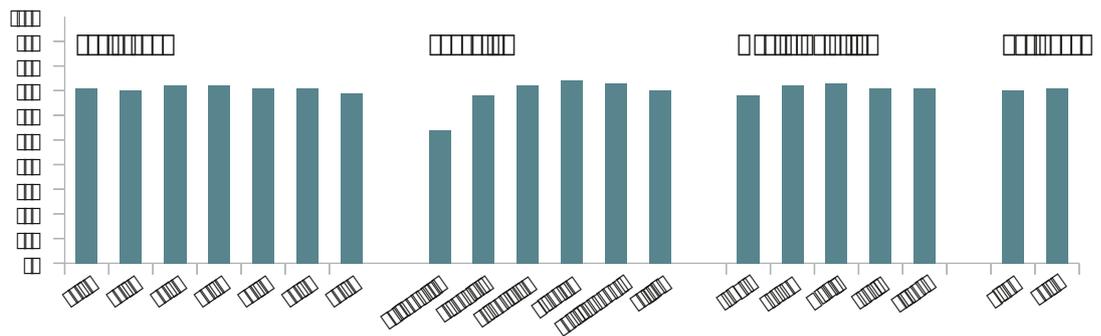
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### Attitudes towards contraceptive use by minors

Attitudes towards contraceptive use by minors have become a significant public health concern. While there is a growing awareness of the benefits of contraception, many minors still face barriers to accessing and using contraceptive services. Understanding the attitudes of minors towards contraceptive use is crucial for developing effective interventions to address these barriers.

Minors often face social stigma and lack of information when it comes to contraceptive use. Many minors are unaware of the different contraceptive options available to them, and they may feel embarrassed or ashamed to seek help from healthcare providers. Additionally, the lack of parental support and guidance can further hinder minors' access to and use of contraceptive services.

Understanding the attitudes of minors towards contraceptive use is crucial for developing effective interventions to address these barriers. This includes providing comprehensive and age-appropriate sex education, ensuring the availability of confidential and accessible contraceptive services, and involving parents and community leaders in promoting positive attitudes towards contraceptive use.



## 6. Adolescents' Abortion and Miscarriage

Adolescents' abortion and miscarriage rates have become a significant public health concern. While there is a growing awareness of the benefits of contraception, many adolescents still face barriers to accessing and using contraceptive services. Understanding the factors that contribute to adolescents' abortion and miscarriage rates is crucial for developing effective interventions to address these issues.

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## B. Laws and Policies on Adolescents' Access to Contraceptive Information and Services

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## 2. Abortion section of the Revised Penal Code

Section 263-A of the Revised Penal Code (RPC) states that a woman who aborts her fetus is liable for a fine of 100 to 200 pesos or imprisonment in the city or provincial jail for a term of 1 to 2 years, or both, if the abortion is performed by a physician or a person who is not a physician but is qualified to practice medicine. If the abortion is performed by a person who is not qualified to practice medicine, the penalty is imprisonment in the city or provincial jail for a term of 1 to 2 years, or both, and a fine of 100 to 200 pesos.

Section 263-B of the RPC states that a physician or a person who is qualified to practice medicine who performs an abortion is liable for a fine of 100 to 200 pesos or imprisonment in the city or provincial jail for a term of 1 to 2 years, or both, if the abortion is performed in a government facility. If the abortion is performed in a private facility, the penalty is imprisonment in the city or provincial jail for a term of 1 to 2 years, or both, and a fine of 100 to 200 pesos.

**The RH Law's IRR clearly states that adolescents must be provided with information and guidance on FP, but minors must get parental consent to access "health products" and "procedures" for FP in government facilities.**

## 3. Presidential Executive Order No. 12

Presidential Executive Order (PEO) No. 12 states that the Department of Health (DOH) is authorized to issue rules and regulations to implement the provisions of the RH Law. The PEO also states that the DOH is authorized to issue rules and regulations to ensure that the RH Law is implemented in a manner that is consistent with the principles of the Constitution and the laws of the Philippines.

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## 4. Implementing Rules and Regulations of the RH Law, including changes mandated by the 2014 Supreme Court decision

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### 7. Philippine Clinical Standards Manual on Family Planning (2014)

Adolescents need to be recognized by the members of their family environment as active rights holders who have the capacity to become full and responsible citizens, given the proper guidance and direction. Before parents give their consent, adolescents need to have a

chance to express their views freely and their views should be given due weight, in accordance with Article 12 of the [Rights of the Child] Convention. However, if the adolescent is of sufficient maturity, informed consent shall be obtained from the adolescent her/himself, while informing the parents if that is in the best interest of the child."

Involving the client's spouse in counseling is helpful, as spousal consent is now being required by service providers. However, FP service providers should ensure that the decision to undergo sterilization is voluntarily made (not pressured or forced) by the client.

### 8. Manual of Operations (MOP) for the Adolescent Health and Development Program (AHDP)

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... giving consent does not mean giving their blessing for their adolescent to have sex, but merely protecting them from sexually transmitted infections and unintended pregnancy. Giving consent is recognizing that adolescence is a risk-taking stage but those risks can be minimized by effective parenting

□ [REDACTED]

[REDACTED]

Many adolescents want their parents, family members or friends to be present when they meet with a health worker, and health centres need to respect their wishes. However, health care providers also need to understand that in some cases, the parents or family member accompanying the adolescents may be an abuser, may have the potential for violence, or may reveal confidential information to a violent member of the house.

□ [REDACTED]

Health care providers need to work with staff to develop policies about when to allow family and friends to accompany adolescents at

different stages of the consultation. These policies should balance the need to protect adolescents' privacy with the need to respect adolescents' preference for having a family member or friend present during the consultation.

Protecting adolescents' privacy may require that providers understand the potential risks, use their judgment about what information to discuss in front of family members, and find creative strategies to obtain consent and to distract family members who may actively try to prevent adolescents from consulting a health worker in private. Provide leaflets or reading materials to the accompanying adults and explain to them that health care providers should meet the adolescents privately.

□ [REDACTED]

LGUs, specifically the Rural Health Units, City Health Offices, and Provincial Health Offices, are responsible for designing, funding, implementing, and monitoring local Adolescent Health and Development programs suited for adolescents in their area, in partnership with youth, government agencies, civil society, and the private sector, under the technical guidance of the DOH.



### 9. Adolescent Friendly Health Facilities (AFHF), 2014 and 2017

AFHF are health facilities that provide a range of reproductive and contraceptive services to adolescents in a safe, confidential, and non-judgmental environment. They are designed to be youth-friendly and accessible, with staff trained to provide respectful and confidential care. AFHF should offer a variety of contraceptive methods, including condoms, pills, injectables, and long-acting reversible contraceptives (LARCs). They should also provide information and counseling on reproductive health and family planning.

AFHF should be accessible to adolescents, including those in remote areas. They should be staffed by trained health workers, including nurses, midwives, and community health workers. AFHF should be equipped with the necessary supplies and materials to provide a range of contraceptive services.

AFHF should be designed to be youth-friendly, with a clean, comfortable, and safe environment. They should have a private and confidential space for adolescents to receive services. AFHF should be staffed by trained health workers who are respectful and non-judgmental.

AFHF should provide a range of contraceptive services, including condoms, pills, injectables, and LARCs. They should also provide information and counseling on reproductive health and family planning. AFHF should be accessible to adolescents, including those in remote areas.

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AFHF should be staffed by trained health workers, including nurses, midwives, and community health workers. They should be equipped with the necessary supplies and materials to provide a range of contraceptive services. AFHF should be designed to be youth-friendly, with a clean, comfortable, and safe environment.

**“The health services are provided in ways that respect the rights of adolescents and their privacy and confidentiality. Adolescents find surroundings and procedures of the health facility appealing and acceptable.”**

**-Standard 3, Philippine National Standards for Adolescent-Friendly Health Services**

### 10. Adolescent Health Providers' Training and Resource Materials

Adolescent health providers should receive training on reproductive health and family planning. This training should cover the basics of reproductive anatomy and physiology, as well as the various contraceptive methods available. Providers should also receive training on how to provide confidential and non-judgmental care to adolescents.

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**“Adolescents should realize the need to balance life with spirituality. As part of their values formation, a deep spirituality is a strong controlling variable that keeps adolescents from delinquent behaviors including sexual promiscuity.”**

**- DOH’s Sourcebook on Behavioral Change Communication Strategies for Preventing Adolescent Pregnancy**

Adolescents should realize the need to balance life with spirituality. As part of their values formation, a deep spirituality is a strong controlling variable that keeps adolescents from delinquent behaviors including sexual promiscuity.

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To avoid unplanned pregnancy, people need to have access to good information about how babies are made and how to prevent pregnancy. To prevent unplanned pregnancy, partners need to remain abstinent or use a reliable method of contraception.

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Values are important in delaying sexual initiation since they serve as the controlling variables that keep adolescents from engaging into sexual initiation. Values set the focus of adolescents towards their aspirations and motivate them to decide responsibly. They also mitigate the influence of sexual drive among adolescents by letting them prioritize their aspirations over short-lived gratifications.

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[Placeholder text block]

... [W]hen information on protected sex are given in a 'shotgun' or 'generic' approach by which even those not intending to engage in sex are covered, the message may be interpreted wrongly. It may send a wrong message among adolescents that sex is okay as long as it is protected. This is the reason why symposiums, forums, or other activities that aim to raise the knowledge and appreciation of the adolescents is not recommended for promoting protected sex. You need to dissect your target audience and seek out to the sexually active to fit in your strategies.

**Had the school and health centers told young people like myself how to avoid pregnancy, I would not have gotten pregnant while I was studying. There would be fewer young people experiencing poverty and hardships.**

**-AC, 17, single mom, from Malabon, Metro Manila**

[Placeholder text block]



### 11. The DepEd’s “Policy Guidelines for the Implementation of Comprehensive Sexuality Education (CSE)”

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### C. Summary of Findings

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**Annual birth rates did not rise in step with the increase in sexual activity. There is strong evidence that the level of unprotected sex is a better predictor of adolescent birth rates than sexual activity per se.**

**Religious doctrines and morality have been cited as the underlying principles in two policies—the requirement for parental consent in the Law and its IRR; and the core message of abstinence by the BCC Sourcebook.**

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# Discussion

This study's review of the DOH tools developed to guide communication and counseling of adolescents reveals two tendencies: avoidance of contraception as a subject matter, such as in ADEPT and Healthy Young Ones; and moralizing against sexual activity, as in the BCC Sourcebook.

## Situation and trends

Adolescent pregnancy and abortion rates in the Philippines are high, and have been increasing over the past decade. This is due to a combination of factors, including limited access to reproductive health services, lack of knowledge about contraception, and cultural norms that encourage early sexual activity. The situation is particularly concerning for young women in rural and low-income areas, who often lack the resources and support needed to make informed choices about their reproductive health.

The DOH has developed several tools to guide communication and counseling of adolescents, including the ADEPT (Adolescent Development and Empowerment Program Tool) and the Healthy Young Ones (HYO) program. However, these tools often avoid discussing contraception as a subject matter, focusing instead on general health and well-being. This approach may be insufficient to address the specific needs of adolescents, who require clear and accurate information about contraceptive options and their effectiveness.

Another trend is the moralizing tone often found in these tools, particularly in the BCC (Behavior Change Communication) Sourcebook. This approach can be counterproductive, as it may lead to shame and stigma for adolescents who are already struggling with their reproductive choices. Instead, a more supportive and non-judgmental approach is needed, one that empowers adolescents to make their own decisions based on accurate information and their own values.

The WHO recommends that reproductive health education should be comprehensive, covering a range of topics including contraception, safe sex, and the importance of informed decision-making. This education should be tailored to the needs and cultural context of the target population, and should be delivered in a way that is accessible and engaging for adolescents. The WHO also emphasizes the importance of involving young people in the development and delivery of these programs, as they are best positioned to understand their own needs and to influence their peers.

## WHO recommendations

The WHO recommends that reproductive health education should be comprehensive, covering a range of topics including contraception, safe sex, and the importance of informed decision-making. This education should be tailored to the needs and cultural context of the target population, and should be delivered in a way that is accessible and engaging for adolescents. The WHO also emphasizes the importance of involving young people in the development and delivery of these programs, as they are best positioned to understand their own needs and to influence their peers.

The WHO also emphasizes the importance of involving young people in the development and delivery of these programs, as they are best positioned to understand their own needs and to influence their peers. This involvement can take many forms, from advisory committees to peer education programs, and can be a powerful way to ensure that the information and services provided are relevant and effective for the target population. Additionally, the WHO recommends that reproductive health education should be integrated into the broader curriculum of schools and other educational institutions, as this can help to normalize the discussion of reproductive health and reduce the stigma often associated with it.

## Barriers to contraceptive information

There are several barriers to contraceptive information, including limited access to reproductive health services, lack of knowledge about contraception, and cultural norms that discourage the use of modern contraceptive methods. These barriers are particularly acute for young women in rural and low-income areas, who often lack the resources and support needed to make informed choices about their reproductive health. Addressing these barriers requires a multi-faceted approach, including increasing the availability and accessibility of reproductive health services, providing comprehensive and accurate information about contraception, and challenging the cultural norms that discourage the use of modern contraceptive methods.

*The Family and Parental Consent ...* There must be a differentiation between access to information about family planning services, on one hand, and access to the reproductive health procedures and modern family planning methods themselves, on the other. Insofar as access to information is concerned, the Court finds no constitutional objection to the acquisition of information by the minor referred to under the exception in the second paragraph of Section 7 that would enable her to take proper care of her own body and that of her unborn child. After all, Section 12, Article II of the Constitution mandates the State to protect both the life of the mother as that of the unborn child. Considering that information to

enable a person to make informed decisions is essential in the protection and maintenance of ones' health, access to such information with respect to reproductive health must be allowed. In this situation, the fear that parents might be deprived of their parental control is unfounded because they are not prohibited to exercise parental guidance and control over their minor child and assist her in deciding whether to accept or reject the information received.

When a minor parent needs the comfort, care, advice, and guidance of her own parents. The State cannot replace her natural mother and father when it comes to providing her needs and comfort. To say that their consent is no longer relevant is clearly anti-family. It does not promote unity in the family. It is an affront to the constitutional mandate to protect and strengthen the family as an inviolable social institution.

More alarmingly, it disregards and disobeys the constitutional mandate that "the natural and primary right and duty of parents in the rearing of the youth for civic efficiency and the development of moral character shall receive the support of the Government."

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**Barriers to contraceptive services**

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**Moralizing against sexual activity and promoting virginity and abstinence as the single “moral option” stigmatizes sexually active adolescents and pushes them away from the services that they most need. Both avoidance and moralizing are ineffective approaches.**

Adolescent pregnancy and childbirth in the Philippines remain a significant public health concern. The 2015 National Survey on Demography and Health (NSD) revealed that 12.5% of women aged 15-19 were pregnant or had given birth in the past 12 months. This rate is notably higher than the 7.5% reported in the 2008 NSD, indicating a concerning upward trend. The highest rates of adolescent pregnancy were observed in the Eastern Visayas region (18.5%), followed by the Western Visayas (15.5%) and the National Capital Region (NCR) (13.5%).

The NSD also identified that 65% of adolescent pregnancies were unintended. This suggests a significant gap between current contraceptive use and the need for family planning services. Many adolescents lack the knowledge, skills, and resources to access and use modern contraceptive methods effectively. This is often due to limited access to youth-friendly reproductive health services, cultural norms that discourage open discussions about sex and contraception, and a lack of comprehensive sex education in schools.

Addressing adolescent pregnancy requires a multi-sectoral approach. Key strategies include strengthening the adolescent reproductive health (ARH) service delivery model, which focuses on providing confidential, accessible, and youth-friendly services. This involves training health workers to provide respectful and non-judgmental care, and ensuring that services are available in community-based settings where adolescents feel comfortable seeking help.

Another critical strategy is the implementation of comprehensive, life-skills-based sex education in schools. This education should go beyond biological facts and include information on decision-making, communication skills, and the importance of using contraception. It should be tailored to the needs and realities of the adolescent population, including those in rural and urban areas. Additionally, community-based interventions, such as peer education and group discussions, can help to reach adolescents who may not have access to formal education or health services.

Finally, it is essential to address the socio-cultural factors that influence adolescent pregnancy. This includes promoting gender equality, reducing gender-based violence, and challenging harmful traditional practices. By creating a supportive environment where adolescents have the power to make their own choices, we can significantly reduce the rates of adolescent pregnancy and improve the health and well-being of young women in the Philippines.

Source: NSD (2015), NSD (2008)



...the right to be heard in a fair and public hearing by an independent and impartial tribunal established by law. The hearing shall be fair and public, unless the interests of children require otherwise. The child shall have the right to be assisted by legal assistance, where the child has the necessary capacity, or where the child lacks sufficient resources and the interests of justice so require.

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**“No child shall be subjected to arbitrary or unlawful interference with his or her privacy ...”**

**- Covention on the Rights of the Child**

# Conclusion

Adolescent pregnancy and contraception in the Philippines remain significant public health concerns. The data shows a high prevalence of adolescent pregnancy, particularly in the rural and urban poor areas. The use of modern contraceptive methods is low, and the majority of adolescents who are sexually active do not use any form of contraception. This is largely due to limited access to reproductive health services, lack of knowledge, and cultural norms that discourage adolescent pregnancy.

The findings of this study highlight the need for targeted interventions to reduce adolescent pregnancy. These include increasing the availability and accessibility of reproductive health services, particularly in underserved areas. Comprehensive sex education and life skills training for adolescents are also essential to increase their knowledge and skills in making informed decisions about their reproductive health. Additionally, efforts should be made to address the socio-cultural barriers that prevent adolescents from using modern contraceptive methods.

# Recommendations

1. Strengthen the reproductive health services for adolescents, particularly in rural and urban poor areas.

2. Increase the availability and accessibility of modern contraceptive methods for adolescents.

3. Implement comprehensive sex education and life skills training for adolescents.

4. Address the socio-cultural barriers that prevent adolescents from using modern contraceptive methods.

5. Conduct research to identify the specific needs and preferences of adolescents in different regions.

6. Engage the community and stakeholders in the development and implementation of reproductive health programs for adolescents.

7. Increase the awareness and knowledge of adolescents about reproductive health and contraceptive options.

8. Provide financial support and incentives for adolescents to use modern contraceptive methods.

9. Strengthen the capacity of health workers to provide reproductive health services to adolescents.

10. Monitor and evaluate the impact of reproductive health programs for adolescents.

# Endnotes

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# Annex 1: Data Tables

Age group	1993	1998	2003	2008	2013	2017	Percent change	AAP change
15-19	50	46	53	54	57	47	-6.0%	-0.3%
20-24	190	177	178	163	148	131	-31.1%	-1.5%
25-29	217	210	191	172	147	135	-37.8%	-1.9%
30-34	181	155	142	136	127	114	-37.0%	-1.9%
35-39	120	111	95	84	84	75	-37.5%	-1.9%
40-44	51	40	43	38	37	29	-43.1%	-2.2%
45-49	8	7	5	6	7	2	-75.0%	-3.7%

Age group	1993	1998	2003	2008	2013	2017	Percent change	AAP change
15-19	50	46	53	54	57	47	-6.0%	-0.3%
20-24	190	177	178	163	148	131	-31.1%	-1.5%
25-29	217	210	191	172	147	135	-37.8%	-1.9%
30-34	181	155	142	136	127	114	-37.0%	-1.9%
35-39	120	111	95	84	84	75	-37.5%	-1.9%
40-44	51	40	43	38	37	29	-43.1%	-2.2%
45-49	8	7	5	6	7	2	-75.0%	-3.7%

Age & residence	1993	1998	2003	2008	2013	2017	Percent change	AAP change
15-19 Urban	36	30	40	42	52	40	11.1%	0.7%
15-19 Rural	72	69	74	71	63	53	-26.4%	-1.3%
20-24 Urban	157	137	157	134	128	114	-27.4%	-1.2%
20-24 Rural	239	233	213	202	174	149	-37.7%	-1.9%
25-29 Urban	203	182	170	159	127	121	-40.4%	-2.0%
25-29 Rural	236	247	219	190	172	149	-36.9%	-1.8%
30-34 Urban	161	133	124	126	110	108	-32.9%	-1.5%
30-34 Rural	205	183	164	149	147	119	-42.0%	-2.2%
35-39 Urban	102	84	77	73	75	71	-30.4%	-1.4%
35-39 Rural	140	142	118	96	94	79	-43.6%	-2.2%
40-44 Urban	42	32	29	27	30	23	-45.2%	-2.3%
40-44 Rural	62	50	61	50	45	34	-45.2%	-2.2%
45-49 Urban	5	4	3	4	4	3	-40.0%	-1.7%
45-49 Rural	12	10	8	7	10	2	-83.3%	-4.3%

Education	1993	1998	2003	2008	2013	2017	Percent change	AAP change
No education or primary	112	98	126	111	139	159	42.0%	1.9%
Secondary education	46	44	52	59	65	50	8.7%	0.3%
Higher education	16	20	18	21	21	18	12.5%	0.6%
All	50	46	53	54	57	47	-6.0%	-0.3%

Residence	1993	1998	2003	2008	2013	2017	Percent change	AAP change
Urban	36	30	40	42	52	40	11.1%	0.7%
Rural	72	69	74	71	63	53	-26.4%	-1.3%
All	50	46	53	54	57	47	-6.0%	-0.3%

Wealth quintile	1993	1998	2003	2008	2013	2017	Percent change	AAP change
Lowest	136	130	134	114	89	98	-27.9%	-1.0%
Second	79	90	84	81	73	57	-27.8%	-1.3%
Middle	48	32	52	52	68	55	14.6%	1.4%
Fourth	35	29	32	43	48	28	-20.0%	-0.5%
Highest	14	12	16	21	24	13	-7.1%	0.3%
All	50	46	53	54	57	47	-6.0%	-0.3%

Age group	1993	1998	2003	2008	2013	2017	Percent change	AAP change
<20	32.8%	36.6%	37.5%	30.6%	32.6%	29.1%	-11.3%	-0.4%
20-24	36.8%	40.8%	41.4%	34.6%	27.1%	28.6%	-22.3%	-0.8%
25-29	42.6%	45.1%	42.7%	34.5%	24.0%	25.1%	-41.1%	-1.7%
30-34	48.8%	46.4%	46.4%	37.2%	25.4%	21.6%	-55.7%	-3.0%
35-39	54.2%	54.2%	48.7%	43.0%	31.9%	30.4%	-43.9%	-2.1%
40-44	64.9%	59.6%	62.2%	52.6%	36.3%	35.5%	-45.3%	-2.1%
45-49	57.8%	46.0%	83.8%	39.8%	28.9%	41.5%	-28.2%	1.5%
All	43.9%	45.1%	44.3%	36.5%	27.8%	27.0%	-38.5%	-1.8%

Age group	1993	1998	2003	2008	2013	2017	Percent change	AAP change
<20	16.4	16.8	19.9	16.5	18.6	13.7	-16.5%	-0.7%
20-24	69.9	72.2	73.7	56.4	40.1	37.5	-46.4%	-2.2%
25-29	92.4	94.7	81.6	59.3	35.3	33.9	-63.3%	-3.4%
30-34	88.3	71.9	65.9	50.6	32.3	24.6	-72.1%	-4.6%
35-39	65	60.2	46.3	36.1	26.8	22.8	-64.9%	-3.9%
40-44	33.1	23.8	26.7	20	13.4	10.3	-68.9%	-4.1%
45-49	4.6	3.2	4.2	2.4	2	0.8	-82.6%	-5.3%

Characteristic	1993	1998	2003	2008	2013	2017	Percent change	AAP change
Had sex in last 4 weeks	5.8%	6.9%	6.7%	8.1%	7.9%	7.0%	20.7%	0.8%
Had sex >4 weeks to 1 year ago	1.3%	1.6%	3.0%	4.5%	4.9%	3.7%	184.6%	5.6%
Had sex >1 year ago	0.3%	0.2%	0.8%	1.0%	1.8%	1.6%	433.3%	14.3%
Never had sex	91.9%	90.9%	89.5%	86.4%	85.3%	87.8%	-4.5%	-0.1%
Had sex within the last year (sum of rows 1 and 2)	7.1%	8.5%	9.7%	12.6%	12.8%	10.7%	50.7%	1.8%

Age group	2003	2008	2013	2017	Percent change	AAP change
15-19	40.8%	50.7%	45.0%	52.9%	29.7%	2.3%
20-24	47.5%	58.9%	57.5%	66.5%	40.0%	2.7%
25-29	50.3%	61.2%	61.2%	68.8%	36.8%	2.5%
30-34	52.8%	63.0%	61.5%	70.9%	34.3%	2.4%
35-39	51.8%	61.7%	60.7%	71.0%	37.1%	2.6%
40-44	51.8%	62.7%	60.9%	70.8%	36.7%	2.6%
45-49	47.6%	58.5%	60.0%	70.0%	47.1%	3.1%
All	48.5%	58.9%	57.1%	66.2%	36.5%	2.6%

Age	1993	1998	2003	2008	2013	2017	Percent change	AAP change
15	0.5%	0.5%	0.5%	0.9%	1.6%	0.5%	0.0%	2.9%
16	1.3%	1.6%	2.2%	4.6%	5.0%	3.7%	184.6%	5.8%
17	3.6%	5.0%	7.0%	7.1%	9.0%	4.9%	36.1%	2.0%
18	10.3%	10.5%	11.9%	14.4%	17.0%	12.8%	24.3%	0.9%
19	19.0%	21.3%	23.5%	24.1%	22.1%	22.4%	17.9%	0.7%
All	6.5%	7.2%	8.0%	9.9%	10.1%	8.6%	32.3%	1.2%

Characteristic	1993	1998	2003	2008	2013	2017	Percent change	AAP change
Had sex within the last year	7.1%	8.5%	9.7%	12.6%	12.8%	10.7%	50.7%	1.8%
Had sex in last 4 weeks	5.8%	6.9%	6.7%	8.1%	7.9%	7.0%	20.7%	0.8%
Current use of any modern contraceptive (married & unmarried)	0.7%	1.0%	1.3%	1.6%	2.4%	2.9%	314.3%	6.9%
Modern contraception gap (difference between rows 2 and 3)	5.1%	5.9%	5.4%	6.5%	5.5%	4.1%	-19.6%	-0.8%
Annual birth rate	50	46	53	54	57	47	-6.0%	-0.3%

Characteristic	1993	1998	2003	2008	2013	2017	Percent change	AAP change
Modern method (currently used)								
Pill	0.5%	0.5%	0.6%	0.9%	1.2%	1.4%	180.0%	5.0%
Injectable	0.0%	0.2%	0.1%	0.2%	0.6%	0.5%		11.5%
IUD	0.2%	0.2%	0.3%	0.2%	0.2%	0.3%	50.0%	3.2%
Condom	0.0%	0.0%	0.1%	0.3%	0.2%	0.3%		15.3%
Implant			0.0%		0.0%	0.2%		
LAM		0.0%	0.0%	0.0%	0.2%	0.1%		-12.5%
Any modern method	0.7%	1.0%	1.3%	1.6%	2.4%	2.9%	314.3%	6.9%
Traditional method (currently used)								
Withdrawal	0.4%	0.4%	0.7%	1.3%	2.0%	0.6%	50.0%	5.1%
Rhythm	0.1%	0.1%	0.4%	0.2%	0.1%	0.1%	0.0%	8.0%
Breastfeeding	0.0%	0.3%	0.0%	0.0%	0.0%	0.0%		-20.0%
Any traditional method	0.6%	0.9%	1.1%	1.5%	2.1%	0.7%	16.7%	2.6%
Adolescents' sexual activity								
Had sex in last weeks	5.8%	6.9%	6.7%	8.1%	7.9%	7.0%	20.7%	0.8%
Had sex within the last year	7.1%	8.5%	9.7%	12.6%	12.8%	10.7%	50.7%	1.8%

Age group	1993	1998	2003	2008	2013	2017	Percent change	AAP change
15-19	2.8	2.8	2.5	2.4	2.4	2.2	-21.4%	-1.0%
20-24	2.9	2.9	2.6	2.5	2.5	2.5	-13.8%	-0.6%
25-29	3.1	3.1	2.9	2.7	2.6	2.7	-12.9%	-0.5%
30-34	3.3	3.3	3.1	3.0	2.8	2.8	-15.2%	-0.6%
35-39	3.6	3.5	3.3	3.2	3.1	3.0	-16.7%	-0.7%
40-44	3.8	3.7	3.4	3.3	3.2	3.1	-18.4%	-0.8%
45-49	4.0	3.8	3.6	3.3	3.3	3.2	-20.0%	-0.9%
Total	3.2	3.2	3.0	2.8	2.8	2.7	-15.6%	-0.7%

Age group	1993	1998	2003	2008	2013	2017	Percent change	AAP change
15-19	19%	20%	23%	22%	29%	44%	131.6%	4.5%
20-24	27%	32%	42%	45%	45%	56%	107.4%	3.5%
25-29	32%	38%	46%	46%	55%	58%	81.3%	2.6%
30-34	38%	43%	50%	50%	58%	62%	63.2%	2.2%
35-39	39%	40%	50%	51%	55%	58%	48.7%	1.8%
40-44	39%	41%	45%	48%	52%	55%	41.0%	1.5%
45-49	46%	44%	51%	43%	42%	46%	0.0%	0.2%
All	36%	39%	47%	47%	52%	56%	55.6%	2.0%

Age group	Agree	Education	Agree	Wealth quintile	Agree	Residence	Agree
15-19	71%	No education	54%	Lowest	68%	Urban	70%
20-24	70%	Grades 1-6	68%	Second	72%	Rural	71%
25-29	72%	Grades 7-10	72%	Middle	73%		
30-34	72%	Grade 11	74%	Fourth	71%		
35-39	71%	Post-secondary	73%	Highest	71%		
40-44	71%	College	70%				
45-49	69%						

