Preface

From my teenage years onward I have been interested in different cultures, I read books about other countries and cultures and had a special interest in Asia. As I grew older I became aware of the problems developing countries have in the process of developing and the issue of equity. When living and working in Thailand for two years from 1999 to 2001 I was very directly confronted with poverty and the problems it poses.

Coming back to Holland I decided to take a course in Human Geography to be able to become a development worker with special interest in urban community development.

During my studies at the University of Groningen population studies caught my special attention and I took several courses in Demography. In these courses Reproductive Health was regularly part of the curriculum, because the professor of Demography undertakes her research in this area.

In my third year I took a course on Geography of Health and sometime later I started to work in the Department of Public Health in the Faculty of Medical Sciences of the University of Groningen.

For me it became more and more clear that I would like to focus on the issue of health during my research for my master thesis, because it has a direct effect on the quality of life and there is an adverse relationship between poverty and health.

As the issue of Reproductive Health is a current concern in many developing countries and the focus of many development programs I chose this particular aspect of health. Also gender issues play an important role in Reproductive Health. As a woman I feel strongly about gender equality and that women should be able to have a say over their lives, their bodies and their reproductive health.

I hope this study will contribute, to some extent, to the empowerment of women in Bacolod City. The final report has been presented to Balayan, La Salle University, the Philippines as well as to the Department of Spatial Sciences at the University of Groningen in the Netherlands.

This research itself has provided me with many valuable experiences. I lived in the Philippines for four months and enjoyed and was challenged by getting to know a different Asian culture from the ones I already experienced before. I was encouraged by the openness and hospitality of the Filipino people I met and their willingness to share their lives with me.

During the process I have learned many things and a good friend's advice to "keep cool, keep smiling and keep praying" (always in my mind while in Asia ☺) helped me to balance my Dutch attitude directed towards results with open mindedness and patience.

During the study I have thankfully profited from the support and assistance of many people in Holland as well as in the Philippines. Here I would like to say a special thank you so much to

- the women in the puroks, who were willing to receive me into their homes and share their, sometimes intimate, stories with me;
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- Ms. Rowena Banes, head of the department of Psychology of La Salle University, for her advice during the research process;
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- my friends and family, who have had to bear with me, as I had little time to socialize during the past six years, trying to combine a fulltime study with a part-time job;
- the Lord of all, for giving me energy, strength and wisdom to keep on going, providing the inspiration to start and to finish the study, to run the race and to continue the work He has given me to do.

For all of you and all the others who contributed, but I did not mention by name,

Salamat gid! Thank you so much!

Anja Holwerda

Groningen, January 2007

Summary

This study focusses on the issues of fertility and population growth in relation to poverty in the Philippines. It seems to be an enormous challenge to reduce poverty while at the same time fertility is hardly decreasing, being one of the factors in the considerable population growth in developing countries. Although it would be misleading to assume there is a direct link between poverty and population growth, population growth has surely a significant impact on poverty at the broadest level, especially when it threatens to outpace domestic economic development. One way of slowing down population growth is increasing contraceptive use.

The main focus of this study is to explore why a large unmet need for contraception and a low contraceptive prevalence rate in the Philippines exist, while for most women in the Philippines the desired family size is two to three children. The contraceptive prevalence rate for modern contraception in Bacolod City is low with 19.8 percent compared to 30.1 percent in the Western Visayas and 33.4 percent as the national average percentage of current users in 2003. It is expected that women in the reproductive age range with a desired family size of 2 to 3 children, would use contraception to prevent further pregnancies, but a large number of these women do not use contraception. This study tried to identify possible reasons for this discrepancy and focussed on the perceptions and attitudes of women in the squatter settlements regarding contraception and factors influencing these perceptions and attitudes.

The study has taken place in Bacolod City, the provincial capital of Negros Occidental in the Philippines. The study design is explorative and descriptive, having used interviews with key informants, focus group discussions and questionnaire-based interviews as main methods. The interviews have been conducted in four squatter settlements among women in the reproductive age (15-45 years) and 116 respondents have participated. The fieldwork has been conducted from September to December, 2005.

One cluster of influencing factors that have been incorporated in this study are external factors like laws and policies, service delivery and information delivery.

At the time of the study educational programmes regarding reproductive health as well as family planning programmes were in place in Bacolod-City, with varying success. The lack of political support by the current administration (fostered by the Roman Catholic church) for population management and reproductive health as well as modern contraception has translated into limited commitment and financial support for these programmes.

Service delivery concerns the availability and accessibility of contraception as well as the quality of the family planning services and follow-up services for contraceptive users and the availability

of adequate human resources. Although in theory family planning services should be readily available, in practice these services do not always meet the needs of the women involved.

Information is an important tool for decision-making. Lack of or incorrect information on the types, costs, availability and side effects of family planning services influences contraceptive behaviour. In this study lack of knowledge appeared to be a considerably greater barrier than inaccessibility or cost of contraception. Overall the results of this study signify interpersonal communication (also by health staff) to be effective in creating awareness about family planning methods.

Other influencing factors are related to cultural factors like gender and religion. Gender based hierarchies, where male control and authority are asserted in the family and in society, and the role and status of women crucially impact decision-making regarding contraceptive use. From the literature as well as from the interviews with key informants the macho image of the Filipino man appears to be an important barrier for contraceptive use in Philippine society.

Next to gender issues, religion can also have a considerable impact on people's beliefs and behaviour regarding contraception. Some religions, like Roman Catholicism, consider it a sin to interfere with normal conception. According to the literature and the key informants the Roman Catholic religion is one of the main determinants of the low contraceptive prevalence rate in the Philippines. Moreover, the Roman Catholic church is an important stumbling block to the government with regard to the implementation of local government policies regarding reproductive health. However, from this study it appears that religion may be a significant factor on macro and meso level, but not on the micro level. Most women in the survey think the use of contraception is at least appropriate under certain circumstances and often in any circumstance.

Finally, the social environment as well as personal and household characteristics have been taken into account as important influencing factors for contraceptive use.

The immediate social context in which people live (the household, the family, the community) is assumed to play a crucial role in the decision making process of people. According to the literature, as well as the key informants and the neighbourhood health workers, the husband's objection is a major obstacle for women's contraceptive use. From the survey it appeared that one in three women in the squatter settlements thinks her husband would not agree with her using a modern contraceptive. In this study the role of the family and the community of the respondent in contraceptive decision-making is clearly less pronounced.

According to the literature native place (rural/urban), socio-economic status of the household, education, employment, and family relations all influence contraceptive behaviour more or less. However, in this study hardly any pronounced differences between different groups were found. The determinants of contraceptive behaviour seem complex, and cannot easily be reduced to factors such as lack of education, unfamiliarity with contraception, or unavailability of services.

Economic reasons are cited by the barangay health workers as well as by the respondents of the survey as the most important factor for wanting to limit the number of children and stimulating the use of family planning methods. However, although people do want to limit the number of children, most of them do not use modern contraception. From this study two reasons for contraceptive non-use stand out. On one hand women's status in general is not very high, making it easier for husbands to dictate their wives' contraceptive behaviour and not allowing use of modern contraception. On the other hand contraceptive knowledge in women as well as men seems to be rather limited, leaving room for all kinds of misconceptions, for example regarding side effects of contraception, creating an atmosphere of fear rather than opportunity with regard to modern contraceptives.

Flowing from the study, it is recommended to empower the women in the purok. This improves their status and may positively influence their decision making capacity regarding reproductive and contraceptive behaviour.

It is also recommended to develop educational programmes for men and women regarding reproductive and contraceptive behaviour to promote co-responsibility for the issue of family planning, which is often regarded as a woman's issue.

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Chapter 1
Introduction

1.1 Background

Most of the international population policies of the last two decades have been directed at reducing the number of births worldwide. The desire to limit fertility rates by the international population-planning community is a response to concerns about rapidly increasing global population. This increase is being experienced significantly more in the periphery and semi-periphery than in the core countries, the last being the countries that dominate trade, control the most advanced technologies, and have high levels of productivity within diversified economies (Knox & Marston, 2001). Accompanying this situation of imbalanced population growth between the core and the periphery is gross social and economic inequality as well as overall environmental degradation and destruction (Knox & Marston, 2001; Potter et al., 1999; WHO, 2004).

This study is concerned with the issues of fertility and population growth in relation to poverty. It seems to be an enormous challenge to reduce poverty while at the same time fertility is hardly decreasing, being one of the factors in the considerable population growth in developing countries.

Population growth and poverty

In 1789 Malthus already hypothesized that at the aggregate level, high fertility results in a high level of population, which in turn will increase demand for food and consequently the price of food and decrease the price of labour, because of its ample supply. Malthus' idea was that a high level of fertility aversely affects the income distribution of the poor, because their main asset is their labour. Lower fertility affects the supply of workers so employment and wages among the poor can increase (In: Achacoso-Sevilla, 2004; Potter et al., 1999). Following this train of thought, people during the 1960s and 1970s believed that high fertility caused poverty; as a result people thought fertility decline and decreasing population growth would ensure poverty reduction.

However, in the 1980s and 1990s, this Malthusian view was replaced by the argument that demographic considerations were not really relevant to poverty reduction. Some even claimed that higher fertility rates were associated with less poverty, not more. This view was used by

people critical of the population programmes in the Philippines to justify the government's lack of support for these programmes (UNFPA, 2002).

Although it would be misleading to assume there is a direct link between poverty and population growth, population growth has surely a significant impact on poverty at the broadest level, especially when it threatens to outpace domestic economic development (see also Achacoso-Sevilla, 2004; Potter et al., 1999; UNFPA, 2002). Besides the issues of equity and accessibility, recent research in developing countries has provided evidence that high fertility rates make it more difficult to reduce poverty because they slow down economic growth and deteriorate the distribution of additional income created by economic growth (Merrick, 2002 in UNFPA, 2002; see also Hugo, 2003). For example a study in the Philippines showed there is a clear relationship between poverty and family size, with poverty being most intense among large families. Poverty incidence increases from 14,9% in families with one child to 59,4 % in families with 9 children. Only with ten or more children does the poverty incidence decrease a little to 53,8 % (Orbeta and Pernia in UNFPA, 2002). According to Sethi & Carter (1996) high population growth contributes to many social, economic, and political problems, and often restrict development. It threatens the supply of natural resources and the provision of public services and utilities become more costly and more complex (Garcia et al., 1984).

Also the government of the Philippines acknowledges that the Filipino population growth is exceeding the economic capacity of the country to provide in the basic needs of the population (PPMP Directional Plan, 2001-2004). The total population of the Philippines has passed the 80 million in 2004. According to the UNFPA (2002) the rapid population growth is one of the country's most critical development problems. The population growth rate for the Philippines is 1,84 % compared to 0,53 % for the Netherlands (both 2005 estimates) (CIA Factbook, 2005)[1]. The growth rate is a factor in determining how great a burden would be imposed on a country by the changing needs of its people for infrastructure (e.g., schools, hospitals, housing, roads), resources (e.g. food, water, electricity), and jobs (CIA Factbook).

Lower fertility levels help reduce the population growth rate (Sethi & Carter, 1996). In the Philippines only modest progress has been made in moderating population growth. The Philippines has had the slowest fertility decline among countries in East and South East Asia over the last 30 years (Achacoso-Sevilla, 2004; see also Hugo, 2003)).

Collymore (2003) also mentions fast-paced population growth and urbanization as major population concerns in the Philippines. Moreover, these issues act as major stumbling blocks in efforts to reduce poverty and improve the living standards in the Philippines (www.prb.org).

[1] The population growth rate is "*the average annual percent change in the population, resulting from a surplus (or deficit) of births over deaths and the balance of migrants entering and leaving a country*" (CIA Factbook, 2005).

Through this high growth rate the number of jobs and facilities in the Philippines cannot keep up and large groups of people are un(der)employed and not able to make a reasonable living. Although the welfare of the Filipino people in general has improved and poverty has been reduced, in 2001 still around 40 percent of the population lived below the poverty line[2] and absolute poverty as measured by international standards is higher than in any other market economy in the region (CIA Factbook, 2005; UNFPA, 2002).
One way of relieving poverty is decreasing fertility. The reproductive health approach is one of the tools to stimulate a decreasing fertility as people become more aware of the health issues involved with reproductive choices. Government policies can help to facilitate this process.

Population policies and reproductive health

In the years preceding 1994 the policy instruments that have been developed to address rising fertility in the periphery and semi-periphery were largely in the form of family planning programs[3].

However, since 1994 there has been a worldwide shift in population policies[4] from family planning to reproductive health. Reproductive health is determined by social and economic development, by life styles, quality and accessibility of health services and by the status of women, but most of all by the freedom to make choices (UNFPA, 1995 in Hutter, 1998).

This shift started at the time of the Cairo International Conference on Population and Development (ICPD) in 1994. The ICPD Programme of Action emphasized balancing the world's population with its resources, improve women's status, and ensure universal access to reproductive health care, including family planning. During this conference nearly all the core and peripheral countries agreed on a plan to encourage freedom of choice in the matter of family size (UNFPA, 2004; Knox & Marston, 2001). Where family planning policies were directive in certain areas like desired number of children per couple and use of contraceptives, the reproductive health approach places individual needs at the centre. Key to this approach is a greater emphasis on women's health and on the social conditions which influence reproductive decisions and their consequences on health (Datta & Misra, 2000; Hutter, 1998; Obermeyer, 2001; Jacobson, 2000; United Nations, 1998). However, the issue of reproductive

[2] The poverty threshold or poverty line is defined by the NSO as the annual per capita income required or the amount to be spent to satisfy nutritional requirements (2000 calories) and other basic needs of a family with six members. For the year 2000, annual per capita poverty threshold was at P 13.916,- (Achacoso-Sevilla, 2004).

[3] Family planning is "*the ability to prevent pregnancies safely by using contraceptives or other forms of contraception such as the Natural Family Planning (NFP) method*". Such ability is crucial to couples who wish to manage the number and spacing of their children (POPCOM, 2000).

[4] Knox & Marston (2001:139) define a population policy as "*an official government policy designed to affect any or all of several objectives including the size, composition, and distribution of population*". A population programme is an instrument used for the implementation of population policies, working on the goals and objectives as identified by the population policy (Knox & Marston, 2001:139).

rights is controversial as it touches on the most personal and intimate areas of life, namely sexuality, sexual relations and reproduction. Reproductive rights are also central to intra-familial relations and are linked with the status and empowerment of women, which are also sources of controversy in many countries (see also United Nations, 1998).

The Cairo consensus made the empowerment of women and ensuring the rights of individuals, including the right to reproductive health and the ability to choose whether and when to have children, to key issues in sustained economic growth and poverty alleviation. It gave priority to investing in people and extending their opportunities instead of reducing population growth (Hutter, 1998; Jacobson, 2000; Knox & Marston, 2001; Tsui et al., 1997; UNFPA, 2004; United Nations, 1998; WHO, 2004). Education is an important instrument in the reproductive health approach. Enabling people to have fewer children, if they want to, helps to stimulate development and reduce poverty, both in individual households and in societies. Family planning can result in improved maternal and infant health; expanded opportunities for women's education, employment and social participation; reduced exposure to health risks; and reduced recourse to abortion. Besides smaller families have more to invest in children's education and health (Tsui et al., 1997; UNFPA, 2004).

Reproductive perceptions and behaviour

Demographic issues such as fertility and population structures are the cumulative and collective results of people's behaviour, for example concerning the formation of unions, child-bearing, and other aspects of reproductive health (POPCOM, 2000). This study will focus on the perceptions and attitudes of women regarding reproductive health that produce this behaviour and the factors that influence these perceptions (the context).

Knowing how women think about these issues will help agencies and governments to develop relevant programmes to help women to exercise their reproductive rights in informed choices. Research and experience has shown that responding to the needs and desires of clients is the most sustainable, and ethical, way to help national fertility levels continue to fall (Sethi & Carter, 1996). Once the perceptions and attitudes of the women involved are known, agencies and governments can develop programmes and materials that address these perceptions and attitudes. It is expected that education regarding reproductive health will help women to improve their reproductive health by making healthy reproductive decisions. It will raise awareness of the possibilities women have to influence their lives by enhancing their choice-making capabilities (see also Hutter, 1998).

Similar research in India has shown that women in general do not wish to give birth to more than two children (Hutter et al., 2002). Following this research in India, culturally relevant materials have been developed to help women to make informed decisions regarding reproductive health.

As women are able to better influence their reproductive behaviour because of being informed regarding reproductive choices, fertility may well decrease (as in India women do wish to limit their fertility to two children) and this decreasing fertility will help to reduce poverty.

1.2 Definition research topic

The following extensive definition of reproductive health was adopted at the International Conference on Population and Development in 1994 (United Nations, 1998):
"Reproductive Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity, in all matters relating to the reproductive system and to its functions and processes. Reproductive health therefore implies that people are able to have satisfying and safe sex life and that they have the capability to reproduce and the freedom to decide if, when and how often to do so. Implicit in the last condition are the right of men and women to be informed and to have access to safe, effective, affordable and acceptable methods of family planning of their choice, as well as other methods of their choice for regulation of fertility which are not against the law, an the right of access to appropriate health-care services that will enable women to go safely through pregnancy and childbirth and provide couple with the best chance of having a healthy infant." (WHO, 2004; see also United Nations, 1998)
It was also acknowledged that "*all couples and individuals have the basic reproductive right to decide freely and responsibly the number, spacing and timing of their children and to have the information and means to do so."* (WHO, 2004; see also United Nations, 1998)

Within the scope of this thesis it is impossible to incorporate all aspects of reproductive health. The necessity to limit the scope has resulted in a focus on one aspect of reproductive health, i.e. "*the right of men and women to be informed and to have access to safe, effective, affordable and acceptable methods of family planning of their choice,...*" Flowing from the Philippine context, outlined in chapter 4, the focus of this study is on the perceptions of women regarding contraception. Contraception, which enables couples to prevent unintended pregnancy, is a key issue for the promotion of good reproductive health (Sethi & Carter, 1996; Singh et al., 2003; Tountas et al., 2004). With respect to meeting ICPD goals the Philippines showed marked deficits in the contraceptive prevalence rate among women of reproductive age[5]. In 2003, the contraceptive prevalence rate of almost 49% for all methods and 33% for modern methods were the lowest in the region (www.unfpa.org.ph). Moreover, the issue of contraception is regarded highly controversial in Philippine society.

[5] The Contraceptive Prevalence Rate (CPR) is the percentage of married women in the reproductive period currently using a contraceptive at a given point in time. It is the result of new acceptors, the numbers of continuing users and discontinuations (Hutter, 1998).

Research Problem

The main focus of this study is why there is a large unmet need for contraception[6] in the Philippines and a low contraceptive prevalence rate, while for most women in the Philippines the desired family size is two to three children. It is expected that women in the reproductive age range with a desired family size of 2 to 3 children, would use contraception to prevent further pregnancies, but a large number of these women do not use contraception. This study tried to identify possible reasons for this discrepancy.

The main objectives of the study are to:

- identify the perceptions (thinking) and attitudes (acting) of women in the reproductive period regarding contraception and contraceptive methods;
- identify how women and couples are influenced in their decision-making by people in their immediate social environment or health service personnel;
- identify possible constraints for contraceptive use for Filipino women.

The main research question "What are the perceptions and attitudes of women regarding contraception in Bacolod and which factors influence these perceptions and attitudes" will be worked out in the following research questions.

1. What is the current situation (period 2000 – 2005) regarding contraception in Bacolod also in comparison with the national situation in the Philippines, according to the government officials, health workers, and NGO's?
2. How do women in Bacolod perceive contraception? What are their beliefs regarding the different contraceptive methods?
3. In what ways do religion and status of women in Philippine society influence the perceptions of women in Bacolod regarding contraception?
4. In what ways do age, native place (rural/urban), socio-economic status of the household, education, employment, and family relations of an individual Filipino woman influence her perceptions and attitudes regarding contraception?
5. In what ways is the decision-making of Filipino women regarding contraception influenced by their social environment?

In this study individual women are the study subjects and the study is aimed at uncovering their perceptions and attitudes regarding contraception. However, these women are studied as part

[6] *Unmet need* for contraception refers to women and couples who do not want another birth within the next two years, or ever, but are not using a method of contraception (UNFPA, 2004).

of their social environment. Their role in the household and the demographic phase of their household as well as their socio-economic status are taken into consideration.

1.3 Geographical context

The study has taken place in Bacolod, the provincial capital of Negros Occidental in the Philippines.

The Philippine archipelago is made up of 7,107 islands with a total land area of 298,170 square kilometers. It is located in South East Asia, north of Celebes, Indonesia and south of Taiwan surrounded by the South China Sea, the Philippine Sea, the Sulu Sea and the Celebes Sea. It has a tropical marine climate with a northeast monsoon from November to April and a southwest monsoon from May to October. As it is located in a typhoon belt, the country is frequently hit by heavy tropical storms. The Philippines are rich in natural resources like timber, petroleum, nickel, cobalt, silver, gold, salt and copper (CIA Factbook, 2005).

The Philippines is divided in seventeen political and administrative regions (NSO, 2004).

Population

In July 2004 the Philippines had an estimated population of 86,241,697 and a population growth rate of 1.88 percent (CIA Factbook, 2005). According to the Annual Demographic Report of 2002 the nationwide average household size was estimated to be 5.3 (www.census.gov.ph). Of the population 61 percent lived in urban areas and an urban growth rate of 3.1 percent was estimated between 2000 and 2005 (UNFPA, 2004).

Most Filipinos adhere to the Roman Catholic religion (81.5 %). Besides about 5.5 percent is protestant, 4.2 percent adheres to the Islam and 8.8 percent to other religions (NSO, 2004).

At the time of the National Demographic and Health Surey 2003, the Filipino population consisted of 38 percent below 15 years of age, 57.8 percent between 15 and 64 years of age and 4.2 percent of 65 years and older (NSO, 2004). The percentage of female headed households during the period 1990 – 2004 was 15%.

Living conditions

The Philippines belong to the lower middle income group of countries as indicated by the World Bank (www.worldbank.org.ph). The gross national income per capita (formerly gross national product (GNP) per capita) was 1,300 dollars in 2005 (World Bank, 2006). Partly as a result of the annual remittances from overseas workers, the country was less severely affected by the Asian financial crisis of 1998 than its neighbours. However, of the more than 80 million people in the Philippines in 2001 still around 40 percent of the population lived below the poverty line

as indicated by the CIA Factbook. In 2000 15.5 percent of the population lived even below 1 dollar a day (World Bank, 2006).

Participation in the labour market was estimated 34.6 million in 2003 of which 45 percent is working in agriculture, 15 percent in industry and 40 percent in services. The unemployment rate amounted to 11.4 percent (CIA Factbook, 2005). Male participation in the labour market in 2004 amounted to 84.6 percent, while female participation reached 55.5 percent. Employment in the urban informal sector (in percentage of total urban employment) was 16 percent for men and 19 percent for women over the period from 1995 – 2003 (NSO, 2004).

Negros Occidental

Negros Occidental is one of the provinces of the Western Visayas (region VI), in the mid west of the country, bordering the Sulu Sea. The population of Negros Occidental reached 2.6 million (NSO Census 2000 in Diocese of Bacolod, 2005) (www.negros-occ.gov.ph/population.php)

According to the NSO Census 2000, the number of households in Negros Occidental amounted to 503,663 and the average household size was 5.32 (In: Diocese of Bacolod, 2005; see also www.negros-occ.gov.ph/population.php).

The majority of the Negrenses are Roman Catholic, 84.7 percent, and this is slightly more than the national percentage of Roman Catholics (www.negros-occ.gov.ph/religious.php).

In a study of the National Statistical Coordination Board regarding poverty statistics, Negros Occidental was classified among the poorest 44 provinces in the country, with 50.2 % of the province's population being poor. (www.nscb.gov.ph/poverty/2000/povertyprov.asp)

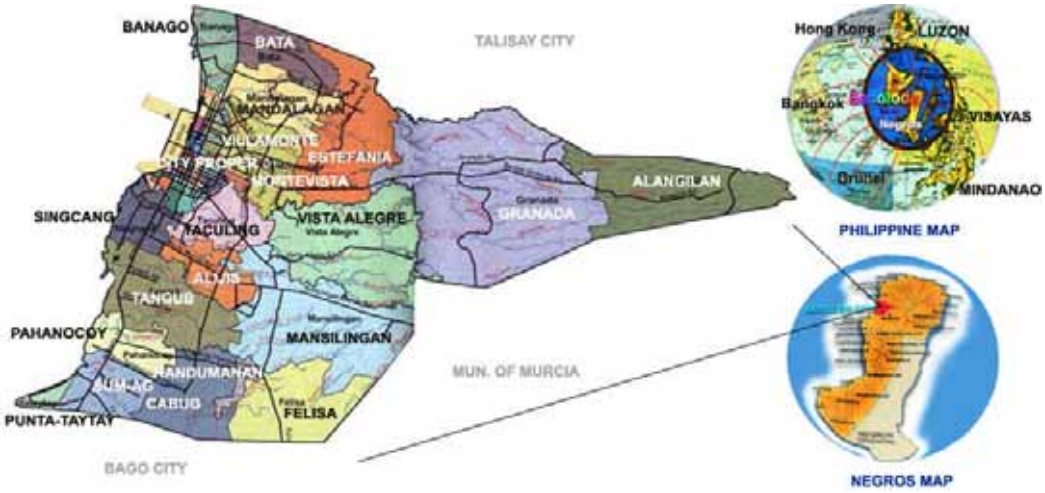
Bacolod City

Bacolod City is the provincial capital of Negros Occidental, located on the northwest coast. It has a total land area of 16,145 hectares.
Bacolod City is divided in 61 barangay (= villages) and 639 purok (=communities). The land use within the city is divided in residential (30.0%), commercial (5.0%), institutional (7.4%), agricultural (51.4%) and industrial (2.2%). (www.bacolodcity.gov.ph)

In 2000 the population of Bacolod City amounted to 429,076 with an annual growth rate of 1.39% and 87.441 households with an average household size of 4.91 (www.bacolodcity.gov.ph). The population density in Bacolod City amounted to 2,757 persons occupying a one-square kilometer land in the city (www.negros-occ.gov.ph/population.php). From the 2000 census it appeared that barangay Singcang, in which the field work was done, was registered as one of the three barangay with the highest population (29,019 inhabitants) (www.bacolodcity.gov.ph).

The Philippines

Map of Bacolod City



(www.bacolodcity.gov.ph)

The communities, where the survey took place, were all located close to the sea. Fishing and connected activities were an important source of income. These communities were among the poorest of the city.

For an overview of the Filipino context in the frame work of this study, see chapter 4.

1.4 Structure of the thesis

The methods used in this study will be described and discussed in chapter 2.

The theoretical framework and the conceptual model, on which this study is based, are explained in chapter 3. In this chapter a compilation of the studied literature is also presented.

Chapter 4 will deal with the Filipino setting regarding the subject matter, on a national as well as a regional level.

The findings from the interviews with key informants are presented in chapter 5 and the focus group discussions are described in chapter 6.
The results from the questionnaire based interviews and from the analysis of these results are presented in chapter 7.

In chapter 8 conclusions are drawn as well as recommendations given for further research as well as for policy matters in Bacolod City.

Chapter 2
Methodology

This thesis is based on a study regarding the perceptions of women regarding reproductive health, especially contraceptive use. The study design is explorative and descriptive, having used interviews with key informants, focus group discussions and questionnaire-based interviews as main methods.

In this study two qualitative research methods have been chosen because qualitative research is especially helpful to study feelings, experiences, beliefs and attitudes from the perspective of the people involved, to map the interaction between people involved and to acquire insight in the empirical situation (Gatrell, 2002, De Groot et al., 2000). This study uses qualitative research because it seeks to understand human beliefs, values and actions (Gatrell, 2002). Besides the adoption of the theoretical framework of the proces-context approach (which is related to the definition of reproductive health as adopted in Cairo 1994, i.e. the focus on needs and ambitions of individuals, on reproductive choice, i.e. individual reproductive behaviour is embedded in the economic, social and cultural context) requires application of small-sale research methods, such as participant observation, in-depth interviews, focus group interviews and key-informant interviews (see Hutter, 1998).

The study carries a comparative element. Four different age groups have been taken in the sample, namely women of 15-19, 20-24, 25-30 and 30+ years old. These age groups have been chosen in order to be able to compare the findings of the study with the research of prof.dr. Inge Hutter in India (Hutter et al., 1999; idem, 2002). Moreover this study will try to identify possible differences between these age groups in their perceptions regarding contraceptive use.

Further differentiation of respondents is based on the socio-economic status of the household, origin of the household (rural/urban) and demographic phase of the household (single, just married, having one or more child(ren)).
For the selection of the neighbourhood, suitable for this study, the author asked for suggestions from the staff of Balayan as well as the Chief of the Maternal and Child Health Division of the City Health Office.

The following selection criteria were used:
- Accessibility of the neighbourhood for the researcher
- Availability of a neighbourhood health centre
- Reasonable population size within the neighbourhood

The neighbourhood chosen had a considerable number of squatter settlements. Of the four communities selected three were fishing communities. There were only slight differences between the four communities. It was considered a depressed area, with the majority of the people being poor and high unemployment rates. Of the households in the survey 21.6 percent lived in houses of makeshift materials. The infrastructure in the communities was poor with only few paved roads. Half of the respondents had their own electricity supply and 68 percent made use of a shared water supply (well or pump). Of the households 19 percent had no sanitation facilities.

2.1 Explanation of Ilongo terminology

Ilongo	local language of Negros Occidental
Barangay	neighbourhood/village, smallest political unit within the Philippines
Purok	community, subdivision within a barangay

2.2 Data collection and research team

The primary data were collected during the fieldwork in Bacolod in the period between September 12 and December 22, 2005.

Before starting the fieldwork for the study, permission was asked from the City Health Officer, the government official responsible for health issues in Bacolod City.

After selection of the neighbourhood, the Barangay Council was asked for permission to conduct the fieldwork in their barangay. Also the Medical Officer of the selected barangay was asked permission and gave her approval.

The following methods were used during the study:

- Interviews with key informants
- Focus groups with barangay health workers
- Questionnaire-based interviews with women in the purok

After the selection of the neighbourhood in Bacolod, the researcher joined several barangay health workers in their work in the neighbourhood and their work in the health centre to get more insight in the relationships between the women of the neighbourhood and the health workers. Also it has provided insight in the information provided by health workers, working in the neighbourhood.

The women involved in the study were women in the reproductive age, from 15 to 45 years old in the neighbourhood of Singcang, Bacolod City.

2.3 Interviews with key informants

To get insight in the Filipino situation regarding reproductive health policies and practices in the period 2000 - 2005 (research question 1), interviews have been held with three City Councillors, an officer of the Roman Catholic Dioces of Bacolod, staff of the Bacolod City Health Office and of the Bacolod Population Office, one of the deans of St. La Salle University, an NGO and with neighbourhood health workers and neighbourhood officials.

As the different key informants come from different perspectives and have different opinions, it is important to approach their information with care. The information collected gives a taste of some of the views that are present within Bacolod society and the opinions presented are perceptions of reality and need to be read as such.

2.4 Focus groups

A focus group is a collection of a small number of people, between 4 and 12, that meets to discuss a topic of mutual interest, with assistance from a facilitator or moderator. Usually, the group members are ‘key informants’: they represent particular positions or interests. The discussions are informal and consist essentially of exchanges of views and opinions and the swapping of personal experiences (Gatrell, 2002).

According to Gatrell (2002) focus groups can serve as a way to give people a sense of ‘ownership’ in any research. It is also a good way to establish rapport in a local community and introduce the study to the people involved.

The focus group discussions were intended to collect and discuss an as broad as possible range of opinions, experiences and ideas of neighbourhood health workers regarding influencing factors and intervening factors on contraceptive behaviour. The focus groups were meant to give insight in possible answers to questions 2, 3 and 5. The findings of the literature study were presented to the focus groups to see whether the aspects found in the literature regarding reproductive health and contraceptive use are also relevant and important to the Filipino women.
For the invitation for the focus group discussions see appendix A. The outline for the focus group discussions is presented in appendix B.
Four focus group discussions have been held with seven neighbourhood health workers in each focus group. Most of them knew each other at least for some years, because they regularly meet at the neighbourhood health centre, when on duty. Moreover they have regular meetings with the public health nurse and public health midwife of the neighbourhood health centre.

The focus groups were conducted by the researcher together with one assistant, who wrote notes. The meetings were also taped. The questions were asked in English by the researcher and if necessary translated in Ilongo, the local language in Bacolod, by the assistant. The barangay health workers answered in English or Ilongo, whatever they felt most comfortable with. The tapes were transscripted by the assistant.
The results of the focus group discussions were used for input in the survey questionnaire and are described in chapter 6.

2.5 Survey

The survey questionnaire (see appendix D) was meant to provide possible answers to the research questions 2, 3, 4 and 5.

According to Parfitt (in Flowerdew & Martin, 1997) survey questionnaires are indispensable tools for research in Human Geography involving people, their behaviour, attitudes and opinions. At the same time questions regarding behaviour and attitudes may present difficulties because of susceptibility to biased responses, as respondents may want to give socially acceptable responses rather than their own opinions. For this reason some concepts have been formulated in different questions, so to be able to compare the answers given.
In this study, an analytic survey design has been adopted, so to be able to establish and explain relations and associations between variables (Parfitt in Flowerdew & Martin, 1997).

Validity and reliability

Two important issues to consider when working with quantitative survey techniques are validity and reliability. Validity means whether the survey measures what it intended to measure. Reliability is related to the replicability of the results of the survey. Good survey design helps to mimimize errors that may negatively influence the validity and reliability of the questionnaire data. (Parfitt in Flowerdew & Martin, 1997).
Here three kinds of errors are highlighted: sampling errors, non-response errors and response errors.
The sampling error occurs when there are chance differences between the sample and the population from which the sample has been derived. These appear to be more common in smaller samples (Parfitt in Flowerdew & Martin, 1997). In this study the sample, although relatively small, has been chosen from the communities, rather than from the women visiting the barangay health centre to minimize this error.
The non-response error occurs when the respondents differ significantly from non-respondents in key characteristics. Although there were only few refusals, it is possible that the non-respondents differ in some aspects from the respondents. The percentage refusals was highest in the age groups 20-24 years (18%) and 40-45 years (22%) and lowest in the age groups 30-

34 years (5%) and 35-39 years (7%). In general women were very willing to cooperate.
To reduce the non-response error as a result of non-contacts, a home/family has been visited up to three times, before the family was registered as a non-contact.
The response error is a distortion occurring during the process of interviewing. The questions asked may not be properly understood, or the respondent may be influenced by the presence of the interviewer or by the way the questions are formulated (Parfitt in Flowerdew & Martin, 1997). One of the methodological problems in conducting interviews is that the interview setting is invariably power-laden, in the sense that the respondent may feel in an inferior position relative to that of the interviewer, especially as the researcher/interviewer is a Westerner. The interview is a social relationship involving both the researcher and the researched and it is important to establish rapport, before asking intimate questions (Gatrell, 2002). Careful questionnaire design can minimize these errors.

Besides the results of the focus group discussions, the following sources have been used as input in the questionnaire used for the survey:
- Child Information Form from BACPAT Youth Development Foundation Inc. Bacolod
- Sample questionnaire (Hardon et al., 2001, annex 29.2, pp 258-259)
- Questionnaire Reproductive Health and Child spacing (Hutter et al., 1999, pp 209-221)

The English questionnaire was checked by several researchers and tutors in the Netherlands as well as in Bacolod. Moreover the questionnaire was presented to Filipino women to check the cultural relevance of the questions. The final English questionnaire was translated in Ilongo and this translation was checked by someone, fluent in Ilongo and English. The comments were discussed with the translator and also some of the questions were again discussed with the translator to make sure the translation was adequate. The second Ilongo version of the questionnaire was checked by a researcher at the Research Centre of the University of St. La Salle. This resulted in a pilot version of the Ilongo questionnaire.
This questionnaire has been tested with five Filipino women of reproductive age in a neighbourhood, close to the neighbourhood where the study took place. After this small pilot, the questionnaire has been finalized and printed.

2.6 Questionnaire-based interviews

After finalizing the questionnaire, four communities in the chosen neighbourhood have been randomly selected. The total population in these four communities is 4328 persons and there are 946 families living in these communities. All four communities were depressed areas, although there were slight differences between them.
The survey was conducted by face-to-face questionnaire based interviews. This provided the opportunity to establish rapport and get a feel of the surroundings, the social environment and the living conditions. The questionnaire was designed to be able to establish rapport before

asking the more intimate questions. Besides the questions were asked in Ilongo and could be answered in Ilongo to the assistants, so the respondents might feel free to talk.

Before the start of the interviews permission was obtained from the purok officials (of the communities involved) to conduct questionnaire based interviews with women in their purok.

The expected response rate was 70%, based on a survey in Japan regarding knowledge of and attitudes toward the pill (Kihara et al., 2001) were the response rate was 61% (39 % non-response includes non-contacts as well as refusals to participate) and on a survey in India regarding child spacing (Hutter et al., 1999) were a response rate of 78 % was reached. As it was expected that the women in the depressed areas of the study area would have more in common with the Indian women than with the Japanese, an expected response rate of 70% would be on the safe side.
In every community some 12 % of families were asked to participate in the survey. The families were again randomly selected by going to every fifth house in different allies of the communities. In case of a non-contact the house/family was visited up to three times, before the family was registered as a non-contact.

In the end 116 women of reproductive age participated in the survey. The overall response rate was 87,22 %. The average non-response of 12,78 % includes only refusals to participate. There were seven non-contacts (= 5,69%).

The following aspects were part of the survey questionnaire and seen as influencing factors on contraceptive behaviour:

- age of the respondent
- educational level of the respondent
- marital status of the respondent
- occupational status / economic activity of the respondent
- socio-economic status of the household as indicated by monthly income, status of house and lot, facilities available, number of assets and appliances
- family size / type of family or household: single household, co-residing family (two or more families sharing accommodation), nuclear family (living with or without additional family members), extended family
- place of birth of the respondent and time spend living in Bacolod
- religion of the respondent
- health status of the respondent and use of neighbourhood health centre services

The interviews were conducted by the researcher, together with four different assistants. Because of the language barrier, the assistants asked the questions in Ilongo and filled in the questionnaire. The researcher checked whether the questionnaires were filled in rightly and no questions were missed.

2.7 Analysis

Individual women of reproductive age (15-45 years of age) are the units of analysis. In the questionnaire the characteristics of the respondent's household have also been taken into account as the household is an important social unit in the Philippines and provides part of the context the respondent is living in. In the analysis the results from the questionnaire-based interviews have been compared with the literature and other (national) data and statistics.
The data from the questionnaire have been analysed with the software programme SPSS. In the paragraph regarding contraceptive knowledge (§ 7.3) nonparametric tests have been used to determine whether characteristics of respondents influence knowledge regarding contraception. In the paragraph regarding influencing factors on contraceptive behaviour (§ 7.4) the logistic regression is used to determine the interaction between the factors described and the effect on use of contraception.The regional results have been compared with the available national data.

As the sample was relatively small it is not possible to draw definite conclusions from the survey data. However, the data do give an indication of possible relations and associations between contraceptive behaviour and the other characteristics of the respondents.

Field close to Eroreco

One of the purok in Bacolod City

Houses and fisherboats of one of the purok

Chapter 3
Conceptual and theoretical framework

3.1 Approach

In this study the Structuration theory of Giddens is used as the theoretical framework. In this theory equal importance is placed on human agency (actions of individuals) and social structure. Within Structuration theory individuals are contextualised individuals; they act within a certain context. There is a clear role for the individual to respond to opportunities and constraints in their environment (Boyle et al., 1998).

The theory is concerned with structural factors influencing decision making of government and individuals, while at the same time these structural factors can be influenced and often will be reproduced by the decision making of government and individuals.

According to Giddens ”*patterns of human organisation are changeable by human agency and structure is actively produced and reproduced by reflexive human agents*” (Turner, 1986). In using the rules and resources of structure, human agents reproduce these very rules and resources. This is what Giddens called the “duality of structure” (Turner, 1986). These interactions between structure and human agency are ordered in space as well as time.

All human decision making takes place within a structural context. The stronger the relationships between a particular meaning system and the institutional context, the stronger their influence can be on individual behaviour. This applies especially when these relationships are enforced by laws, rules and constitutions (formal constraints) and reinforced by social pressure and sanctions. The reproductive choices available to an individual during the life-course are dependent on structural factors, e.g. state policy, the availability of family planning services and contraceptives, as well as influenced by cultural norms (Hutter, 1998).

Moreover reproductive behaviour, like contraceptive behaviour, is a cultural event, because individuals are formed by and part of different cultures. These cultures introduce them to and socialise them into the normative behaviour and responses of the structures described by Structuration theory.

However, individuals are not just passive agents, subject to external forces. Although individual behaviour is governed by laws, rules, norms and values, individuals themselves are also able to actively shape institutions and culture (Mc. Nicoll, 1994 in Hutter, 1998). Besides it is important to acknowledge that personal characteristics, such as beliefs, aspirations and obligations, never

provide a direct link to the likelihood of reproductive choices, but they do influence the decision making. Moreover, these characteristics themselves are also influenced by the context an individual is functioning in. That is why it is important to incorporate the context into the conceptual model.

The structuration theory can be applied to the process-context approach. According to the process-context approach, "*the reproductive health status of a woman at a given moment in time can be seen as the outcome of a process (which can be behavioural but also biological or chance) that involves a series of individual decisions and actions taking place within a social, economic, ecological, cultural context.*" (Hutter, 1998). Besides contemporary factors, also living conditions, health status, and reproductive behaviour in the past affect the present reproductive health behaviour. In the conceptual model individual decisions and the embedding context are seen from a dynamic perspective: over the life course and through time (Hutter, 1998; Hutter et al., 1999; idem, 2002). The life course can be defined as "*the sequence of events and experiences in a life from birth until death and the chain of personal states (infancy, childhood, adolescence and adulthood) and encountered situations which influence and are influenced by this sequence of events*" (Runyan, 1984 in Hutter, 1998). Contextual variables like economic and political circumstances, institutions and cultural meaning systems are not static, but change over time, thereby affecting individual decision making and individual behaviour. Contraceptive behaviour also changes over time and generations (Hutter, 1998). Younger women may think differently about contraception than their mothers did.

Following the life course perspective, every woman has her own reproductive career. Careers can be associated with each attribute or characteristic of a person that changes over the life time (Willekens, 1989 in Hutter, 1998) and are related to each other. The reproductive career of women is for example related to their educational career, their employment career, their marriage career, and so on.

3.2 Conceptual model

The process-context approach is adopted by the Population Research Centre at Groningen and worked out in detail by Willekens (1990, 1992) and De Bruijn (1992; 1993; 1998) (In: Hutter, 1998).

Figure 1 summarizes the factors included in the theoretical framework for the study of reproductive behaviour. Subsequently these separate factors related to reproductive behaviour are explained in more detail.

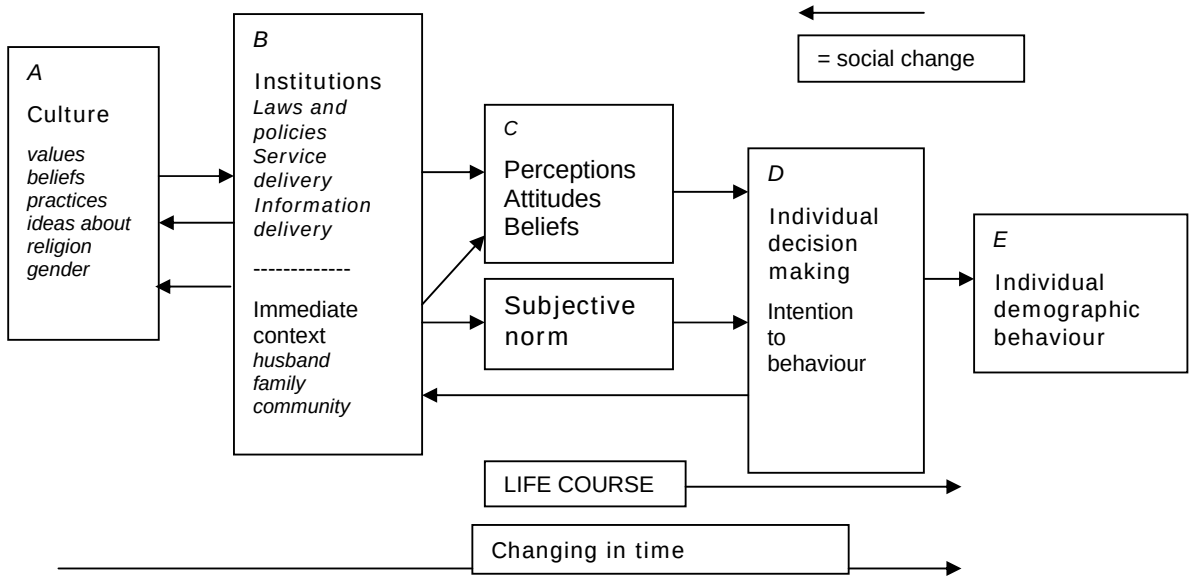


Figure 1: The process-context approach (adapted from Hutter et al., 1999; idem, 2002)

3.2.1 Culture (A)

Culture is an important influencing factor in how people deal with reproduction and contraception. In general culture helps people to integrate into the world through shared language and custom, behaviour and habits of thought (Tuan in Crang, 1998; see also Potter et al., 1999). According to Knox & Marston (2001) "*Culture is a shared set of meanings that are lived through the material and symbolic practices of everyday life. The "shared set of meanings" can include values, beliefs, practices, and ideas about religion, language, family, gender, sexuality and other important identities.*"

Cultures are constructed and reconstructed as a result of different influences and change over time and the influence hereof on perceptions and beliefs of women can be different for different generations of women.

People's perceptions of health and their quality of life as individuals and members of society are largely shaped by the prevailing values in a group or culture. As cultural representations of the human body, time, life, death and disease vary, so do people's approaches to action, prevention and treatment. Procreation, childbirth, sexuality, death, disease and suffering are not just private experiences but do all have a social dimension. The health conditions in which they take place are often determined as much by cultural practices as by biological and environmental factors (Nakajima & Mayor, 1996). Reproductive behaviour often expresses norms about appropriate social conduct, implicit views of the body, and orientations about life (Obermeyer, 2001). Reproductive health may also present special difficulties deriving from social and cultural factors such as taboos surrounding reproduction and sexuality, women's lack of decision-making power

related to sex and reproduction, low values placed on women's health, and negative or judgemental attitudes of family members and health-care providers (WHO, 2004). Moreover reproductive health and reproductive rights touch on matters that in many societies are inextricably bound up with morality, tradition, and cultural and religious values and may arouse strong feelings in many people (United Nations, 1998). The number of children a woman desires not only depends upon her personal circumstances, but also is largely conditioned by the socio-economic organization, cultural values, family system and gender relations in the society where she lives. Cultural and social norms may prevent partners to talk openly with each other about sexuality, contraception and so on, thereby putting them at risk of unwanted pregnancy (Jacobson, 2000).

3.2.1.1 Gender & women's status

Gender based hierarchies[7], where male control and authority are asserted in the family and in society, and the role and status of women crucially impact decision-making concerning every aspect of reproductive health (Castle et al., 2002; González Montes, 2001; Hutter et al., 1999). Women's sexuality is often repressed and discouraged, while men's is often encouraged and seen as an indicator of manhood. Gender ideas are translated into behaviour and values and women may face constraints because of inequitable gender and power relations that undermine their ability to negotiate reproductive decisions equally with their partners or to raise the topic at all (Achacoso-Sevilla, 2004; Jacobson, 2000; Santelli et al., 2003, Sethi & Carter, 1996; Tsui et al., 1997; UNFPA, 2004). In many countries the sexes are not treated equally in marriage and family relations. Women are regularly forced to seek the permission of spouses in order to undertake certain activities (United Nations, 1998). The relative low status of women within the family in many societies often limits the access of women to reproductive health care since it makes their wishes subordinate to the desires of their husbands or other male relatives. Such low status is reflected, e.g. in the existence of spousal consent requirements for the use of reproductive health services, particularly family planning services. In some countries, these requirements are mandated legally, while elsewhere they are dictated by tradition and custom (United Nations, 1998). As gender issues underlie every aspect of reproduction and sexuality, services need to take into account that women and men have different health needs and that they play very different roles within a sexual relationship (Sethi & Carter, 1996).

There is a close relationship between women's status and fertility. Women with access to education and employment tend to have fewer children because they do not need children to provide economic security and social recognition. In general, better educated women, women with income from their own jobs and women active in community organisations have more

[7] Gender is the different meanings and roles that societies and cultures assign to people based on whether a person is male or female (Sethi & Carter, 1996).

decision-making power within the marriage, including more influence over decisions about reproduction and family planning. More equality between men and women inside and outside the household is also believed to have a significant impact on reducing fertility (Knox & Marston, 2001; Achacoso-Sevilla, 2004; United Nations, 1998). Moreover, control over their fertility and the ability to contribute economically to the household may give women more confidence and decision-making power within the household (Achacoso-Sevilla, 2004; Singh et al., 2003). Women of all ages report that using contraception to time births and avoid unintended pregnancies improves their personal well-being and status in the household. Women mention that delayed childbearing and smaller families, achieved through contraceptive use, allow more leisure time as well as educational and economic opportunities (Singh et al., 2003).

In the Philippines, women enjoy relatively high social status relative to their counterparts in other Asian countries. However, the Philippines remain a male-dominated society, in the decision-making as well as in domestic spheres (Safe Motherhood Survey, 1993 in UNFPA, 2002). In 'macho' societies some men consider it a sign of virility and masculinity to have a large family and more children will assure parents of security in their old age (Garcia et al., 1984). The cultural belief that binds women to provide for their husbands' sexual need regardless of their own preferences diminishes their control over their fertility (Achacoso-Sevilla, 2004). A number of health studies have shown that 'women's problems' frequently receive a low priority and tend to be surrounded by a 'culture of silence' (Obermeyer, 2001).

3.2.1.2 Religion

Next to gender issues, religion can also have a considerable impact on people's beliefs and behaviour regarding contraception (United Nations, 1998). Some religions, for example Roman Catholicism, consider it a sin to interfere with normal conception and an additional child is seen as God-sent.

The Roman Catholic Church prohibits the use of modern contraception in any form. According to the Catechism of the Catholic Church *"every action which, whether in anticipation of the conjugal act, or in its accomplishment, or in the development of its natural consequences, proposes, whether as an end or as a means, to render procreation impossible is intrinsically evil.*" (Catholics for a Free Choice, 2004)

However, according to Ledesma (2002) the church is not against the principle of family planning. Neither is the church advocating large families. The Church does have objections to methods of birth control that are deemed as un-natural or artificial. The Second Plenary Council of the Philippines states: "*Christian parents must exercise responsible parenthood. While nurturing a generous attitude towards bringing new life into the world, they should strive to beget only those children whom they can raise up in a truly human and Christian way. Towards this end, they need to plan their families according to the moral norms taught by the Church*." (In: Ledesma, 2002). For this purpose the church organizes pre-marital catechesis involving

education on the duties and obligations of parents and rights and responsibilities of husband and wife according to the new Family Code of the Philippines. To correct the (according to the church) wrong notions presented by the Department of Social Services and Development, the City Health Office, and the Population Commission regarding contraception, natural family planning seminars are given by the church (Diocese of Bacolod, 2005).

Flowing from the examples mentioned above, cultural norms constrain the range of socially acceptable reproductive choices and a variety of socio-economic and cultural factors shape the individual's reproductive aspirations and behaviour (Hutter, 1998; Livi-Bacci, 2001; United Nations, 1998;). As contraception is bound up with sexuality, it is subject to the same cultural, moral and religious influences, and therefore has political as well as personal dimensions (Schwartz & Gabelnick 2002).

3.2.2 Institutions (B)

Institutions are '*clusters of behavioural rules governing human actions and relationships in recurrent situations*' shared by a group of people. To (public) violations of these rules is responded with sanctions, either by an external authority or self-imposed. Social pressures and social control ensure individuals adhere to the rules. Laws, rules, constitutions are formal rules and norms and codes of conduct are seen as informal rules (Mc Nicoll, 1994 in Hutter, 1998). North (1994) defines institutions as "*humanly devised constraints that structure human interaction*" (In: Hutter, 1998).

Norms refer to the perceptions of social pressure put on a person to perform or not to perform certain behaviour (Ajzen & Fishbein, 1980 in Hutter, 1998). From the context in which they live, whether the ecological and economic context, the social context and/or the cultural context, people derive incomplete information on which they decide and act. The way in which significant others influence the behaviour of individuals is captured in the subjective norm (see § 3.2.3) (Hutter, 1998). According to Hutter (1998) the status of an individual and her or his relationships with other people vary over the life course, and are defined within society and reinforced by norms and rules.

Economic modernization, urbanization and mass communications are having a substantial impact on the expectations and behaviours of (young) people. Nevertheless, women are still subject to many constraints flowing from long-held beliefs and traditions regarding marriage and sexual relationships, often being reinforced by the laws, policies and practices of their societies' most powerful – religious, cultural or governmental –institutions (The Alan Guttmacher Institute, 1998). According to Jones et al. (1989) three institutional factors, relating to family planning and influencing reproductive behaviour, can be discerned: laws and policies, service delivery and information delivery (In: Den Draak, 1998).

3.2.2.1 Laws and policies

Government policies are based on a complex political interplay of social forces (González Montes, 2001). As one of the signatories of the 1994's ICPD Plan for Action the Philippine government is obliged to implement policies regarding the provision of high-quality services for family planning and the promotion of sexual health (WHO, 2004). As a result the reproductive health programs in the Philippines are facilitated by government interventions, while leaving the ultimate responsibility for reproductive health with Filipino men and women, who still can choose whether to participate in a certain program or not.

This is called 'engineering' (Boyle et al., 1998). In this case the Philippine government is concerned with social engineering. Social engineering is concerned with government interventions based on social motives. Engineering is an example of structure influencing human agency according to the Structuration Theory by Giddens (see § 3.1).

One of the government interventions are educational programmes regarding reproductive health. Education about contraception, the process of acquiring information and forming attitudes in order to make informed choices about contraceptive behaviour, intends to reduce the risks of unwanted or unplanned pregnancies and to enhance the quality of sexual life, relationships and well-being in general (Tountas et al., 2004). However, the introduction of these programs for adolescents calls forth strong religious or political opposition, because of fear that these programmes will encourage sexual activity among young people. This in spite of research indicating that sexuality education does not encourage young people to engage in sex; most studies show that education about reproductive and sexual health is associated with the postponement of the first sexual experience and with the use of contraceptives among those who are sexually active (The Alan Guttmacher Institute, 1998).

Another government intervention is the provision of family planning programmes. Family planning regulations can also include authorizing the age of marriage; offering incentives to couples who have a limited number of children and mandating disincentives to couples who have larger families. In India, family planning policies offering free contraceptives and family planning counselling have also had the impact of lowering the birth rate (Knox & Marston, 2001). Many governments and donors traditionally created family planning programmes, isolated from efforts to change the cultural and economic conditions that contribute to the subordination of women and keep birth rates high (Jacobson, 2000). However, important success factors for decreasing population growth seem to be establishing greater access to social resources such as health care and education, particular for women and empowering people, especially women, to make informed choices (Knox & Marston, 2001).

3.2.2.2 Service delivery

Services need to provide contraceptive choices, suitable to clients' needs and in harmony with clients' belief systems. Needs and relationships of individuals change over time, so one method cannot satisfy an individual's needs throughout the reproductive period (Sethi & Carter, 1996;

Schwartz & Gabelnick, 2002; United Nations, 1998). Quality care, including counseling with an emphasis on sensitivity, privacy, confidentiality and informed choice, follow-up and good interaction with providers can increase demand for services and prevent method discontinuation (Albsoul-Younes et al., 2003; UNFPA, 2004; United Nations, 1998). Better treatment makes a difference, especially to poor women. While service quality affected contraceptive adoption for all women, it was far more important as a determinant for continued use among poor and uneducated women (UNFPA, 2004). Also power disparities between patients and reproductive health service providers may shape contraceptive choices and behaviours (Santelli et al., 2003).

In many countries, inadequate human resources are a major barrier to the expansion of reproductive and sexual health services. Where reproductive and sexual health services exist, there are different barriers – social, economic, and cultural - preventing people to benefit from these services (WHO, 2004). There are many different reasons for lack of access, for example poor distribution systems; lack of proper health centres and personnel to dispense contraceptives, distance from services, lack of transport, cost of services and discriminatory treatment of users and lack of government commitment and funding (Herrin, 2003; Jacobson, 2000; Petchesky, 2000; Schwartz & Gabelnick, 2002; United Nations, 1998; WHO, 2004). Many countries are assessing means of charging for services, given shortfalls in government and donor funding for reproductive health (UNFPA, 2004). With the increasing feminisation of poverty, however, greater reliance of the health care system on out-of-pocket payments reduce access of poor women to health services (Lakshminarayanan, 2003). Also prices for commercial contraceptives are high in the Philippines compared to other Asian countries (POPCOM, 2000).

The ability of women and men to fully exercise their reproductive rights, to negotiate decisions about whether and when to have children, and to enjoy high levels of reproductive health is not just a function of reproductive health programmes, or of access to services only, but is also strongly dependent on the social environment in which people live. Reproductive health and behaviour depends largely on the conditions in which people live, and on the tools - such as information and health services - that are at their disposal (Jacobson, 2000; The Alan Guttmacher Institute, 1998). According to Jacobson (2000) health programmes often reflect, replicate and reinforce the social climate in which they exist.

3.2.2.3 Information delivery

Information is an important tool for decision-making. For a variety of reasons, couples are not able to meet their fertility goals. These may include lack of or incorrect information on the types, costs, availability and side effects of family planning services. To be offered real choices regarding reproductive health, people must be empowered with accurate and complete knowledge about all the methods and services available to choose. Misconceptions about issues block the way to informed choice (Herrin, 2003; Sethi & Carter, 1996; Hutter et al., 2002). Improving the level of education and access to family planning options do have a positive

impact on increasing the use of contraceptive methods and proper family planning (Albsoul-Younes et al., 2003).

The media is one of the tools that can be used to inform and reinforce norms. Mass media are a major source of ideas and information among people around the world. The values and lifestyles depicted in movies and on television have a powerful influence on the attitudes and behaviour of (young) people (The Alan Guttmacher Institute, 1998; United Nations, 1998). Also the media – television, music, magazines, movies and the internet – are important sex educators. Such information, however, is typically limited, sometimes erroneous and, often glamorised. Moreover, the media seldom have been concerned with the outcome of their ubiquitous sexual lessons (The Alan Guttmacher Institute, 1998; Brown and Keller, 2000). The clash between the media's depiction of sexual relations and the real-life experiences of youth contributes to their difficulties in making healthy sexual decisions (Brown and Keller, 2000).

Popular culture and the modern media can easily mislead people but they can also be used to lead them to better health for themselves and their children (Maldonado & Belsey, 1996). According to the UNFPA, radio and television programmes dealing with family planning, adolescent health, HIV/AIDS prevention, and early pregnancy have become common in the Philippines (www.unfpa.org/asiapacific/rhealth.htm).

3.2.3 Immediate context

The immediate social context in which people live (the household, the family, the community) is assumed to play a crucial role in the decision making process of people (Hutter, 1998). Reproductive health and behaviour results from inter-personal relations and cannot be separated from the social dynamics of a couple, household or community (Castle et al., 2002; Petchesky, 2000). Although marital status and a woman's desire to have a child are important determinants, in some settings, the expectations of a woman's family or the norms in her community may have an even greater influence on whether a woman will practice contraception or not (The Alan Guttmacher Institute, 1998).

First we will focus on the role of the husband in the decision making process regarding contraceptive behaviour.

3.2.3.1 Husband

For a variety of reasons, couples are not able to meet their fertility goals. One of the reasons may well be gender inequities because husbands frequently prefer to have more children than their wives. Even if spouses agree on the ideal number of children, they do not need to agree on how to achieve this (e.g. modern contraception or traditional methods). One of the most important reasons cited for not using or for discontinuing the use of any contraceptive method is "husband's objection" (Achacoso-Sevilla, 2004; Catholics for a Free Choice, 2004; NDHS 1998; Tsui et al., 1997; United Nations, 1998). What stands out in recent studies is that men tend to be the ultimate decision-makers in sexual relations and childbearing decisions among most

couples, because of their greater access to resources and power (Achacoso-Sevilla, 2004; UNFPA, 2004). However, some men are reluctant to assume any responsibility for family planning, or for the consequences of sexual behaviour more generally (United Nations, 1998). Other studies also confirm husband's lack of support accounting for drop-outs in family planning programs. In situations of disagreement on fertility desires between Filipino husbands and wives, the husbands' preferences and views of contraception explain their wives' unmet need for family planning. Moreover, husbands of women with unmet need also tend to view contraception as socially unacceptable and potentially damaging to women's health. In contrast with women, men believe that the use of contraception poses more health hazards to women than pregnancies. Spousal disagreements over both the number of children and timing of pregnancy is often resolved with the husband's decision prevailing over that of his wife. It is presumed that wives submit to their husband's decision to preserve marital harmony, as part of a deeply ingrained cultural value and expectation of women or out of fear of violent reprisal, desertion, or accusations of infidelity (Achacoso-Sevilla, 2004; González Montes, 2001; United Nations, 1998).

In the Philippines and other developing countries, traditional values about women's sexuality (i.e. virginity and chastity) predominate. There is the belief that by virtue of marriage, a woman becomes her husband's possession and has the right to her body. Men view sexual nurturing as an entitlement, although this does not mean compliance at all times. For some women, poverty enables them to renegotiate their sexual obligation (Fabros et al., 1998 in Achacoso-Sevilla, 2004). Still on many occasions women give in to their husbands' desires. Maintaining harmony within the family is an important reason, in addition to rewards and other entitlements that the concession brings (Fabros et al., 1998 in Achacoso-Sevilla, 2004; The Alan Guttmacher Institute, 1998). A woman's sense of entitlement is continually being negotiated in a field of power relations. They seem "*to weigh the cost of refusing their husbands' sexual demands against what they may gain from giving in*" (Fabros et al., 1998 in Achacoso-Sevilla, 2004).

3.2.3.2 Family

In the world as a whole, probably a minority views a couple as the only decision maker in reproductive issues. The idea that only the preferences of a couple should count is a recent development even where it is now the dominant view. Reproductive decisions (including marriage) are mostly regarded as too important to leave to individual men and women, particularly young ones (Tsui et al., 1997). This means family relations can have a large impact on decision-making concerning sexual and reproductive behaviour (Castle et al., 2002). How the members of a family relate to one another and how they perceive themselves influences how they deal with the most intimate and personal areas of life, namely, sexuality, sexual relations and reproduction (United Nations, 1998).

For example, intergenerational differences in ideal family size may be more pronounced than differences between husband and wife. According to Tsui et al. (1997) family planning program managers in South Asia commonly believe that the chief opponents of small families are domineering mothers-in-law.

3.2.3.3 Community

Next to the wishes of her family, also the values of her community may influence a woman's contraceptive behaviour. Childbearing may be one way for a (young) woman to ensure the stability of her marriage and to acquire status within her community (The Alan Guttmacher Institute, 1998).

As individuals are always a part of a community, their decisions and behaviours are influenced by the members of this community. The community also shapes the kinds of services that are made available for issues like (reproductive) health care. The attitudes and actions on the community level can work to either facilitate or deny access to services and information on contraception (Sethi & Carter, 1996).

People in general will be motivated to conform to the social system and the immediate context, because of sanctions (external or self-imposed), social pressure (from partner, family, friends, religion, etc), social control and intrinsic motivation to conform (Den Draak and Hutter, 1996 in Den Draak, 1998).

The culture, institutions and the immediate context (household, family and community) of an individual all influence the perceptions, attitudes and beliefs of this individual.

3.2.4 Perceptions, attitudes, beliefs and subjective norm (C)

Factors associated with non-use of contraception include negative attitudes about contraceptive methods; increased perceived barriers to method use; perceived low support from partner, other kin and other community members; low self-efficacy; poor communication skills (Santelli et al., 2003). According to Casterline et al. (1997) the lack of strong fertility preferences and little perceived risk of conception as well as perceptions that contraceptive practice is socially and culturally unacceptable influence contraceptive decision making (In: Achacoso-Sevilla, 2004). These factors influence perceived behavioural control.

Perceived behavioural control describes whether women feel able to influence reproductive health choices. In this study perceived behavioural control refers to the ease or difficulty to use a contraceptive method in the eyes of the respondent. Perceived behavioural control is determined by beliefs, which may be based on past experiences, may be influenced by second hand information about the behaviour and/or by the experience of family and friends, and other factors (Ajzen, 1992 in Hutter, 1998). Beliefs come from feelings as well as knowledge. Feelings are difficult to modify, particularly when they are deeply rooted in cultural myths and beliefs (Maldonado & Belsey, 1996).

Attitudes[8] are being defined as the perceived or expected consequences of behaviour and the evaluation of these consequences (Fishbein and Ajzen, 1980 in Hutter et al., 2002; idem Hutter et al., 1999).

The individual subjective norm is formed by the influence of people in the direct social environment of a woman, like her partner, her family and family-in-law, and the people of the community she lives in (see § 3.2.3). The subjective norm is determined by perceived beliefs of important others and motivation to comply with these others (Hutter, 1998).

The perceptions, attitudes and beliefs regarding contraceptive behaviour of women may change during the life course of the woman. A woman that has just married could think differently about contraception than a woman who has been married for many years and has given birth to one or more children.

3.2.5 Individual decision making & intention to behaviour (D)

Contraceptive behaviour may well be the result of multiple, interwoven social and economic influences rather than a product of an individual's intentions (Santelli et al., 2003). Intention[9] is determined by two factors, namely the attitude towards certain behaviour and the subjective norm (Ajzen & Fishbein, 1980 in Den Draak, 1998). The decision making processes of the women involved are seen in the political, economic, social and cultural context in which women live. The women involved make their decisions based on their perceptions and beliefs, as well as on the subjective norm (see § 3.2.4). In this study the constraints and facilitating factors as well as the influence of the direct social environment (subjective norm) on the contraceptive behaviour of the respondents are studied.

3.2.6 Individual demographic behaviour

Individual demographic behaviour, flowing from this individual decision making process, is influenced by all the above mentioned factors. Contraceptive behaviour is part of this individual demographic behaviour and also viewed as outcome of a decision making process.

For explaining the individual demographic behaviour the behavioural model of Fishbein and Ajzen (1980) will be used. Applied to the subject of this study, contraceptive behaviour is determined by the intention to use or not to use contraceptives, which in turn is determined by attitudes of respondents towards contraception in general and towards the different available methods, the subjective norm (see § 3.2.4) and perceived behavioural control (see § 3.2.4) (Fishbein and Ajzen, 1980; Ajzen 1991 and Bandura, 1986 in: Hutter et al., 1999). In the next paragraph these influences will be operationalised.

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[8] Attitudes refer to "*the organization of several beliefs around a specific object or situation*" (Rokeach, 1973 in Hutter, 1998)

3.3 Operationalisation

In demography, differences in behaviour of a group of individuals are 'explained' by differences in background characteristics of these individuals. Socio-demographic and sexual behaviour factors that are known in the literature to influence attitudes towards, and practice of contraception, are age, educational level, residency, relationship status, experience of unintended pregnancies that were terminated, and sources of information (Tountas et al., 2004).

Questions asked regarding background characteristics of the respondents were:

- What is the place of birth of the respondent(rural/semi-urban/urban)?
- How long has she been living in Bacolod?
- What is the age and the civil status of the respondent?
- What is the highest educational attainment of the respondent?
- What is the monthly income of the different household members of the respondent?

3.3.1 The cultural meaning system

The cultural meaning system of the individual women was operationalized in three areas, family system, women's status and religion.

3.3.1.1 Family system

The family system may influence contraceptive behaviour of women as a woman in a household may have little privacy to be able to use contraception. According to the definition used in the National Demographic and Health Survey 2003 the household refers to "*a person or group of persons who usually sleep in the same housing unit and have a common arrangement for the preparation and consumption of food*" (NSO, 2004). In this study a distinction is made between a nuclear and an extended household. A nuclear household is being defined as "a single person or a couple with or without children living together with each other, sharing a residence without other persons participating in the household".

An extended household is being defined as "a single person or a couple with or without children living together with each other, sharing a residence with one or more other relatives or in other ways related person(s)".

To determine the status of the household the following questions were asked:

- Who are the members of your household and what is their gender, age, civil status and highest educational attainment and status within the household?

3.3.1.2 *Status of women in society*

Commonly used proxies for status of women are female education and labour force participation (Hutter et al., 1999) but it can also be assessed by their health status and their access to resources and opportunities referring to economic assets and political participation

[9] Intentions are "*indications of how hard people are willing to try, of how much of an effort they are planning to exert, in order to perform the behaviour*" (Ajzen, 1991 in Den Draak, 1998, pp 24/25).

(UNFPA, 2004). Women's status is assumed positively correlated with the number of family decisions women are involved in (NSO, 2004).

To operationalize the above, respondents were asked the following questions:

- What is the highest educational attainment of the respondent?
- Who makes the decisions in the household regarding household expenditures, education of the respondent and the children, seeking health care and family planning? (Does the resppondent have the final say, jointly with another person or by herself)
- Who in the opinion of the respondent should be responsible for taking care of the family expenses?
- Does the respondent engage in work/livelihood activities and if so, what is her work status? Does the respondent have her own income and is she able to keep her own salary and/or have a say in how to spend the money?
- On a scale of one – five with one as very poor and five as very good, how does the respondent assess her own health status?
- Does the respondent participate in a community organisation or organised group, like a women's group?

3.3.1.3 Religion

From the literature it appears that religion can be a major stumbling block for contraceptive behaviour. In the questionnaire the following questions were asked:

- What is the religion of the respondent? On a scale of one to five with one as not important and five as very important, how important is religious belief and practice in her daily life?
- How does the respondent think her pastor/priest will respond to her using a contraceptive method? On a scale of one to five, with one as not important and five as very important, how important is it for the respondent that they would agree if she decided to use a contraceptive method?

3.3.2 Institutions

3.3.2.1 Service delivery

To assess the service delivery and access of the Barangay Health Centre as perceived by the respondent, the following questions were asked:

- In the past year how often has the respondent visited the barangay health centre? Which BHC-services has she availed off?
- On a scale of one – five with one as very difficult and five as very easy, how easy is it for her to make time to visit the Barangay Health Centre?
- On a scale of one – five with one as very difficult and five as very easy, how easy is it for her to go to the Barangay Health Centre? (transport)?
- In the past year how often has the respondent been visited by the barangay health worker at her home?
- How does the respondent think her health care providers will respond to her using a contraceptive method? On a scale of one to five, with one as not important and five as very important, how important is it for the respondent that they would agree if she decided to use a contraceptive method?

To assess access and availability of contraceptive methods respondents were asked the following questions:

- If the respondent decided she wanted to use a contraceptive method, would she know where to get it? On a scale of one – five with one as very difficult and five as very easy, how easy would it be for her to go there and get it, if she decided she wanted to use a contraceptive method?

- On a scale of one – five with one as very difficult and five as very easy, how easy would it be for the respondent to pay the cost if she decided she wanted to use a contraceptive method?

3.3.2.2 Information delivery

To assess the knowledge and perceptions of respondents regarding contraceptive methods, respondents were asked whether they knew of a contraceptive (family planning) method and if so which methods they knew. After this open ended question, the following questions were asked:

- Which of the following contraceptive methods has the respondent heard about? (the different contraceptive methods that were not mentioned by the respondent are mentioned to her (see 3.4)). How did she hear about the different contraceptive methods?
- Which of the following contraceptive methods does she think are effective in preventing a pregnancy, convenient to use, safe (health wise) to use and effective in preventing infection with sexually transmitted diseases and HIV/AIDS?

To assess the influence of the media on the lives of the respondents, the respondents were asked:

- How often does she spend time listening to the radio, watching television and/or reading a newspaper or a magazine?

3.3.3 Immediate context

In order to be able to estimate the influence of important people in the immediate environment of the respondent (= subjective norm) on her contraceptive behaviour, questions were asked how – according to the respondent – these people would think regarding contraceptive use of the respondent. The immediate social context being operationalized in husband, family (parents, mother, family-in-law) and community (friends/colleagues and neighbours).

3.3.3.1 Husband

- What, in the opinion of the respondent, does her partner/husband think would be the ideal family size for her?
- Subjective norm: How does the respondent think her partner/husband will respond to her using a contraceptive method? On a scale of one to five, with one as not important and five as very important, how important is it for the respondent that he would agree if she decided to use a contraceptive method?

3.3.3.2 Family

- What, in the opinion of the respondent, do her parents think would be the ideal family size for her?
- Subjective norm: How does the respondent think her mother will respond to her using a contraceptive method? On a scale of one to five, with one as not important and five as very important, how important is it for the respondent that she would agree if she decided to use a contraceptive method?
- What, in the opinion of the respondent, does her family-in-law think would be the ideal family size for her?
- Subjective norm: How does the respondent think her family-in-law will respond to her using a contraceptive method? On a scale of one to five, with one as not important and five as very important, how important is it for the respondent that they would agree if she decided to use a contraceptive method?

3.3.3.3 Community

- How does the respondent think her friend, colleagues and neighbours will respond to her using a contraceptive method? On a scale of one to five, with one as not important and five as very important,

how important is it for the respondent that they would agree if she decided to use a contraceptive method?

3.3.4 Perceptions and attitudes

The ideal family size or the desired number of (additional) children as well as the ideal (desired) sex composition of children also influences a woman's decision to practice contraception (Hutter et al., 1999). Contraceptive behaviour is determined, among others, by underlying perceptions and beliefs regarding fertility and child bearing. These perceptions have been operationalized by asking:

- Would the respondent like to have any (more) children?
- Does the respondent think it is up to herself to decide whether to have children and how many children to have?
- What is, according to the respondent, the ideal number of children?
- What is her ideal / preferred sex composition of her children?
- In her opinion in what circumstances would the use of contraception be appropriate?

Attitudes were measured by asking whether (some kind of) contraception would be acceptable to the respondent.

- Under what circumstances / in what situation would she want to use contraception?
- If she decided she wants to influence her childbearing, what would she use ….
  (any method, only artificial methods, only natural methods, no method)

3.3.5 Intention to behaviour

The intentions of the respondent were measured by asking:

- Has the respondent ever considered using a contraceptive method? If not, why not?

3.3.6 Individual demographic behaviour

To measure the actual contraceptive behaviour of respondents, the following questions were asked:

- Did the respondent ever use contraception? If so, which method did she use?
- What were the reasons for her using contraceptive?
- Does she currently use contraception?
- If she ever stopped using a contraceptive method, what made her decide to stop using it?

3.4 Contraceptive methods

There are different kinds of contraceptive methods with varying degrees of effectiveness. The modern permanent methods are the most effective (99.9%), followed by the modern temporal methods with an effectiveness between 98 and 99.6 percent. Effectiveness of modern natural family planning methods is not without debate while the effectiveness of traditional natural methods is very limited. Although the Lactational Amenorrheic Method (LAM) for breastfeeding woman is regarded as an exception. According to the literature its effectiveness is 98 percent if the woman practicing the method meets the criteria (see appendix E). Below an overview is presented of the most well known contraceptive methods.

1. Modern temporal methods:
    a. Oral contraceptive (pill)
    b. Injectable (Depot Medroxy-Progesterone Acetate (DMPA))
    c. Intrauterine device: IUD (Copper T)
    d. Condom
    e. Vaginal barrier methods (diaphragm, cervical cap and spermicides)
2. Modern permanent methods
    a. Vasectomy (sterilization)
    b. Tubal ligation (sterilization)
3. Traditional natural family planning method
    a. Rhythm / calendar method
    b. Withdrawal
    c. Periodic abstinence
    d. Lactational Amenorrheic Method (LAM)
4. Modern natural family planning method
    a. Ovulation method
    b. Basal Body Temperature (BBT)
    c. Sympto-Thermal Method (STM)

For a detailed description of the different methods see appendix E. Modern methods today account for 90 % of contraceptive use worldwide. In particular, three female-oriented methods are most commonly used: female sterilization, intra-uterine devices and pills (UNFPA, 2004). Sterilization (male and female) accounts for nearly 40 % of world contraceptive use, however, female sterilization is much more common than male sterilization. Intrauterine devices (IUD's) account for about one fifth of contraceptive use worldwide. According to Albsoul-Younes et al. (2003) the IUD is the most widely used reversible birth control method in the world with an efficacy in an ideal situation comparable to that provided by female sterilization. Globally, 8 percent of contraceptive users use condoms.

In this study modern natural family planning methods are left out of the analysis, because hardly any respondents had heard about these methods. The same applies to vaginal barrier methods, like diaphragm, cervical cap and spermicides.

3.5 Glossary

Barangay: neighbourhood/village, the smallest political unit in the Philippines
Purok: community, subdivision within a barangay

In the next chapter the Filipino context regarding reproductive health and contraception will be presented.

Houses of Couples for Christ close to the seaside donated to poor families in the purok

Water pump in one of the purok

Chapter 4
Reproductive Health in the Philippines

As mentioned in chapter 1, the reproductive health approach is one of the tools to stimulate a decreasing fertility as people become more aware of the health issues involved with reproductive choices. Government policies can help to facilitate this process. The existence of national political will and leadership to provide the resources needed to deliver reproductive health services is critical to this (Yazbeck, 2004). Moreover, the use or non-use of contraception has been an important aspect of population policies in the last two decades.
In the next paragraph we will look at the national population policies in the Philippines, as part of the institutions mentioned in the process-context approach.

4.1 Population policies in the Philippines

In this paragraph the main issues regarding population policies and family planning programmes in the Philippines during the different administrations since the 80s will be highlighted. Political leadership has fluctuated in its commitment to reproductive health goals; consequently reproductive health has not been a consistent government priority (Lakshminarayanan, 2003).

During the Marcos administration (1967-1986), the negative consequences of rapid population growth on the attainment of social and economic objectives were emphasised. The family planning programme provided information and services as well as advocacy for a small family size norm (Herrin, 2003). In the early 1980s the family planning programme was severely criticized by the Catholic Church and eventually caused policy debates on the programme's emphasis on fertility reduction (commonly termed as "population control") and its selective push for certain contraceptives to meet demographic targets (PPMP Directional Plan 2001-2004).

Under the Aquino administration (1986-1992) the right of couples to determine the number of their children was emphasized. The 1987 Constitution states that: "*The State shall defend the right of spouses to found a family in accordance with their religious convictions and the*

demands of responsible parenthood[10]" (Article XV, section 3.1). (Herrin, 2003; UNFPA, 2002; see also State of the Philippine Population Report 2000, 2001 a.o. in UNFPA, 2002).

In 1988 the Philippine Family Planning Program (PFPP) became primarily a health intervention, promoting maternal and child health (Herrin, 2003) and emphasizing health reasons for the provision and use of family planning (PPMP Directional Plan 2001-2004).

During the Ramos administration (1992-1998), influenced by the 1994 International Conference on Population & Development, there was a policy shift from "population control" to "population management", although the awareness of the constraining effect of rapid population growth on socio-economic progress was still there (Herrin, 2003). A balance among population, resources and environment became the objective of the programme instead of fertility reduction (CPA, 1999 in UNFPA, 2002; NDHS 2003). The family planning programme became part of the promotion of Reproductive Health without strong governmental intervention.

In contrast the Estrada administration (1998-2001) emphasized the role of the government in assisting couples/parents to achieve their desired family size. As the Philippine Government was committed to implementing the Programme of Action of the International Conference on Population and Development (ICPD), in 1999 the following objectives of the Philippine Population Management Programme (PPMP) were adopted:

- to help couples achieve their fertility goals within the context of responsible parenthood (see also Herrin, 2003);
- to prevent teenage pregnancies and reduce incidence of early marriage;
- to reduce infant and maternal mortality and help improve the (reproductive) health of individuals;
- to contribute to achieving a balance between population distribution and economic activities

(PPMP Directional Plan 2001-2004; see also United Nations, 1999; UNFPA, 2002).

To raise public awareness about reproductive health, a nationwide multimedia campaign was launched, supported by the UNFPA. Although these efforts proved useful in raising awareness about reproductive health, according to the United Nations (1999) they had limited impact on changing attitudes and behaviour.

Presently, the Arroyo administration (2001-present) states the adverse consequences of continued rapid population growth and the need to reduce fertility. In practice, however, the implementation of the Population Program is delegated to the local government units (Administrative Order No. 158, 8 July 2004), who are expected to fund population management and Reproductive Health initiatives together with programs for poverty alleviation as well as

[10] Responsible parenthood is "*the will and ability to respond to the needs and aspirations of the family and the children*" (POPCOM, 2000).

taking responsibility for contraceptive provision at local level. Moreover, in the absence of national law and policy regarding standards of care and service delivery, many local government officials do not consider themselves obliged to follow the national Directional Plan (Austria, 2004). This undermines the accessibility and delivery of reproductive health services, especially family planning being controversial and thus susceptible to local pressures (Lakshminarayanan, 2003). Also a bias towards curative health investments, which is observed in both public and private expenditure patterns in the Philippines undermines reproductive health services that are largely preventive in nature (Lakshminarayanan, 2003).

Moreover Arroyo has articulated that although quality reproductive health services and information should be easily accessible and available to give clients informed choices, family planning technologies should be based on the social and cultural beliefs of the people being served. The consequence is that the Arroyo administration is now pushing strongly for natural family planning (Herrin, 2003; UNFPA, 2002; Achacoso-Sevilla, 2004). Several public statements have been made against modern family planning methods and this administration stated it would not make up for the impending funding deficit after the phase-out of USAID support for the provision of modern methods of contraception in 2004 (Jimenez, D.R. Interview with President Macapagal Arroyo in the Philippine Daily Inquirer d.d 7 July 2002, p 7). During the celebrations for International Women's Day in 2003, Arroyo announced that her administration was going to focus exclusively on natural family planning (Austria, 2004).

The anti-contraception position of the present government reflects the position of the conservative Catholic Church leadership (Austria, 2004). Conservative church interests seem to dominate state policy in the Philippines, merging state and church interests. Although both free expression of religion and choice of family planning method, based on grounds of conscience, are Constitutional rights in the Philippines (Austria, 2004), Herrin (2003) noted that the persistent and consistent opposition of the Catholic Church hierarchy is one of the most important factors influencing Philippine population policy making (see also Hugo, 2003).

In the PPMP Directional Plan 2001-2004 the focus has shifted to reducing or eliminating the unmet need[11]. Surveys indicate that, in developing countries and countries in transition, more than 120 million couples have an unmet need for safe and effective contraception despite their expressed desire to avoid or to space future pregnancies. The result is that every year about 80 million women have unintended or unwanted pregnancies, of which 45 million are terminated (WHO, 2004). Unmet need for family planning is higher among rural women, among women who have no education or have only reached elementary education. The policy includes helping couples to achieve their fertility goals. In the long-term, the PPMP envisions the Philippines

[11] Unmet need is the percentage of women, who do not want any more children or want to wait at least two years before having another child but are not using any contraceptive (NSO, 2004).

filled with "*well-planned, healthy, prosperous and happy families, responsible individuals, empowered communities, guided by the Divine Providence, living harmoniously and equitably in a sustainable environment*" (POPCOM, 2000).
The re-formulated policy framework emphasizes that people's capabilities, including the capability to have the desired number of children, have a direct link to the quality of life or well being of families and couples. In this framework, achieving one's fertility preferences is a critical part of quality of life and well-being.

In general population growth and family planning continue to be contentious issues in the Philippines. The lack of political support by the current administration for population management and reproductive health has translated into limited financial support for the population programmes and reproductive health programmes (UNFPA, 2002; see also United Nations, 1998).

To estimate the current situation regarding reproductive health in the Philippines we will look at some indicators of reproductive health.

4.2 Indicators of Reproductive Health

Different indicators regarding Reproductive health are mentioned in the literature. Below only these indicators that are directly related to fertility and family planning will be mentioned.

Total Fertility Rate
An important indicator of Reproductive Health is the Total Fertility Rate (TFR). The Total Fertility Rate is the average number of children a woman will have during her reproductive years. It gives a figure for the average number of children that would be born per woman if all women lived to the end of their childbearing years and bore children according to a given fertility rate at each age. This indicator shows the potential for population growth in the country. High rates will also place some limits on the labour force participation rates for women. Large numbers of children born to women indicate large family sizes that might limit the ability of the families to feed and educate their children. In general women in wealthier households have fewer children than women in poorer households (NSO, 2004). As table 4.1 shows poorer women have a higher TFR than women in the higher wealth index quintiles.

Table 4.1: Total Fertility Rates by wealth index quintile in the Philippines

TFR 2003 By wealth index quintile	**Lowest**	**Second**	**Middle**	**Fourth**	**Highest**	**Total**
Philippines	5.9	4.6	3.5	2.8	2.0	3.5
Western Visayas						4.0

Source: NSO, 2004

The difference between the poorest women (5.9) and the richest (2.0) is almost 4 children. In the Western Visayas the total TFR is 4.0 children, 0.5 higher than the national total TFR. Although the total fertility rate in the Philippines had declined from 4.8 births per women in 1980 to 3.5 births per women in 2003, it is still quite high (CIA Factbook, 2005; World Bank, 2001; see also NDHS, 2003). In the Netherlands, for example, the total fertility rate (TFR) is 1.9 child born per women on average (CIA Factbook, 2005). Also, the fertility decline in the Philippines has been slow compared to neighbouring countries, e.g. South Korea and Thailand. According to Herrin (2003) this could well be one of the reasons the Philippines lack the favourable age distribution these countries had, which contributed to their sustained economic growth and higher standards of living.

Teen pregnancy

Teen pregnancy is another indicator of reproductive health. Postponing the first birth contributes to overall fertility reduction. So the start of childbearing is an important fertility indicator. The percentage of women in the Philippines aged 15-19 years, who have begun childbearing, amounts to 8 percent (NSO, 2004, see also The Alan Guttmacher Institute, 1998). The percentage of the Total Fertility Rate attributed to births by women aged 15-19 years is 6 percent (www.prb.org). The median age at first birth among women age 25-49 is 23,2 years for the Philippines as compared with 22,9 years in the Western Visayas (NSO, 2004). As the start of childbearing is closely related to marriage in the Philippines, the age at first marriage is also an important indicator. A worldwide trend towards later marriage plays a key role in the fertility decline in many countries, because most births continue to occur within marriage (United Nations, 1998). The timing of a first union or marriage is strongly associated with a woman's educational attainment and early marriage among young women is universally associated with low levels of schooling (The Alan Guttmacher Institute, 1998; United Nations, 1998). In general, urban, better educated, and wealthier women marry later than other women. Especially women with no formal education and/or coming from the lowest wealth index quintile have a lower median age at first marriage of 18.9 and 19.5 respectively than their educated and wealthier peers (above 21.0 and 22.0 respectively) (NSO, 2004).

Contraceptive prevalence rate

The rising use of contraception is the main direct determinant of the fertility decline in developing countries (United Nations, 1998; Santelli et al., 2003). This transformation in contraceptive practice reflects the growing desire of couples and individuals to have smaller families and to choose when to have children. It also reflects the increasing availability of modern contraceptives and family planning services in developing countries (United Nations, 1998; UNFPA, 2004). For assessment of the progress of a national family planning programme, one of the most widely used indicators is the level of current use of contraception. The

contraceptive prevalence rate is defined as "*the proportion of married women age 15-49 who were using some method of family planning at the survey date*" (NSO, 2004). In developing countries worldwide 38 percent of women aged 15-49 use a modern reversible contraceptive method and 9 percent of women aged 15-49 are using a traditional contraceptive method – principally periodic abstinence and withdrawal – which do not require specialized advice or supplies, but which have relatively high failure rates (Singh et al., 2003).

Table 4.2: Percentage of married women 15-44 using modern and traditional methods, Philippines, 1973-2003

Year	1973	1983	1988	1993	1998	1999	2001	2003*
Modern methods	10.7	18.9	21.6	24.9	28.2	32.4	33.1	33.4
Traditional methods	6.7	13.1	14.5	15.1	18.3	16.9	16.4	15.5
Total	17.4	32.0	36.1	40.0	46.5	49.3	49.5	48.9

Sources: 1998 NDHS and Annual Family Planning Survey Reports (NSO) (in UNFPA, 2002)

* NSO, 2004

The CPR for modern methods has steadily increased from 2.9 per cent in 1968 (NDS, 1968) to 33.4 percent in 2003 (NSO, 2004; see table 4.2). According to the 2003 National Demographic and Health Survey (NDHS), in the Philippines the total contraceptive prevalence rate (CPR) for modern and traditional methods was 48.9 percent with 33.4 percent of the women using modern methods. The most popular modern methods are the pill (13%) and female sterilization (11%). The traditional methods withdrawal (8%) and periodic abstinence (7%) are also quite popular (See also www.prb.org).

In the Western Visayas the contraceptive prevalence rate was 46.1 percent with 30.1 percent using modern methods. Also here the pill (14.6%) was the most popular method, followed by the traditional natural methods calendar/rhythm/periodic abstinence (10.2%) (NSO, 2004).

Table 4.3: Contraceptive Prevalence Rates by wealth index quintile in the Philippines

CPR 2003 By wealth index quintile	**Lowest**	**Second**	**Middle**	**Fourth**	**Highest**	**Total**
Philippines	37.4%	48.8%	52.7%	54.4%	50.6%	48.9%

Source: NSO, 2004

Among the findings of the 2003 NDHS are the substantial differences in the overall levels of contraceptive use between poor and non-poor women in the Philippines (see table 4.3). Of the poorest women 37.4 percent use contraception, while 50.6 percent of the wealthiest women is user. Overall, improvements in CPR in the Philippines after more than three decades are much smaller than those of Southeast Asian neighbours such as Malaysia, Indonesia and Thailand (UNFPA, 2002).

According to the United Nations (1999) these data indicate a large unmet need for family planning and point to the gap between motivation to control fertility and the actual use of contraception (see also United Nations, 1998; Achacoso-Sevilla, 2004). Possible reasons for unmet need are a growing demand for contraception, service delivery constraints, lack of support from communities and spouses, misinformation, financial costs and transportation restrictions (UNFPA, 2004). Most married couples still do not use any method of contraception. Besides, the government still excludes single and unmarried women and adolescents from family planning services (Austria, 2004). Among users of modern methods, almost 40 percent discontinue contraceptive use within one year from starting. Moreover male participation in family planning practice is low and has received inadequate attention. Nowadays NGO's are actively promoting male support for women's empowerment and rights with respect tot reproductive health (UNFPA, 2004).

Desired fertility

The demand for children is commonly measured by reference to the average desired family size (Hutter, 1998). The term 'unwanted' fertility refers to a pregnancy or birth to a woman who reports that she did not want any more children; 'mistimed' for a pregnancy or birth to woman who wants more children, but not in the near future, and 'unintended' to cover both (Tsui et al., 1997). Women are most at risk of unwanted births in countries where contraceptive use is in the range 20-40 percent, like in the Philippines, presumably because contraceptive behaviour and fertility are lagging behind the more rapid change in fertility preferences (Tsui et al., 1997).
According to the NDHS 2003 the actual Total Fertility Rate (TFR) of 3.5 is higher than the desired TFR of 2.5, indicating a mean difference of one child between actual and desired fertility. In the Western Visayas this gap is even wider, with an actual TFR of 4.0 and a desired TFR of 2.7 (NSO, 2004). This implies that many women are not able to achieve their desired fertility. In general poorer women and those with less education are more likely to have higher ideal family sizes than their respective counterparts. Although these marginalised families have tremendous difficulty in making ends meet, they often have bigger families, resulting in a lower resource allocation per family member (Achacoso-Sevilla, 2004).
Husbands also have fertility preferences (see Tsui et al., 1997). Studies have found that husbands generally prefer higher fertility than their wives (Achacoso-Sevilla, 2004). The majority of women (67%) report consensus with their husbands regarding the desired family size. However 22 percent of women believe their husbands prefer to have more children than they themselves, while 7 percent think their husbands prefer to have fewer children than they themselves (4% don't know/missing) (NSO, 2004).
More than half (56.4%) of the currently married women with two children indicated not wanting any more children. In the Western Visayas this percentage is 65.4 .
Twenty-four percent of the births in the five years preceding the National Demographic and

Health Survey 2003 were wanted, but at a later time and twenty percent were not wanted at all (NSO, 2004).

Nearly 18 percent of Filipino women have unmet need for family planning, either because they want to adequately space their next child (7.9%) or because they want no more children (9.4%) (NSO, 2004). However, they are not using contraception to achieve their desired fertility. This number would be significantly larger if it would include those couples practicing traditional, non-effective family planning methods (Austria, 2004; see also The Alan Guttmacher Institute, 1998). The percentage of unmet need has slightly decreased since 2000 when unmet need was nearly 20 percent (State of the Philippine Population Report 2000, 2001 in UNFPA, 2002; see also Achacoso-Sevilla, 2004)

Unmet need declines with increasing educational attainment and rising affluence, indicating that these women have been more successful at implementing their fertility preferences. Moreover as the decision making power of a woman increases, the more likely she will be able to achieve her fertility preferences and the less likely she is to have an unmet need for family planning (NSO, 2004; United Nations, 1998; Nakajima, 1995; Achacoso-Sevilla, 2004).

Abortion

Partly as a result of the unmet need for contraception, many abortions are performed worldwide (United Nations, 1998). Unsafe abortion practices are a considerable threat to the reproductive health of women. Abortion is illegal and considered morally wrong in the Philippines (UNFPA, 2002). In the Philippines a woman can only legally have an abortion to save her life or preserve her physical health (The Alan Guttmacher Institute, 1998). However, 17% of the Catholics in the Philippines say abortion is not wrong if a fetus has serious defects or if a family has a very low income (Catholics for a Free Choice, 2004).

Indirect estimates of the number of induced abortions, based on the number of post-abortion cases hospitalized, indicate a rate of about 25 abortions per 1000 women aged 15-44 years (United Nations, 1999). Estimates based only on hospital records show that about 400,000 abortions are performed annually in the country (UNFPA, 2002; Perez et. al. 1997). Women who have had an abortion come from all sectors of the population and all ages but more of them were within the ages 20-29. Induced abortion is relatively common among women with low status whose self awareness does not permit their basic entitlement such as the right to determine when to have children. A large proportion of pregnancy termination was performed illegally by service providers under conditions of secrecy, inadequate preparation and practically without any training. As the prevailing culture prescribes women to accept their suffering in silence, the victims of abortion bear the burdens of physical pain, emotional trauma and personal violation. Yet these burdens arise from abuses of women's reproductive and sexual roles such as those associated with forced sexual encounters, unwanted pregnancies and threatened break-off in relations (CPA, UNFPA 1999 in: PPMP Directional Plan 2001-2004).

4.3 Factors influencing reproductive behaviour

Background

One of the factors influencing fertility is whether women come from a rural or an urban background. In general the residential background of women has an impact on how their lives look like. There is an effect on education and employment as well, but the differences are not as pronounced as expected.

Table 4.4: Educational attainment of women ages 15-49 by background characteristic

Background characteristic	No education	Elementary education	High school	College or higher
Urban	0.6%	15.7%	44.9%	38.8%
Rural	2.4%	33.2%	44.7%	19.7%
Western Visayas	1.8%	27.0%	44.0%	27.2%
Total	1.4%	23.1%	44.8%	30.7%

Source: NSO, 2004

Although rural women are as likely as urban women to have reached secondary education, they are less likely to continue to college or higher levels of education (NSO, 2004; see table 4.4). For the Western Visayas the percentage of women reaching higher education (27.2%) is larger than this percentage for rural women (19.7%), but lower than this percentage for urban women (38.8%) (NSO, 2004). The same data also show higher enrolment rates among girls in urban (87.9%) than in rural areas (83.2%) for primary education as well as secondary education (54.9% for urban girls and 52.8% for rural girls) (NSO, 2004; Achacoso-Sevilla, 2004). Regarding employment 43.3 percent of rural women were employed in 2003 and this applies to 47.2 percent of urban women (NSO, 2004).

Table 4.5: Total Fertility Rate and Contraceptive Prevalence Rate by background characteristic

Background characteristic	TFR	CPR
Urban	3.0	50.1%
Rural	4.3	47.4%

Source: NSO, 2004

The difference between the total fertility rate of rural (4.3) and urban women (3.0) is 1.3 children. Also the percentage of rural women using contraception (47.4%) is slightly lower than that of their urban counterparts (50.1%) (see table 4.5).

Education

One of the factors influencing fertility is the education level of women. Education is widely acknowledged as the key basis for informed decision-making on matters of sexuality and

reproduction. Schooling provides literacy skills, stimulates cognitive development, promotes change in values and opens up economic opportunities (United Nations, 1998). According to Knox & Marston (2001) access to education and employment for women means in general that women tend to have fewer children, because they do not need children to provide economic security (see also McKinney & Schoch, 2003; idem Sethi & Carter, 1996; United Nations, 1998).

Table 4.6: Total Fertility Rate and Contraceptive Prevalence Rate by educational attainment

Educational attainment	TFR	CPR
No education	5.3	18.1%
Elementary education	5.0	44.0%
High school	3.5	51.9%
College or higher	2.7	51.4%

Source: NSO, 2004

The fertility rate of women with college or higher education is substantially lower (2.7) than that of women with no (formal) education (5.3) (NSO, 2004; see table 4.6). Educated women are better able to achieve their desired fertility. First, because knowledge of contraception among educated respondents is significantly higher than among respondents who have not attended formal education. Second, because use of contraceptive methods is consistently higher among better educated women than among those with less education. Education enables women to be more proactive in addressing their reproductive health and economic well-being (NSO, 2004; see also The Alan Guttmacher Institute, 1998; idem United Nations, 1998).

In the Philippines, at least at the national level, the participation of women in education and employment seems to be quite high. The ratio of female to male enrolments in primary and secondary school, as a measure of promoting gender equality, is 103 % (World Bank, 2003). Across all background characteristics, women consistently have more years of schooling than men (NSO, 2004). Primary school enrolment in 2003 was 85.3 percent for females (compared to 81.0% for males). Secondary School enrolment in 2003 was 54.0 percent for females (compared to 43.9% for males)[12] (NSO, 2004). However, above mentioned percentages/rates are the national averages.

For the region of Western Visayas the percentage of primary school age population attending primary school in 2003 was 84.7 percent for females (compared to 79.0% for males) and 54.0 percent for females (compared to 40.5% for males) for secondary school. These are comparable to national averages (85.3% for females / 81.0% for males at primary school and 54.0% for females / 43.9% for males at secondary school) (NSO, 2004).

However, high enrolment rates (in elementary and secondary education) may mask low achievement scores and large regional and economic differentials in educational attainment.

[12] The percentages mentioned for primary school enrolment is the proportion of women/men ages 6-11 enrolled in primary school and regarding secondary school enrolment it is the proportion of women/men ages 12-17 enrolled in secondary school (NSO, 2004)

Low cohort survival rates[13] and low quality of schooling accompany the quantitative achievement of high enrolment rates. The low quality of schooling is reflected in the poor performance of students in standardized tests (Achacoso-Sevilla, 2004). During the period 1990 – 2001 on average 68 percent of elementary school pupils finished grade six and 73 percent of secondary school students finished high school. Children from the poorest income class often go to school at a later age and drop out sooner (Achacoso-Sevilla, 2004).

Employment

Employment for women means in general that women tend to have fewer children, partly because they do not need children for economic security and partly because they do not have time to raise children. As far as employment is concerned, in 2003 45.5 percent of the women ages 15-49 participated in the labour force on a national level. In the Western Visayas the percentage of women ages 15-49 employed in 2003 was slightly higher (49.9%) (NSO, 2004).

Women's status

Women's status is also generally considered to be an important factor affecting the use of contraception. The ICPD Programme of Action stated that "*improving the status of women also enhances their decision-making capacity at all levels in all spheres of life, especially in the area of sexuality and reproduction*" (UNFPA, 2004, p 29). The decision making power of women on sexuality and reproduction depends largely on the relationship between women and men and the status society ascribes to women. Women with a higher status have more freedom in making decisions regarding their sexuality and reproduction than those with a lower status (NSO, 2004). In the NDHS 2003 decision making power is estimated by the number of decisions in which a woman has a final say, either by herself or jointly with others. Issues concerned are the woman's own health care, large household expenses, daily household expenses, visiting family or relatives and what food is to be cooked each day. Of women without any autonomous decision making power, 59.5 percent is not using contraception and 10.5 percent is a user. At the other side more than 49 percent of the women who do have decision making power in several of the above mentioned areas are also using contraception. (NSO, 2004)

Religion

Fundamentalist religious movements pose particularly profound threats to women's health and rights (Jacobson, 2000). The Catholic Church regards the term reproductive health as abortion, sterilization and contraception (Tripon, 2001). This Church disapproves of the use of artificial contraceptives as morally wrong and accepts only natural family planning methods, herewith

[13] The cohort survival rate is "*the proportion of the cohort of school children at the beginning grade or year who reached the final grade or year at the end of the required number of years of study*" (Achacoso-Sevilla, 2004).

greatly reducing women's decision-making capacity over their fertility (Herrin, 2003, see also Lakshminarayanan, 2003 and Tripon, 2001).

4.4 Contraceptive behaviour in the Philippines

Knowledge of family planning

Knowledge of family planning methods and their sources are necessary preconditions to the use of contraception. In 2003 almost all women (97.9%) knew of one or more family planning methods (97.6% knows at least one modern method). Among married women this percentage amounted to 99.1 percent. In Western Visayas this percentage is 99.7 percent. The most well-known modern methods are pill and condom. The traditional methods calendar/rhythm, periodic abstinence and withdrawal are also well known methods. (NSO, 2004)

Contraceptive discontinuation rates

For a contraceptive method to be effective in preventing a pregnancy, continuous use is required. Reasons mentioned for discontinuation are contraceptive failure (23.5%), side effects (16.6%), desire to become pregnant (15.5%), health concerns (9.4%), inconvenience to use (4.4%), husband's disapproval (2.7%), lack of availability (2.6%) and cost (0.8%). High rates of discontinuation may indicate need of improvement in family planning counselling, follow-up care and accessibility of services. The percentage of contraceptive users, who discontinued use of a contraceptive method within 12 months after beginning its use is 39.1 percent, with 4 percent of them having a desire to become pregnant and 13 percent switching to another method (NSO, 2004).

Intentions for family planning use

In the Philippines 94 percent of the population said it is important 'to have the ability to control one's fertility or plan one's family' (Pulse Asia Poll of 1,200 respondents, reported in Philippine Daily Inquirer, March 16, 2001) (In:Catholics for a Free Choice, 2004).

Of the currently married women not using a contraceptive method, 55 percent does not intend to use a method in the future and almost 40 percent does intend to use, 5 percent is unsure about future use. Reasons most cited for intended non-use are: fertility related reasons (e.g. wanting as many children as possible, infrequent or no sexual relations, infecundity) (42.9%), health concerns (14.3%), fear of side effects (14.2%), respondent's opposition to use (8.8%), husband's opposition to use (3.7%) and religious prohibition (6.2%). Costs are mentioned by 1.8 percent and lack of access by 0.4 percent. (NSO, 2004; see also Achacoso-Sevilla, 2004).

Source of supply of contraception

According to the NDHS 2003 more than 67 percent of women currently using a modern method, obtain their contraceptive supplies and services from the public sector, 29.3 percent from the

private medical sector (including pharmacies) and 2.7 percent from other sources. Only for condoms, pharmacies are the most important source of supply. However, since 1998 there is a slight decrease in the use of the public sector for family planning services, from 72 percent in 1998 to 67 percent in 2003 (NSO, 2004).

Family planning messages in the media

According to the NDHS 2003 59 percent of women ages 15-49 have heard family planning messages on the radio and 64 percent has seen such messages on television. Between 30 and 40 percent of the women were reached by printed media on this subject. 20 percent of the women were not reached by any of the above mentioned media. As expected, women in urban areas are more likely to be exposed to this media information than women in rural areas. (NSO, 2004)

Exposure to family planning messages increases with education. Of women with higher education, 90 percent received a family planning messages via at least one of the above mentioned media compared with 29 percent of women with no formal education. Also poor women have less access to family planning messages from any media source, 43 percent of them was not reached by any media message regarding family planning (NSO, 2004).

In the Western Visayas the percentage of women exposed to the different media messages regarding family planning is lower for television (56.7%), and newspaper/magazine (31.6%). The percentage of women here who has received none of these messages is slightly higher (21.4%) compared to 20 percent nation-wide.

4.5 Family Planning Service in Bacolod City

Reproductive Health is one of the policy areas of the national Department of Health. The Department of Health (DOH) issues policies, guidelines, etc. on Reproductive Health which are delegated to local government units for implementation. So local policies do not differ from the national policies, although priorities may differ and policies might only be partly implemented. The City Health Office (the Local Government Unit responsible for public health) is responsible for the local implementation of the Reproductive Health policies, guidelines, etc. in Bacolod City.

Within the City Health Office, the chief of the Maternal and Child Health Division is responsible for the Reproductive Health and family planning programme. Besides there is a special coordinator Family Planning.

Goal

The goal of the family planning section is "*to provide married couples the information and means to space or limit pregnancies. One of the important goals of the programme is child survival and safe motherhood.*" (unpublished document City Health Office, 2005). As a result of

the strong relation between maternal care and family planning, many women do not visit the family planning consultation of the barangay health centre until their first pregnancy (see also Den Draak, 1998; idem Hutter, 1998 for a similar situations in Chile and India respectively).

Pre-marriage counseling

The City Health Office is also responsible for the pre-marriage counselling, an obligatory programme for every couple wanting to marry. The City Health Office offers this counselling and also the Church conducts pre-marriage seminars for couples. After having a counselling session with the Population Programme Officer or having attended a pre-marriage seminar at the Church, the couple will receive a certificate that enables them to apply for marriage (with the Government or the Church). The emphasis of the pre-marriage counselling is on responsible parenthood and proper child spacing to safeguard the health of mother and child. It is not meant as birth control. During the session at the City Health Office couples receive information on modern contraceptives as well as natural family planning methods and are supplied with materials about modern contraception on request. Before the counselling session the couple is asked to fill in a questionnaire, which enables the counsellor to see where the needs are and which aspects need special attention. The counsellor uses a picture book to show the different aspects of family planning. There are pictures of reproductive organs, pictures of contraceptives, etc. There are brochures available in the Tagalog language about the pill, the IUD and sterilization (funded by USAID).

Barangay Health Centres

Within the city of Bacolod there are 61 barangays. Most barangays (community/neighbourhood) have a Barangay Health Centre. All the Barangay Health Centres offer in principle the same basic services. Every Barangay Health Centre has a nurse and/or a midwife. Every doctor of the City Health Office is assigned to one or more Barangay Health Centres and should at least once a week visit the Barangay Health Centre for consultation. All Barangay Health Centres should be able to supply women with the temporary contraceptive methods, like pills, IUD and DMPA. However, only married couples are approached regarding family planning. In addition, certain family planning methods are advised only to women of a certain age and parity. Moreover, there is a sort of gender bias, as the barangay health worker – being a woman – only advises women in the villages, and mostly not the men (see also Hutter et al., 2002 for a similar situation in India).

Over the years, many of the contraceptives have been donated by international agencies, like the United States Agency for International Development (USAID). However, in December 2005 supplies were running out in the Barangay Health Centre where the study took place. barangay health workers indicated the City Health Office would not provide new supplies for the Barangay Health Centres, as there was no national or local funding available for contraceptives and contraception is also no longer provided by foreign donors.

For sterilization women and men need to go to the Clinic at the City Health Office (or go to a (private) hospital).

The barangay health workers, working in the Barangay Health Centre, are assigned to one or more purok and are visiting the homes of families there. Their task is to assess health problems and to motivate families to participate in the different government health programmes, like family planning, to refer people to the Barangay Health Centre and to follow-up clients. The health worker is an intermediary between the patients/clients in the purok and the Barangay Health Centre. The services of the Barangay Health Centre and of the health workers are free of charge.

Activities of the Barangay Health Centre include mother's classes in the different purok. These are scheduled topical meetings, for example regarding family planning. Staff of the Barangay Health Centre educates the health workers about a certain topic and they take care of the further information dissemination into the community. For educating women the Barangay Health Centre has flyers on different topics available.

Service health centres

From observation it appeared the limited supply of contraceptive methods is not the only problem the family planning programme is facing. The quality of the health centre services leaves enough to be desired too. There are long waiting hours and the average consultation lasts only a few minutes and takes place in the presence of other women. Also the respect for clients in the interpersonal relationships is far from ideal. There is a lack of courtesy towards patients, scolding nurses and authoritarian relationships between health staff and clients. Because of this, women may not receive sufficient information regarding the different contraceptive methods and about side-effects of the different methods. This could explain the prevalence of discontinuation of contraceptive method.

In the next chapter the results of the interviews with key informants in Bacolod City will be presented.

Barangay Health Centre

Meeting of staff and barangay health workers in Barangay Health Centre

Chapter 5
Opinions on Reproductive Health in Bacolod City

Key informants interviewed

To get insight in the local situation regarding reproductive health policies and practices in the period 2000 – 2005 (research question 1), again part of the institutions mentioned in the process-context approach, interviews have been held with a number of key informants. The following persons have been interviewed:

- three City Councillors (5.1.1),
- two staff members of the Bacolod Population Office (5.1.1),
- six officials of the Barangay Council (in a meeting) (5.1.1),
- four staff members of the Bacolod City Health Office (5.1.2),
- one of the deans of St. La Salle University (5.1.3),
- one of the Non Governmental Organisations working on advocacy regarding Reproductive Health (5.1.4),
- an officer of the Roman Catholic Dioces of Bacolod (5.1.5),

Below the different perspectives of the key informants are highlighted. Some perspectives have only been represented by one agent in the field. So it is important to keep in mind that these are verbalized opinions of the people interviewed and they might not be representative for the ideas living in this particular field.

5.1 From a government policy maker's perspective

Overall concern

The Barangay Councillors state that they are really concerned about the continuing population growth, because more and more areas become residential areas and less land is left to grow food on. Also the population density on the land is rising, so areas become more crowded. There is little room for families to live, as families are living close together. As the barangay is located close to the sea, a lot of families within the barangay are dependent on fish for their livelihood and need to share the limited fishing grounds with more and more people.

Objectives and programmes

The goal of the family planning section of the City Health Office is "*to provide married couples with the information and means to space or limit pregnancies*." According to one of the City Councillors the main government focus regarding family planning is on informed choice and safe sex. One way of promoting family planning is to give incentives to families with no more than 4 children. When people have 4 children or less they are entitled to tax exemption. Families with more than 4 children are not entitled to tax exemption. Another way of promoting family planning is the family planning seminars and pre-marriage counselling programmes (see § 4.5) that have already been in place for more than 18 years. However, it is a standard requirement and people are obliged to participate, so motivation is often lacking.

The pre-marriage counselling is prescribed in the Executive Order 209, article 16 in the Family Code of the Philippines (965). Besides it is regulated in City Ordinance 3167. Besides the pre-marriage seminars, the City government started to promote an awareness raising programme for children aged from 10-14 years regarding reproductive health and sexuality. According to the government sexual education for these age groups is important, for them to be able to make responsible choices. According to one of the City Councillors there are a lot of teenage pregnancies because of ignorance. However, the Roman Catholic Church is against sexuality education in schools, because it might stimulate young people to engage in sexual activity outside marriage, which is seen as sin.
One of the City Councillors mentions that the Gender and Development (GAD) Council is also working on seminars regarding sexuality and Reproductive Health for adolescents. A national study has shown that the number three in the top ten of most rampant health hazards for adolescents is unwanted pregnancy.

As in general it is hard to get men interested in issues regarding reproductive health and family planning, but also responsible parenthood, the Gender and Development (GAD) Council has organised a campaign regarding male participation in programmes that usually are regarded to be women's issues.

Internal constraints

Even though there are different government programmes regarding reproductive health, the sectoral approach is seen as an internal constraint of the Government preventing effective cooperation. There is a Committee on Family and Children, a Committee on Women and a Committee on Health and it is difficult for these different committees to work together and to coordinate their efforts.

Another governmental constraint is the male–bias in the Local Government Unit. In 2005 there were thirty men in the City Council and only a few women. Filipino men are sometimes more conservative than women. For example, most of them agree with the church that sexual

education for adolescents increases the risk of promiscuity. Besides family planning is mostly regarded as a women's issue and not every council member sees the need to make women's issues a priority.

External constraints

The male bias mentioned above is a reflection of the male dominance in society. The macho image of the Filipino man, the City Councillors agree, is an important barrier for reproductive health in Philippine society. The status of a man improves as he has more children. As one of the men interviewed commented:

"*The more children a man has, the more powerful and potent he becomes in the eyes of the community. People look at such a man as able to produce and able to satisfy his wife, which are seen as good qualities of a man."*

This macho image applies mainly to the lower strata in society, men with lower education and living in rural and urban poor areas. Poorer men are more susceptible to macho images. Especially among people with lower education, there is a difference between men and women regarding the desired family size. In general men want more children and large families, while women mostly desire fewer children.

People with lower education often do not consider the consequences of large families, like the difficulty of providing food, shelter, clothing, etc. to their children. There are a lot of street children in Bacolod, because the parents cannot take care of them. Besides children are sometimes regarded as an added work force, who can also bring in money, but this seems to apply mainly in rural parts of Negros on the farms and in the haciendas. The middle and upper class do not need children to improve their status.

Moreover, especially for poor men *"making love is one of the few pleasures they have in life and they do not like it to be taken from them."* (citation Barangay Councillor)

Some men are reluctant to use family planning methods, because they suspect contraceptives will diminish their pleasure in sexual intercourse and the sexual urge, either in themselves or their wives. Also Filipino men with lower education might not want their wives to use contraception because of their perception of the increasing risk of them becoming promiscuous. When men, still seen as the head of the family in Philippine society, do not want women to use contraceptives, there is little women can do about it. In general men are more powerful in society, and because of this, society is not very open towards women's rights. Most women, especially in the squatter areas are financially dependent on the husband, which makes it difficult to make their own choices.

However, there are signs that the government is taking actions to increase the status of women. In every barangay social workers of the Department of Social Services and Development (DSSD) train women in skills, like assertiveness, but also on rights and empowerment. Also there is training in practical income generating skills for women in the barangay, so they are no

longer dependent, but can market their skills and earn their own income. According to a DSSD official, women feel more confident and become more assertive and self-reliant because of this training, and their decision making power increases.

According to several City Councillors, the Roman Catholic Church is a major stumbling block in the promotion of reproductive health and family planning within Bacolod City. As the church sees procreation as natural and as the sole purpose of marriage, it is strongly against any intrusion or manipulation in this area. Sexual relations outside marriage and preventing a pregnancy in general is seen as sin. Only natural family planning methods, like rhythm and the basal body temperature method, are allowed by the church.
To influence public opinion the church organises its own campaigns regarding reproductive health. Because of this church interference, family planning programmes in the Philippines have become a political issue. Although the policies regarding family planning are there, the government encounters many problems in the implementation of these policies.
From the interviews it appears there is a wide gap between the government and the church. As an illustration, one of the City Councillors told me the following story:
"The church believes there is a global conspiracy coming from developed countries regarding the by developed countries desired reduction of the population in poor countries. As international donors like USAID, UN, WHO have been donating contraceptives for free in the first few years of the programme and also the Ford Foundation has provided a huge grant to promote family planning, there is the suspicion of a hidden agenda. Once the family planning programme was established and institutionalized, the donations stopped and the family planning programme now becomes business. Developed countries are selling contraceptives to poor countries and this is seen as another way of imperialism. The church believes rich countries want to control population growth in poor countries, so sustained economic development is possible."
The Barangay Council members refer to this when they indicate that the research topic might meet resistance in the barangay. Under influence of the church, the poor people in the barangay suspect that America and Europe want to sell birth control methods to poor countries and become richer in the process. One of the City Councillors suggests barangay health workers might be careful or reluctant to introduce family planning methods to people, because of the attitude of the church. As Filipinos in general are very religious, some people will not advocate issues on Reproductive health because of its controversial nature.

One City Councillor mentions that another problem regarding Reproductive Health and family planning is its image. The international Reproductive Health agenda also emphasizes the right of women to have a safe abortion. This international policy is not acceptable to the government of the Philippines and neither to the church. This has caused some groups to become completely anti-reproductive health and disregard all aspects of reproductive health, also family planning issues.

According to the government officials, every barangay health Centre has ample supply of contraceptives and especially modern contraceptive methods are promoted. According to one of the Barangay Councillors, barangay health workers are only allowed to promote modern family planning methods, because of monetary reasons. Natural family planning methods do not cost anything and will not supply any cash to the City Health Office. At first the modern contraceptives were free of charge, but since the USAID and other donors pulled out and are not supplying free contraceptives anymore the government wants to recover expenses. So clients need to pay for their contraceptive methods. However, according to one of the City Councillors, most people from the squatter areas are not going to the Barangay Health Centres, irrespective of whether they need to pay for a service or not. Sometimes people do not know about the service, but often they do not take the initiative to go and get the service. When asked why they do not use the (free) governmental services, they say they don't have time to go and get it.

Partnerships

In spite of the opposition of the church, the local government does not want to loose the church as a partner in working on other social issues. So the government decided to proceed in this field in dialogue with the church.

According to one of the City Councillors, partnerships of the Local Government Units (LGU) with Non-governmental organisations (NGOs) in this field are very important. Because of budgetary constraints, the possibilities of the government are limited. Additional funding is needed from partnerships with other organisations, for example in the field of education. Already government and several NGOs work together in a Forum on Reproductive health and Resource Development in Negros (FORWARD Negros). One of the activities is looking for funds for family planning. As international agencies are withdrawing the financing of contraceptives, the forum is looking for new sponsors.

5.2 From a City Health staff perspective

According to the staff, health workers are supposed to be trained in family planning methods, but because of budgetary constraints, it is not possible to train them all. Besides there is a dilemma in educating health workers, because the ones that are properly trained often leave their job to find a better paid one, which becomes accessible once they have been trained. The job of Barangay Health Worker is regarded as badly paid.

Family planning services are mostly used by women. However, some men come to the Health Centre to get condoms. Most men regard family planning as a responsibility of the wife. However, the Barangay Health Centre always asks for spousal consent before supplying a family planning method. The women need to sign a form in which they declare that their partner

agrees with them using a family planning method. Spousal consent is also part of the counselling session by the nurse or the midwife before providing a contraceptive method. If a woman has not talked with her spouse about contraception, the woman will receive the recommendation to discuss the topic with her husband and also suggestions how to discuss the issue. Now, with the new Administrative Order on Reproductive Rights, permission by husbands/partners is not needed anymore for women to make use of family planning methods. In spite of this new Order, the health staff mentions that *"women are still likely to ask permission of their husbands, because women in Filipino society are taught to be submissive to their husbands."*

5.3 From a scientist's perspective

Growing poverty has brought about a change in governmental Reproductive health policies. To decrease poverty the government has taken action to educate people on Reproductive Health, hoping they will make choices according to the responsible parenthood principle. This principle teaches people, that through a reduction in their number of children, they are able to invest more in the children they have, rather than divide their limited resources over many children, the last resulting in the children being limited in their opportunities too, which keeps the cycle of poverty intact. However, according to one of the deans of the University, many people are misinformed and adhere to superstitious beliefs regarding family planning. These beliefs have been handed down from generation to generation and are not specially connected to religion, but a mixture of religion and culture.

5.4 From a Non Governmental Organisation's advocacy perspective

Policies

According to the Non Governmental Organisation (NGO) representative health policies in the Philippines are largely dependent on who is in charge at the Department of Health within the national government. Conservative Presidents of the Department of Health will bring forward conservative policies, while liberal (protestant) presidents will broaden their policies and allow budget for promotion of artificial contraceptive methods too. Contraceptive use was considerably higher when a protestant president was in charge of the Department of Health.

Programmes

At the moment the NGO is working on a programme to heighten the contraceptive self-reliance of people in the Phillippines. When people invest in a contraceptive method, they will take more responsibility to use it properly and continue using it. When the government provides the pills for free, people do not feel responsible to use them properly. In India they have been working to improve the contraceptive self-reliance and it seems to work well.

The media is an influential sector, also in the Philippines, and is used for education regarding reproductive health. Every family will have a radio and probably a TV, and listen to the radio often and watch TV a lot. Especially the radio is a very powerful media and probably the most listened to in the Philippines. Most women listen to the radio every day. There have been and still are radio programmes that are broadcasted over the whole of Visayas and discuss issues like violence on women, family planning, contraception, etc.

The NGO representative also mentions the pre-marital counselling. Although it is an acknowledgement of the government that Reproductive health needs attention, it is not known, whether this programme is effective. The course is obligatory and couples are not always really interested.

External constraints

Although there is a lot of information available, still the contraceptive prevalence rate is low and the estimated unmet need is large. Contraceptive use is more common practice among middle and upper class women than among poor women. According to the NGO representative there is a failure in education and advocacy regarding contraception. Although people have often heard of contraceptives, there are a lot of misconceptions. People think for example that pills enlarge ones chances of getting cancer and vasectomy diminishes the sexual urge for men.
So there is an urgent need for massive education and empowerment of people to make informed choices. It is very important that people are well informed about the different methods, so not one method is imposed on the people by the government, because it is cheap or easy, but that people, men and women, are able to choose themselves, without pressure, which method suits them best.
In some barangay health centres the condoms and pills go to waste, because the health workers do not distribute the materials and do not inform the people that they are available. Besides often health workers themselves are not well informed and have not received adequate training to be able to pass the information on to their clients. According to the NGO representative the City Health Office has a lot of materials, but does not promote contraception.

According to the NGO representative cost is not an issue regarding contraception in the Philippines. Women can buy pills for as little as 20 pesos per month (about 30 eurocents). But it is the attachment of sin to the use of contraception that keeps many women from using them. The church hierarchy has a very strong influence on the lives of many believers. And local parishes are obliged to follow the Church rules. Ligtas Buntis (= safe pregnancy), the promotion campaign of the national government, got a lot of attention, also in the local media, because of the opposition of the church. The church labelled the campaign as a sinful programme and even organised rallies against it. At one barangay health centre where women could have an IUD

inserted for free, women who actually had the IUD inserted were expelled from the church. The Church persuaded the women who wanted to come to Church again to have the IUD removed.

The NGO representative indicates that there is a distortion of values because of the strictness of the church.

She told me:

"Some things, like using contraception, are regarded as sin. So unmarried people engaging in sexual activity do not use contraception, because it is sin, although the very act is sin too, they accept one but not the other. At the other side, if they have an unwanted pregnancy they choose to have an abortion, which is sin too, but they do not take contraceptives, because it is sin."

According to the NGO representative abortion practices seem to be commonplace in every barangay and every barangay has a place where abortions take place. Surveys have shown that most users of abortion are not single, promiscuous or teenage women, but married catholic women from urban poor areas. They are told by the church that using contraceptive is sin, and when they become pregnant, but are not able to support another child, they do not see any other way than abortion.

Reproductive health as such has been stigmatized by the church as being a way to promote birth control and abortion, rather than being a broad range of issues related to health. So often it happens that all aspects of Reproductive Health are being disregarded, just because they are labelled as an aspect of reproductive health, even if it is about maternal and child care. The Church is weary of any kind of reproductive health and people related to the church are also informed according to this prejudice. So people do not really know what reproductive health is all about.

The NGO representative also mentions the husband as a constraint for using contraception. A lot of husbands don't allow their wives to use contraception. It is commonly believed that a contraceptive using wife can easily become promiscuous. The Philippine culture is a very macho society, where husbands have a lot of power. Men are allowed to be promiscuous, but women are not. There is a clear double standard. Some husbands threaten to leave the wife when she will use contraception. Some become violent, when they find out their wife is using contraception or suspect that she wants to. The wife may even get in trouble, only wanting to discuss the issue with her husband. However, it is unthinkable that a woman will take contraceptives without telling her husband. A Filipino woman needs her husband's permission to use contraceptives. Therefore it is important to involve men in the programmes related to Reproductive Health.

5.5 From a religious perspective

The Roman Catholic church sees reproductive health in the context of marriage. The majority of weddings is still performed by the church and in this case the church also takes care of the obligatory pre-marriage counselling. Before the wedding ceremony there is a Canonical investigation by the church about the motives of the couple to get married.

In the pre-marriage counselling, responsible parenthood and family planning is explained, as well as the stand of the church against artificial family planning methods. According to the church officer a couple cannot choose to have no children, because the Bible says '*a man will join his wife and they will become one*' and '*Go and multiply*'. The purpose of marriage is to create a family, because that is the plan of God and He will provide for them. When asked what their desired number of children is, many couples mention 2 or 3 children as their desired family size, because of the economic crisis. When couples want to use a family planning method, the church advises natural family planning (mainly the calendar method) because of health reasons; these methods do not have side effects. According to the church officer pills have a negative effect on the health of women and are therefore discouraged by the church. However, according to the church officer, the church leaves the issue to the consciousness of the individual believer to choose their own method for responsible parenthood. Couples are encouraged to think about responsible parenthood and to carefully think about the number of children they can support.

Regarding family planning methods, only the calendar method is explained to couples. Other natural family planning methods are too difficult to apply for people. The calendar method is easy for everyone to understand and to use. Withdrawal is not advised to use as a family planning method, because it produces nervousness and irritability and no satisfaction. Besides the church believes the seed from the man comes from God, so it is important to take good care of it and '*to follow the plan of God'*. Condom is seen as a sin, because of this.

The church is against civil marriages, which are now allowed in the Philippines. The church believes marriage is an institution, founded by God, so only the church has the authority to conduct marriages.

5.6 Summary

The key informants mentioned two main cultural factors associated with contraceptive use.The Roman Catholic church is mentioned as a main stumbling block by different government officials as well as the NGO. The church sees itself as a guard of important values. Although the church officially states that it is up to the consciousness of the individual believer to choose a method for responsible parenthood, in practice it opposes any (promotion of) artificial contraception.

Another important stumbling block, mentioned by the government officials, as well as by the NGO and the city health staff, is the macho image of the Filipino men, which opposes the use of contraception by their wives. Also the misconceptions regarding contraception do not stimulate the men to change their opinion and it is difficult for a woman to use contraception without the consent of her husband.

According to the key informants also the following institutional factors are important. Although there are government programmes regarding family planning, the implementation of these programmes is not without problems. Within the government the sectoral approach and the male bias are hindering the smooth implementation. Also the apparent lack of training of the barangay health workers does not help to solve this problem. Outside the government the prejudices regarding Reproductive Health, including family planning, are mentioned by government officials as well as by the Non Governmental Organisation as an obstacle.

The above mentioned cultural factors have an impact on the institutional factors. The male-bias in the government does not help to promote women's issues. Also the government is using the opposition of the Roman Catholic church as an excuse for the lack of success in the implementation of family planning programmes.

According to the NGO there is an urgent need for education and advocacy regarding reproductive health and contraception to overcome these problems.

In the next chapter the results from the focus group discussions with the barangay health workers will be presented.

Some participants of the focusgroup discussions with barangay health workers

Chapter 6
Perceptions on Contraception in the Barangay

Focus group discussions with barangay health workers

In the period from 26 -28 October 2005 four focus group discussions were held with barangay health workers in Bacolod. In each focus group discussion seven barangay health workers participated, thus 28 in total. Most of them knew each other at least for some years, because they regularly meet at the Barangay Health Centre when on duty. Moreover they have regular meetings with the public health nurse and public health midwife of the Barangay Health Centre.

Participant characteristics

All participants were women. The majority of the participants (85.7%) were between 40 and 60 years of age. Only two of them were younger (32 and 37 years old) and two of them were older (67 and 73 years old).

Fourteen participants had completed high school. Eight of them had college education and three more had finished third year college. Of the three remaining participants, one had completed vocational training, one elementary education and of one participant the educational attainment is not known.

Twenty-six participants (92.9%) were Roman Catholics. Only two of them belonged to another Christian group.

Twenty-four participants (85.7%) were born and raised in an urban setting. Two of them came from a semi-urban setting and two from a rural background.

Purpose of the focus group discussions

The focus group discussions were intended to collect and discuss an as broad as possible range of opinions, experiences and ideas of barangay health workers regarding influencing factors and intervening factors on contraceptive behaviour of women in the purok.

The results of the focus group discussions were used in the development of the survey questionnaire.

6.1 Main responses of the focus groups

Below the questions asked and the responses received are presented.

1. **What do you estimate is the number of women in this barangay using contraceptive methods?**

   According to the barangay health workers the estimated percentage of current contraceptive users in their purok ranges from 5 percent to 75 percent per purok. Differences between purok are partly explained by different socio-economic circumstances.

2. **Which factors do you think are influencing contraceptive behaviour of the women in the Barangay?**

   According to the barangay health workers some factors influencing contraceptive use are education (people with lower education are less likely to use family planning than people with higher education), geographical background (urban people are more likely to use family planning than rural people), poverty (people in squatter settlements are less likely to use family planning than in other areas of the barangay) and employment (working mothers are more likely to use family planning than unemployed women).

   Stimulants

   Economic reasons are cited by the barangay health workers as the most important factor stimulating the use of family planning methods. Couples want to be able to attend to the needs of their children and want to be able to afford to send their children to school. Because of the economic crisis, people do have limited resources and they say it is cheaper to use family planning methods than to raise many children. This applies more to young couples than to older couples. According to the barangay health workers younger women are more likely to use contraception than older women.

   The government provides an incentive for workers (in formal employment) not to have many children. When employees do not have more than six children they are liable for tax exemption.

   Constraints

   According to the barangay health workers one of the main reasons for women not using contraception is their husbands' objection to them using contraceptive methods. However, some women do use contraception, mainly pills, secretly.

   Fear of side-effects of contraceptive methods is a second reason mentioned for women not using contraception. Many side-effects are mentioned by the barangay health workers, but when asked, they indicate not being aware of many current users of contraception who suffer significant side-effects.

A third reason for non-use of contraception are the medical conditions in woman for which modern (hormonal) contraceptive methods are contra-indicated. Asthma, blood sugar problems, high blood pressure, problems with veins and heart failure are given as examples.

A comment that is made several times is the difficulty to persuade people to visit the Barangay Health Centre. Many women say they have no time to visit the centre. In the depressed areas quite a few people (women as well as men) are gambling and the barangay health workers perceive that gambling has a higher priority to the poor people in the purok than family planning.
Moreover it is often mentioned by the barangay health workers that having sex is one of the few pleasures in life for poor people, because they have no other attractions or distractions, like TV. So they do not like to think about family planning, because they feel it is taking away their enjoyment and pleasure.

Religion was only mentioned in one focus group as a reason for not wanting to use contraception. Most barangay health workers do not regard this as an important constraint. According to the barangay health workers sex preference of a child also does not play an important role in the purok, this is not a reason for couples to have more children than their desired family size. Also some barangay health workers mention financial constraints for people to be able to afford contraception.

3. **Which contraceptive methods are most used by the women in the Barangay and why?**
   According to the barangay health workers the oral pill is the most used contraceptive in the purok, because pills are easy to use and available at low cost. Before pills are provided, women are required to have a medical examination to determine suitability. The use of injectables (DMPA) is less prevalent, because it is more expensive than pills.
   Only few women use Intra-Uterine Device (IUD) and few have had ligation. For both methods spousal consent is required. IUD has more side-effects and is less convenient to use than pills. With ligation men fear their wives might become promiscuous, because there is no risk of pregnancy. For sterilization a woman must at least be 32 years of age. However, sterilization is strongly recommended or even required after three caesarean operations. Vasectomy is rarely used.
   There are also couples who use condoms, but according to the barangay health workers most people do not like to use condoms, because they are uncomfortable to use.
   According to the barangay health workers quite a few people use traditional natural family planning methods, like the calendar/rhythm/cycle method or withdrawal. Withdrawal seems to be practised by many couples. However, many women complain about nervousness as a side-effect, because of the risk of becoming pregnant.

The modern natural family planning methods like Basal Body Temperature, Ovulation Method and Sympto-Thermal Method are not used as far as known by the barangay health workers. People are not familiar with these methods and they are complicated to teach. Barangay health workers only advise to use natural family planning methods, when use of modern contraception causes (health) problems or is not possible (e.g. because of medical conditions). But normally they first promote modern family planning methods, like the oral pill.

4. **According to your observation what would be the most important side-effects of the following contraceptive methods**:
   The side-effects mentioned by the barangay health workers are described in the table in appendix F.

   According to the barangay health workers most people are satisfied with their contraceptive method. When women have a complaint or a method is not comfortable, the barangay health worker refers them to the Barangay Health Centre for a check-up and a possible change of method.
   According to the barangay health workers the women do not come to the Barangay Health Centre for check-ups, because they have no time. They say they are too busy. Then infections and cancers can develop without adequate treatment.

5. **To whom is information and services regarding family planning provided? (only married women/couples / adolescents / on request /..)**
   Information on family planning and related services are mainly provided to married couples or couples who are living-in. The barangay health workers usually advise couples regarding family planning methods after they have delivered their first child. Family planning information in general is provided to women in the mothers-class that is conducted in the different purok by the barangay health workers. In school, from grade 6 (age 11 years or older), students receive information regarding reproductive health.
   The Barangay Health Centre does not provide information to adolescents. The barangay health workers sometimes educate mothers to tell their daughters about reproductive health. Although there are quite some women in the age group 15-19 years coming to the health centre, most of them pregnant already, Barangay health workers are not allowed to give contraception to adolescents or to single women/mothers. If asked, barangay health workers do give advice to single women. However, single women/mothers mostly go to private providers (pharmacies, private hospitals) for family planning methods, not to the Barangay Health Centre, because of privacy considerations.
   For prostitutes there is a special arrangement. They are licensed and have a monthly check-up in the City Health Office. Most of the prostitutes work in clubs.

6. **How do you think about spousal consent for a woman to be provided with her desired contraceptive method?**
   The barangay health workers hold different opinions whether it is appropriate to provide contraception to women without spousal consent.
   Some fear conflict with the husband, when they would provide contraceptive methods to the wife without consent of the husband. Some, however, do provide contraception to women on their request, irrespective whether the husband agrees.

7. **In what ways is the status of women in Filipino society related to the use of contraceptives?**
   In the traditional Filipino family the husband is the head of the family and the wife is dependent on the husband. The head of the family is usually responsible for the decision making in the household. However, in general women are quite independent and most decision making takes places in consensus between husband and wife. According to the barangay health workers, family planning is usually discussed between husband and wife. Most unplanned pregnancies are in adolescents. A lot of young people live-in with their partners, rather than marry. The negotiation power of these young women might well be less than that of their older, married counterparts.

8. **Do you know about any traditional beliefs, practices and taboos regarding to human sexuality, fertility and reproduction?**
   The barangay health workers know a lot of traditional beliefs and practices regarding pregnant women, but they are not aware of any traditional beliefs, practices or taboos regarding human sexuality, fertility and reproduction in general.

6.2 Summary

The barangay health workers see the current economic situation in the Philippines and also in Bacolod as the main stimulating reason for people to use family planning methods. According to the barangay health workers most couples that use family planning choose the oral pill because of the convenience in use.

The most important reasons for contraceptive non-use in women mentioned are their husbands' objection, fear of side-effects and contra-indicated medical conditions.
Other constraints for contraceptive use mentioned are the higher priority that is allotted to gambling and the fear that contraceptive use will decrease pleasure in sexual activity.

In the next chapter the results from the questionnaire-based-interviews with individual women in the purok will be discussed.

Educational materials regarding reproductive health in the Barangay Health Centre

Poster in Barangay Health Centre regarding Family Planning

Physical examination table in the midwifery room

Chapter 7
Contraceptive behaviour in the purok

7.1 The sample

In this study 116 women in their reproductive age (from 15-45 years of age) have been interviewed based on a questionnaire (see appendix D).

In table 7.1 the women interviewed are described according to their basic characteristics. The respondents were relatively evenly distributed over the different age-groups. The majority of respondents were married (68.1%) or lived-in (15.5%). Most respondents had completed high school (51.7%) or higher education (19.8%).

Table 7.1: Descriptive characteristics of respondents (n=116)

Characteristic		Number n	Percentage %
Age			
	15–19 years	12	10.3
	20–24 years	18	15.5
	25–29 years	18	15.5
	30–34 years	21	18.1
	35–39 years	26	22.4
	40-45 years	21	18.1
Civil status			
	Single	14	12.1
	Married	79	68.1
	Live-in	18	15.5
	Widowed	1	0.9
	Separated	4	3.4
Education			
	No formal schooling	1	0.9
	Elementary	32	27.6
	High school	60	51.7
	Vocational Graduate	5	4.3
	University / College	18	15.5

Characteristic		n	%
Employment			
	Regular	1	0.9
	Casual / contract	5	4.3
	Self-employed	39	33.6
	Unemployed	71	61.2
Place of birth			
	Rural	44	37.9
	Semi-urban	6	5.2
	Urban	66	56.9
Household status			
	Nuclear family	68	58.6
	Extended family	48	41.4
Household income			
Per month	< 2000 pesos	4	3.5
	2001 - 4000 pesos	38	33.0
	4001 - 6000 pesos	31	27.0
	> 6001 pesos	42	36.5
Number of children			
	0 child	23	19.8
	1 or 2 children	44	37.9
	3 or 4 children	31	26.7
	5 or more children	18	15.6

Of the respondents 61.2 percent were unemployed and 33.6 percent were self-employed. More than 50 percent of the respondents had an urban background (56.9%) and 37.9 percent a rural background. Almost 60 percent of the respondents lived in a nuclear family (58.6%). The majority of the respondents found it difficult to comment on the total household income. They stressed most of their income was irregular and therefore could fluctuate considerably. As control variables for income the questionnaire also included questions regarding status of the lot and the house the family lived in, facilities like electricity, sanitation and water supply, assets and appliances to measure the affluence of the family. When compared with income, the affluence index showed a significant correlation with income (Spearman's nonparametric correlation coefficient .508, p=.000, α=0.01).

The number of children per respondent ranged from no children (n=23) to 10 children (n=2).

7.2 Indicators of Reproductive Health

Teen pregnancy

Within the sample one respondent had her first child at age 13. Another 31 respondents (26.7%) had their first child between 15 and 19 years of age. This means one in four women ran considerable health risks by becoming pregnant while they were still adolescents. This percentage is also high compared with the national percentage of 8 percent.
Most respondents (35.3%) had their first child between 20 to 24 years of age. Another 15.5 percent had their first child between 25 to 29 years of age. Only 3.5 percent of the respondents had their first child in their thirties.

As the start of childbearing is closely related to marriage in the Philippines, the age at first marriage is also an important indicator. Two respondents (1.7%) started to live in before their 15th birthday. Of the respondents, 29.3 percent married between 15 to 19 years of age and 40.5 percent between 20 to 24 years of age. Another 16.4 percent married after their 25th birthday. 12.1 percent of the respondents were not (yet) married.

Contraceptive prevalence rate

Of the respondents 63.8 percent had ever used some kind of contraception (n=74). However, the percentage of current users of any kind of contraception was 31.0 percent.

Table 7.2: Contraceptive use among respondents

Contraceptive use	Total		Modern		Traditional	
	n	%	n	%	n	%
Never used contraception	42	36.2	53	45.7	92	79.3
Ever used contraception						
20-24 years	*10*	*13.5*	*8*	*12.7*	*4*	*16.7*
25-29 years	*15*	*20.3*	*11*	*17.5*	*8*	*33.3*
30-34 years	*13*	*17.6*	*13*	*20.6*	*2*	*8.3*
35-39 years	*19*	*25.7*	*17*	*27.0*	*5*	*20.8*
40-45 years	*17*	*23.0*	*14*	*22.2*	*5*	*20.8*
Total	74	63.8	63	54.3	24	20.7
Currently using contraception						
20-24 years	*8*	*22.2*	*5*	*21.7*	*3*	*21.4*
25-29 years	*9*	*25.0*	*5*	*21.7*	*4*	*28.6*
30-34 years	*9*	*25.0*	*8*	*34.8*	*2*	*14.3*
35-39 years	*6*	*16.7*	*3*	*13.0*	*3*	*21.4*
40-45 years	*4*	*11.1*	*2*	*8.8*	*2*	*14.3*
Total	36	31.0	23	19.8	14	12.1

Although the majority of respondents had ever used a modern contraceptive (54.3%), the current use of modern contraception among respondents was low with 19.8 percent of the respondents, especially compared to the national average percentage of current users of 33.4 percent in 2003. Within the age group of 15-19 years no respondent ever used contraception. The percentage of respondents ever using a traditional method (20.7%) or currently using a traditional method (12.1%) is considerably lower than use of modern contraception. Of the respondents 11.2 percent (n=13) had ever used modern as well as traditional methods.

The most popular modern method is the pill (16.4%). The traditional methods rhythm/calendar method (6.1%) and withdrawal (5.2%) are also quite popular.

Desired fertility

In this study the respondents have been asked for their own ideal family size as well as the ideal family size of their partner, their parents and their family-in-law according to their opinion. These indications do not necessarily express the opinions of the people involved, but those of the respondent. The respondent was asked how she perceived her partner, parents and family-in-law would think about the ideal family size for her.

Asked what the ideal number of children was to the respondent the answers ranged from 1 to 10, with most respondents choosing 2 children (37.1%) or 3 children (29.3%). The average ideal number of children was almost 3 children (2.96). The major reason for respondents to desire the reported number of children is economically in character (64.7%). Other reasons were to be able to provide good education to the children (8.6%) and health reasons (6.0%) (see also Hutter et al. (1999) for similar results). One of the respondents commented that she decided to have 10 children, because "*it is not good to abort a baby*" as if there are no other choices.

Table 7.3: Ideal family size as indicated by the respondent

Ideal family size according to	Number of children	sd
Respondent	2.96	1.36
Parents respondent	2.98	1.44
Husband respondent	3.08	1.65
Family in law respondent	3.20	1.63

The average ideal number of children of the husbands according to the respondents was just over 3 children (3.08). According to the respondents almost 14 percent (13.9%) of the husbands would not have a clear opinion on the ideal family size, but would be content with any number of children or leave the decision up to his wife. The average ideal family size of the parents was almost 3 children (2.98) according to the respondents, with 36.1 percent of the parents not wanting to interfere with their daughter's choice. The average ideal family size of the family in

law was the highest with 3.2 children, according to the respondents, although also 36.3 percent of the family in law would not interfere with the choice of their son and daughter in law.

According to the United Nations (1998) the predictive power of responses to hypothetical inquiries about ideal family size is, however, rather limited and might be erratic, especially because reproductive targets are continuously revised during the process of childbearing. Another limiting factor is that most available data, in relying exclusively on female reporting of fertility preferences, overlook the role of partners and other family members in reproductive decision-making. Nevertheless it is interesting to see that in this study husband and family-in-law are perceived to have higher ideal family sizes than the respondent and her parents.

Unmet need

Of all the respondents indicating they do not want any (more) children, the majority (65.3%) does not use any kind of contraception (see table G.1 in appendix G). Almost 80 percent (77.3%) does not use any modern contraception. Only 22.7 percent of these respondents does use a modern contraceptive (see table G.2). Moreover, 13.3 percent of the respondents indicating they do not want any (more) children is using a traditional (ineffective) contraceptive method (see table G.3). This means there is a large unmet need among the respondents of the study.

Most respondents also indicated that they were worried whether they would have enough resources to take care of the baby expected. 64.7 percent worried often and 13.8 percent worried sometimes. Among the respondents who often worried 68.0 percent had ever used modern contraception but 62.7 percent did not currently use any contraception to prevent pregnancy.

7.3 Contraceptive knowledge

Knowledge of family planning

Respondents were asked whether they could mention a contraceptive method they knew of (active knowledge). After mentioning the methods they knew, the contraceptive methods they did not mention were read to them and they were asked whether they heard about this particular method (passive knowledge). Almost 90 percent (88.8%) of the respondents knew of a modern contraceptive method and all respondents had at least heard of one modern contraceptive method. Most of them knew about the oral pill (82.8%). IUD (40,5%) and condom (39.7%) were also well known. When asked more than 90 percent of the respondents had heard of modern methods, like oral pill (99.1%), injectable (90.5%), IUD (94.0%), condom (99.1%). Besides the natural contraceptive methods like rhythm (93.1%) and withdrawal (90.5%) were very well known.

In addition respondents were asked whether – according to the respondent – the methods they heard about are effective (prevents pregnancy), are convenient to use, and are safe to use (health-wise). As respondents were only asked to comment on the methods they heard about some percentages might be slightly underestimated.
As 16.7 percent of the respondents had not heard about tubal ligation and 17.4 percent of the respondents had not heard about vasectomy, these percentages may be lower than otherwise might have been the case.

Perceived effectiveness of contraceptive methods

The contraceptives in table 7.4 are ordered in relation to their perceived effectiveness. More than half of the respondents were convinced of the effectiveness of modern contraceptive methods. The perceived effectiveness of traditional methods is considerably lower.

Table 7.4: Perceived effectiveness of contraceptive methods

Contraceptive method	n having heard of method		n thinking method is effective	
	n	%	n	%
Oral pill	115	99.1	82	71.3
Tubal ligation	97	83.6	76	66.7
Injectable	105	90.5	69	60.0
IUD	109	94.0	66	57.4
Vasectomy	96	82.8	66	57.4
Condom	115	99.1	59	50.9
Rythm / calendar	108	93.1	36	31.3
Withdrawal	105	90.5	32	27.8
Periodic abstinence	25	21.6	9	7.8

Respondents were most convinced of the effectiveness of the oral pill (see table 7.4.). Only half of them were convinced about the effectiveness of the condom. Many of the respondents were aware of the limitations of the condom, mentioning it can leak.

Education and age did not significantly influence the perceptions of the respondents regarding the effectiveness of contraceptive methods (Nonparametric Tests, Jonckheere-Terpstra). The majority of respondents from an urban background (63.9%) thought condoms were effective, while not even half of the respondents from a rural background (47.4%) thought so.
Regarding the rhythm/calendar method, half of the respondents from an urban background (50.9%) thought of this method as effective, while 29.7 percent of the respondents from a rural background thought the same. Most rural respondents (70.3%) perceived this method as being ineffective in preventing a pregnancy. The same is the case regarding withdrawal; many respondents from an urban background perceived withdrawal as an effective contraceptive method (41.5%) compared to 23.7 percent of respondents from a rural background.

Also unemployed respondents were slightly more optimistic regarding the effectiveness of withdrawal (35.1%) than their self-employed counterparts, of whom 28.6 percent thought withdrawal is an effective contraceptive method.

However, unemployed respondents were slightly less optimistic regarding the effectiveness of rhythm / calendar method (33.9%) than their employed counterparts, of whom 42.1 percent thought the calendar method is an effective contraceptive method.

Perceived convenience of contraceptive methods

The oral pill was not only perceived as the most effective, but also as the most convenient contraceptive method (see table 7.5). The contraceptives in table 7.5 are ordered in relation to their perceived convenience.

Table 7.5: Perceived convenience of contraceptive methods

Contraceptive method	n having heard of method		n thinking method is convenient	
	n	%	n	%
Oral pill	115	99.1	101	87.8
Condom	115	99.1	77	66.4
Injectable	105	90.5	66	57.4
Rythm / calendar	108	93.1	63	54.8
Withdrawal	105	90.5	62	53.9
Tubal ligation	97	83.6	52	45.6
IUD	109	94.0	41	35.7
Vasectomy	96	82.8	39	33.9
Periodic abstinence	25	21.6	13	11.3

Education and age did not significantly influence the perceptions of the respondents regarding the convenience in using contraceptive methods (Nonparametric Tests, Jonckheere-Terpstra). A majority of respondents from an urban background (52.0%) did think the IUD was convenient to use, while 37.1 percent of their rural counterparts did think so (62.9% did think the IUD was inconvenient to use).

Employment status only significantly influenced the perceptions regarding the convenience of using condoms (p=0.007 Mann-Whitney U test). Of the unemployed respondents 88.1 percent thought condoms are convenient to use, while 65.8 percent of the employed respondents agreed with this.

In general the respondents were not very convinced the contraceptive methods were safe to use health wise. More than half of the respondents, however, thought the condom and the rhythm/calendar method were safe to use (see table 7.6).

The contraceptives in table 7.6 are ordered in relation to their perceived safety.

Table 7.6: Perceived safety of contraceptive methods

Contraceptive method	n having heard of method		n thinking method is safe to use health wise	
	n	%	n	%
Condom	115	99.1	64	55.2
Rythm / calendar	108	93.1	62	53.9
Withdrawal	105	90.5	39	33.9
Oral pill	115	99.1	37	32.2
Vasectomy	96	82.8	37	32.2
Tubal ligation	97	83.6	35	30.7
IUD	109	94.0	27	23.5
Injectable	105	90.5	21	18.3
Periodic abstinence	25	21.6	13	11.3

Education, age and employment status of the respondents did not significantly influence the perceptions of the respondents regarding the safety of contraceptive methods (Nonparametric Tests, Jonckheere-Terpstra). In another study measuring attitudes towards oral contraception, women of higher education were less likely to believe that taking the pill would necessarily involve health risks (see Murphy et al., 1999 in Tountas et al., 2004). However, this finding cannot be confirmed in this study. Of respondents with an urban background, 73.2 percent thought a condom was safe to use, while 48.8 percent of their rural counterparts thought this was the case. The same applies to the perceptions on the safety of the rhythm / calendar method: 78.8 percent of the respondents from an urban background think this method is safe to use, while 50.0 percent of their rural counterparts thinks the method is safe.

Information regarding contraceptive methods

Participants were also asked to report the sources of information from which they had learned their knowledge about contraception (see table 7.7).

Table 7.7: Sources of information on contraceptive methods

Heard about contraception from	n	%
Partner	2	1.7
Mother	12	10.3
Friends / colleagues / neighbours	62	53.5
School	11	9.5
Premarital Counselling	2	1.7
Health staff	80	69.0
Newspapers / magazines	0	0.0
Radio/TV	3	2.6
Ligtas Buntis (national government campaign)	0	0.0
Family	34	29.3
Church group	1	0.9

Of the respondents 69.0 percent heard about contraceptive methods through a medical service, like the Barangay/City Health Centre, hospital personnel, etc (see table 7.7). Half of the respondents heard about contraception through friends, colleagues and neighbours. Family (mother not included) was also an important source of information (29.3%). Although 90.5 percent of the respondents profess Roman Catholicism, the church is only mentioned by one respondent as a source of information regarding family planning and contraceptive methods. Newspapers and magazines and the national government campaign Ligtas Buntis were not mentioned at all by the respondents as a source of information regarding contraceptive methods.

Appropriateness contraceptive use

Of the respondents 83.6 percent believed it is up to them to decide whether to have children and if so, how many children to have.
When asked in what circumstances they thought the use of contraception would be appropriate most of the respondents (75.9%) indicated any circumstance would be appropriate.
Respondents were also asked whether they thought contraceptive use was appropriate under the specific circumstances mentioned below. Slightly higher numbers of respondents thought contraceptive use would be appropriate in these specific circumstances (see table 7.8).

Table 7.8: Appropriateness contraceptive use according to respondent

Appropriate circumstances/ reasons for contraceptive use	Yes %
As spacing method between births	92.2
For health reasons	88.8
After achieving desired family size	87.1
After birth first child	80.2

Intentions for family planning use

After asking for the appropriateness of contraceptive use in general, the respondent was asked in what circumstances she herself would want to use contraception.
Half of the respondents would want to use contraception under any circumstance and half would only use contraception under specific circumstances or even under no single circumstance (2.6%) (see table 7.9).

Table 7.9: Circumstances in which the respondent would want to use contraception

Circumstances/ reasons for contraceptive use	Yes %
As spacing method between births	83.6
For health reasons	81.9
After achieving desired family size	73.3
After birth first child	59.5
Never	2.6

Respondents were also asked if they decided to use a contraceptive method, what kind of method they would choose (see table 7.10).

Table 7.10: Contraceptive method choice if the respondent decided to use contraception

Contraceptive method choice	n	%
Any method	2	1.7
Only artificial method	68	58.6
Only natural method	36	31.0
No method	10	8.6

Most respondents (58.6%) would choose a modern artificial contraceptive method, like the pill if they decided to influence their childbearing. 31.0 percent of the respondents would choose a natural traditional method.

Contraceptive discontinuation rates

Of the respondents 36.2 percent never considered using contraception, 32.8 percent of the respondents did use contraception, either modern or traditional, but stopped using for different reasons (see table 7.11). 31.0 percent is still using some kind of contraception. Of the respondents who ever used modern contraception, 34.5 percent did stop using. According to Achacoso-Sevilla (2004) the fear of side effects of contraception stands out as a main obstacle to contraceptive use. This is confirmed by this study.

Table 7.11: Reasons for the respondent to stop using contraception

What reason made the respondent stop using contraception?	n	%
Because of side-effects	27	45.8
Desire to become pregnant	10	16.9
Because of health reasons	6	10.2
Because of concern regarding method safety	4	6.8
Because of the costs	2	3.4
Other	10	16.9

Most respondents who stopped using contraception, stopped because of side-effects (45.8%). Only 2 respondents (3.4%) mentioned costs of contraception as a reason to stop using contraception. Apparently the cost of contraception is not a major issue in use or non-use of contraception (see also below).

Source of supply of contraception

A vast majority of the respondents (97.4%) knew where to get contraception and also a majority indicated it was easy (28.4%) or very easy (44.0%) for them to go there and get the contraception if they decided they wanted to use a family planning method. Moreover, 62.9 percent of the respondents mentioned it was easy or very easy for them to pay the cost of the contraception, if they decided to use it.

Asked how easy it was for respondents to make time to visit the Barangay Health Centre, 73.3 percent answered it was easy or very easy for them to make time. For 89.7 percent of them it was also easy or very easy to physically go to the Barangay Health Centre (BHC). No questions were asked regarding psychological factors influencing accessibility of the BHC. Do people feel welcome, are they treated with respect, etc. Almost one in every five respondents (19.8%) did not make use of any BHC service and 25.0 percent of the respondents did not visit the BHC in the past year.

Family planning messages in the media

From the response on the questionnaire, it appeared that the role of the mass media as an information source on contraception is rather limited (see also table 7.7).
Respondents were also asked how often they spent time listening to the radio, watching television or reading a newspaper or magazine, to investigate whether these would be useful sources in the future. In table 7.12 the responses are indicated.

Table 7.12: Exposure of respondents to the media

Media exposure In percentages	Every day	3-5 times a week	1-2 times a week	Seldom	Never
Listening to radio	55.2	10.3	9.5	20.7	4.3
Watching TV	75.0	7.8	5.2	10.3	1.7
Reading newspaper/ magazine	4.3	7.8	12.1	44.0	31.9

From this table it appears that articles regarding reproductive health in newspapers or magazines will hardly reach any respondents, while messages on TV and to a lesser extent on the radio might reach the majority of the respondents.

However experts warn that TV programs and popular press articles that address reproductive health issues can be limited and may contribute to incomplete knowledge and false information on sexual matters (see also Tountas et al., 2004).

7.4 Factors influencing contraceptive behaviour

Background

Age of respondents only significantly influences current use of any contraception. The younger the respondent, the more likely she is to be a current user of any contraception. Place of birth (rural/urban) and household status (nuclear/extended) does not significantly influence contraceptive use. However, respondents from a rural background are less likely to use traditional contraceptive methods (p=.032).
Regarding educational attainment, respondents with high school are less likely to be a current user of modern contraception than a respondent with only elementary education (p=.005). Respondents with university education are more likely than respondents with only elementary education to have ever used traditional contraception (p=.005).
Health status and the making use of the services of the Barangay Health Centre did also not have a significant influence on contraceptive use.

Civil status does obviously significantly influence contraceptive ever use, because most sexual intercourse in the Philippines takes place within marriage. However, this relationship is not evident in relation to current use.

In contrary to the proposition mentioned in the literature the majority of the respondents having ever used (modern) contraception is not employed. The same applies to the current users of (modern) contraception. Of the unemployed respondents half (50.7%) did ever use modern contraception, while the other half (49.3%) never used modern contraception. Of the employed respondents 60.0 percent did ever use modern contraception. At the time of the study the majority of the employed respondents (80.0%) as well as the majority of the unemployed respondents (80.3%) did not use a modern contraceptive method. Employed respondents are less likely to (ever) use traditional methods than their unemployed counterparts (current use p=.035, ever use p=.027).

Economic status

From the literature it appeared that richer population groups have far greater access to contraceptives and other reproductive health services than poorer groups (see UNFPA, 2004). In this study however the total income of the household did not significantly influence contraceptive use.

According to the UNFPA (2004) poor women give birth at earlier ages. This study also found no significant differences in this area. Of the 31 respondents who had given birth between their 15th and 19th birthday, 13 (42%) had a total household income of 2001 to 4000 pesos, another 9 (29%) had a total household income of 4001 to 6000 pesos, and another 9 (29%) respondents had a total household income of over 6000 pesos. Also the proposition that poorer women have more children during their reproductive lives than wealthier women could not be confirmed in this study.

Women's status

Women's decision making capacity is measured by whether a respondent has influence in the decision making regarding household expenditures, education, and in seeking health care. This capacity does significantly influence contraceptive ever use (Pearson chi-square p=0.000). This applies as well to ever use of any contraception as ever use of modern contraception, but not to ever use of traditional methods (p=.792). This significance however is not observed in relation to current use (current modern use p=.693, current traditional use p=.504).

Table 7.13: Women's decision making capacity

Women's decision making capacity	n	%
Very low	16	13.8
Low	17	14.7
Medium	22	19.0
High	43	37.1
Very high	18	15.5

Women's decision making capacity differs per age group, with older respondents being more likely to have a high decision making capacity than younger ones (Jonckheere-Terpstra p=.000).

Table 7.14: Women's decision making capacity by age

Women's decision making capacity	Low		Medium		High	
	n	%	n	%	n	%
15-19 years	12	36.4	0	0.0	0	0.0
20-24 years	9	27.3	3	13.6	6	9.8
25-29 years	4	12.1	5	22.7	9	14.8
30-34 years	5	15.2	6	27.3	10	16.4
35-39 years	2	6.1	2	9.1	22	36.1
40-45 years	1	3.0	6	27.3	14	23.0

Women's status is measured by women's decision making capacity in general (see above), whether the respondent has her own income, whether the respondent has influence in deciding

what to do with her own income and whether she has any responsibility regarding the family expenses. Of the respondents 43.1 percent has her own income (n=50). Of the respondents with their own income 74 percent (n=37) is able to decide what to do with her own income. Of the respondents 42.2 percent (n=49) has (co)responsibility for the family expenses.

Women's status, composed from the variables mentioned above, appears to significantly influence contraceptive ever use (Logistic regression, p=.006). The more influence a woman has regarding decision making in family matters and if she has her own income, the more likely it is for her to use a modern contraceptive method.

Religion

More than 90 percent (90.5%) of the respondents belonged to the Roman Catholic tradition. This percentage is higher than the national average of 81.5 percent. Besides 86.2 percent of the respondents regarded religious belief and practice in their daily life as important (23.3%) or very important (62.9%). When asked whether the priest/pastor would agree with the respondent using a contraceptive method, 30.2 percent of the respondents thought he would not and 15.5 percent thought he would only agree with use of natural methods (these percentages are similar for using and non-using respondents). However, this study was not able to confirm that the Roman Catholic tradition is an important determinant for non-use of modern contraception.

Women's immediate context

Flowing from the conceptual model (chapter 3) the immediate context of a woman can have significant impact on her contraceptive behaviour. Of the currently non-using respondents one in ten (11.8%) thought her husband would not agree with her using a contraceptive method, while 21.5 percent thought her husband would only agree to use natural methods. This means one in three women thinks her husband would not agree with her using a modern contraceptive.

Regarding the family, almost 10 percent of the non-using respondents thought her mother would not agree with her using a contraceptive method and 12.9 percent thought she would agree only with use of natural methods. Only few non-using respondents thought her family-in-law would not agree (4.3%) or agree only with natural methods (9.7%).

Respondents were optimistic over the response of the community. Only 6.5 percent of the non-using respondents thought her friends and colleagues would not agree with her using a contraceptive method and 3.2 percent thought her neighbours would object. Also few respondents thought her community (friends/colleagues 10.8%, neighbours 7.5%) would only agree with her using natural contraceptive methods.

7.5 The current contraceptive (non-)user

One problem with the data is that the numbers of current users of modern contraceptive are too low (n=23) to make statistic analyses relevant. Although this study has not been able to confirm some of the literature findings regarding the influencing factors on contraceptive use, it seems to be illustrative to try and describe the current user of modern contraception and the current non-user of modern contraception.

Current modern contraceptive users

Current users of modern contraception come more often from a rural (60.9%) as from an urban background. Slightly more of them come from a nuclear family (60.9%) as from an extended family. Most of them are between 25 and 34 years of age (56.5%) and all of them are married or live-in with their partner. Almost all of them are Roman Catholic (91.3%). The educational attainment of almost half of the current contraceptive users (47.8%) is elementary school while the other half has at least completed high school. The majority of current users (60.9%) are unemployed. More than 70 percent of them (73.9%) has a total household income of at least 4000 pesos per month.
The majority of current modern users (69.6%) experiences good (43.5%) or even very good (26.1%) health. Most of them do make use of the services of the Barangay Health Centre in general (91.3%) as well as the family planning services (65.2%). More than half (56.5%) of the current modern contraceptive users have a high or even very high decision making capacity.

Current non-users of modern contraception

Of the current non-users of modern contraception 63.4 percent comes from an urban background and more than half of them (58.1%) comes from a nuclear family. More of them come from the age groups of 35-39 years (24.7%) and 40-45 years (20.4%) than from the younger age groups. The majority of non-using respondents is married (68.8%). Almost all of them (90.3%) are Roman Catholic.

The educational attainment of most non-users is high school (57%) or higher (20.4%). More than 60 percent of the non-using respondents has a total household income of at least 4000 pesos. A majority of non-using respondents (57%) is unemployed and one in three is self-employed (33.3%).

Of the non-using respondents, 64.5 percent experiences good or very good health. A majority of non-using respondents (77.4%) makes use of the services of the barangay health centre. Almost one in three (30.2%) of the non-using respondents has a decision making capacity of low or even very low.

Users and non-users of modern contraception in this study are not very different from each other. Non-users do come more often from an urban background and they are more present in older age groups (from 35 years of age) than their using counterparts.

In the next chapter the results will be discussed and conclusions will be drawn. Finally some recommendations will be made.

Public school yard in a barangay of Bacolod City

Children taking a ride with a trisiklad driver leaving the purok looking for passengers

Chapter 8
Discussion, conclusion and recommendations

In this final chapter the findings from the previous chapters will be related to the research questions, as formulated in chapter 1. First in the discussion, paragraph 8.1, some general remarks will be made regarding the study and the limitations that were inherent to the methods chosen, the limited time available and the relatively small sample that was interviewed.
In the next paragraph 8.2, the findings will be related to the research questions in line with the conceptual model presented in chapter 3. In paragraph 8.3 the overall conclusion will be drawn. Finally in paragraph 8.4 some recommendations will be made for further research and possible policy measures in Bacolod-City.

8.1 Discussion

Because of the limited time scope of this study, no time was available for more extensive interviews with more or other key informants and in-depth interviews with the women in the purok. The last also being difficult as a result of the language barrier and the dependency on assistants with different levels of commitment.

There may also be some distortion in the results presented, derived from the questionnaire based interviews, because of the limited sample size of this study (n=116). Especially the number of women currently using contraception was relatively small, making a comparison between users and non-users difficult, because some difference in characteristics may be caused by chance. This study therefore cannot present any definite conclusions, but rather give indications.

One important issue regarding reproductive behaviour that has not been discussed is abortion. Abortion is a sensitive issue in the Filipino society. It was a conscious choice to leave this issue out of the study. However, during the study, information regarding abortion was collected from the literature as well as from informal contacts with the people in Bacolod. Some women mentioned abortion when asked whether they knew of any contraceptive methods (n=2). It was believed that it would be impossible to gather reliable data on this issue, because of the taboo

on this and the difficult and wearisome discussion and advocacy that is taking place in Filipino society and government on this issue right now.

In spite of these limitations this study has given some insights and indications regarding the research questions that will be presented in the next paragraph.

8.2 Research questions and results

One of the major concerns of this study was related to the issues of fertility and population growth in relation to poverty, believing that decreasing fertility would be one way of relieving poverty. The use or non-use of contraception is closely related to fertility. There appeared to be a discrepancy between the desired family size of two to three children and contraceptive use. That is why in this study the perceptions and attitudes of women regarding contraception and the factors that influence these perceptions and consequent behaviour have been studied. Besides the study tried to identify possible constraints for contraceptive use for the women in the squatter settlements of Bacolod-City.

Below the results will be presented in relation to the research questions.

Research question 1

> *What is the current situation (period 2000 – 2005) regarding contraception in Bacolod also in comparison with the national situation in the Philippines, according to the government officials, health workers, and NGO's?*

The current situation has been related to laws and policies, service delivery, information delivery and indicators for reproductive health.

Laws and policies

At the time of the study there were educational programmes regarding reproductive health as well as family planning programmes in place in Bacolod-City, with varying success. The lack of political support by the current administration (fostered by the Roman Catholic church) for population management and reproductive health as well as modern contraception has translated into limited commitment and financial support for these programmes.

Service delivery

According to the local government all Barangay Health Centres in Bacolod-City should be able to supply clients with reversible contraceptive methods. When the study started in September 2005, contraceptives were still available at the Barangay Health Centre and the City Health Office. Women could get them there free of charge (pills, condoms) or only needed to pay a small donation (for the injectable). During the study cost of services and/or contraception did not seem to be an issue in use or non-use of contraception in the Philippines as well as in Bacolod-City. The majority of respondents mentioned it was easy or very easy for them to pay the cost of

the contraception, if they decided to use it.
However, in December 2005 the stocks of the Barangay Health Centre had almost vanished and would not be replaced according to the barangay health workers because of lack of funding. People were referred to the pharmacies and private hospitals for contraceptives. This may well influence the accessibility (physically and financially) of contraception for the women in the squatter settlements considerably.

Another problem concerns the quality of the health centre services. There is little privacy for clients and there are clear power disparities between patients and health service staff that may shape contraceptive choices and behaviours. Also health workers themselves are not always well informed and have not all received adequate training to be able to pass the information on to their clients. In this way inadequate human resources can be a major barrier to the use of family planning services.

Although a large percentage of respondents had ever used a modern contraceptive, many stopped using, now running the risk of unwanted pregnancy. Lack of quality follow-up services could well be one of the reasons for discontinuation of contraceptive use.

Information delivery

Information is an important tool for decision-making. Lack of or incorrect information on the types, costs, availability and side effects of family planning services influences contraceptive behaviour.

Newspapers and magazines and the national government campaign Ligtas Buntis were not mentioned at all by the respondents as a source of information regarding contraceptive methods. This highlights the limited effects of national campaigns on knowledge and behaviour of people. Also pre-marriage counselling, although obligatory, is not mentioned as an important information source for contraception. It could be that most couples follow the seminar of the church that only informs people about rhythm as the preferred method for family planning. Overall the results signify interpersonal communication to be effective in creating awareness about family planning methods. Health staff plays an important role in this and proper training of barangay health workers in knowledge as well as communication skills might have a positive effect on contraceptive use in the purok. The role of mass media in providing information regarding contraception is rather limited. However, messages on TV and to a lesser extent on the radio might reach the majority of the respondents if used appropriately.

Indicators of contraceptive behaviour

The percentage of women in the Philippines aged 15-19 years, who have begun childbearing, is considerably higher in the purok in Bacolod-City (26.7%) than nationally (8%). Lack of perspective in life (i.e. higher education, employment) might cause the girls to live by the day,

not realizing the effect of early motherhood on the rest of their lives, limiting their perspectives considerably.

The contraceptive prevalence rate for modern contraception in Bacolod City is low with 19.8 percent compared to 30.1 percent in the Western Visayas and 33.4 percent as the national average percentage of current users in 2003. Consequently unmet need for contraception in Bacolod-City is considerably higher with more than 60 percent compared to nearly 18 percent of Filipino women nationally. An important reason for this could be lack of knowledge, as this appeared to be a considerably greater barrier than inaccessibility or cost.
Health concerns form another major reason for non-use of modern contraception.

Research question 2

How do Filipino women in Bacolod-City perceive contraception? What are their beliefs regarding the different contraceptive methods?

Although people have often heard of contraceptives, there are a lot of misconceptions. One that was frequently mentioned is that people think contraception takes away sexual pleasure. In the literature the fear of side effects of contraception stands out as a main obstacle to contraceptive use. This is confirmed by this study.

Research question 3

In what ways do religion and status of women in Philippine society influence the perceptions of Filipino women regarding contraception?

Religion

According to the literature Roman Catholic religion is one of the main determinants for the low contraceptive prevalence rate in the Philippines. Also from the interviews with government officials it appears that the Roman Catholic church is an important stumbling block to the government with regard to the implementation of local government policies regarding reproductive health. However, in the focus group discussions, religion was only mentioned in one focus group as a reason for women not wanting to use contraception. Most barangay health workers do not regard this as an important determinant. In the survey the majority of women mention that although religion is an important factor in their life, it hardly influences their reproductive behaviour and their choice to use contraceptives or not.
Also the conviction of local government and NGO's that the attachment of sin to the use of contraception is keeping women from using contraception cannot be confirmed in this study. Most women in the survey think the use of contraception is at least appropriate under certain circumstances and often in any circumstance. It appears that religion may be a significant factor on macro and meso level, but not on the micro level. People seem to make their own choices, based on the different aspects that form their lives.

Gender & Women's status

From the literature as well as from the interviews with key informants the macho image of the Filipino man appears to be an important barrier for contraceptive use in Philippine society. The status of a man improves as he has more children. Also poorer men seem to be more susceptible to macho images than other men.

Women's decision making capacity and women's status is closely related to the attitude of the male part of society. From the literature as well as from the national data it appears women's decision making capacity does significantly influence contraceptive use. This is confirmed by this study. Almost one in three of the currently non-using respondents has a decision making capacity of low or even very low. Moreover, the more influence a woman has regarding decision making in family matters and if she has her own income, the more likely it is for her to use a modern contraceptive method.

Research question 4:

> *In what ways do native place (rural/urban), socio-economic status of the household, education, employment, and family relations of an individual Filipino woman influence her perceptions and attitudes regarding contraception?*

According to the literature all of the above mentioned factors influence contraceptive behaviour more or less. This is confirmed by the key informants and the barangay health workers, but could not be confirmed by the results from the questionnaire. Place of birth (rural/urban) and household status (nuclear/extended) as measured in the survey do not significantly influence contraceptive use. It might be place of birth is not relevant because most respondents lived in Bacolod-City more than 10 years already, so differences between rural and urban respondents have become less pronounced.

Although education is an important determinant worldwide and also nationwide, in this study no significant differences are found for different groups of respondents according to their educational attainment. Only for current use of modern contraception, respondents with high school are less likely to be a current user than a respondent with only elementary education. The quality of public high school education is not without debate and this might be one of the reasons there is hardly any difference between respondents with elementary or high school education in contraceptive knowledge and behaviour. The number of respondents with college education in this study was too small to be significant. It is possible that educational attainment becomes a determining factor with larger numbers of respondents, so the differences become more pronounced.

Also contrary to the proposition mentioned in the literature and to the expectations of the barangay health workers, the majority of the respondents in the survey having ever used

(modern) contraception is not employed. Normally employed respondents might need contraception, because they cannot afford to become pregnant and loose their jobs. However, in the purok many women are self-employed and have a shop at home or offer services from their homes. In this case pregnancies do not hinder their employment. Also their employment might provide them with resources to care for their children. Unemployed respondents might not have the resources to care for a(nother) child. However, the total income of the household did not significantly influence contraceptive use in this study.

Research question 5:

> *In what ways is the decision-making of Filipino women regarding contraception influenced by their social environment?*

Reproductive health and behaviour results from inter-personal relations and cannot be separated from the social dynamics of a couple, household or community.

Husbands play an important role in the contraceptive choices of women and they frequently prefer to have more children than their wives, especially among poorer groups with lower education. According to the literature, as well as the key informants and the barangay health workers, the husband's objection is a major obstacle for women's contraceptive use. From the survey it appeared one in three women in the squatter settlements thinks her husband would not agree with her using a modern contraceptive. Husbands have different reasons for not allowing their wives to use contraception, but spousal disagreements regarding these issues are often resolved with the husband's decision prevailing over that of his wife. Culturally it is unthinkable that a woman will take contraceptives without telling her husband. A Filipino woman needs her husband's permission to use contraception, even though it is legally not allowed to require husband's consent.

The role of the family and the community of the respondent in contraceptive decision-making is clearly less pronounced. More than one in three respondents do not think her family (in-law) will interfere with the choice regarding desired family-size. Moreover, most respondents did not think her family (in-law) would object to her using contraception and the same applied to her community.

8.3 Conclusion

Looking back, and this is confirmed by the literature, it seems the determinants of contraceptive behaviour are complex, and not easily reduced to factors such as lack of education, unfamiliarity with contraception, or unavailability of services. Nevertheless some final comments can be made.

Economic reasons are cited by the barangay health workers as well as by the respondents of the survey as the most important factor for wanting to limit the number of children and stimulating the use of family planning methods. However, although people do want to limit the number of children, they do not use contraception. From the study two reasons for contraceptive non-use stand out. On one hand women's status in general is not very high, making it easier for husbands to dictate their wives' contraceptive behaviour and not allowing use of modern contraception. On the other hand contraceptive knowledge in women as well as men seems to be rather limited, leaving room for all kinds of misconceptions, for example regarding side effects of contraception, creating an atmosphere of fear rather than opportunity with regard to modern contraceptives.

There might well be a lack of trust from the people in the purok towards the health staff regarding motives for promotion of contraception. It seems also to be hard for health staff to persuade people to visit the Barangay Health Centre, for education and information as well as services. It might be that a lack of perspective keeps people down, not feeling able to influence their future, including their reproductive and contraceptive behaviour.

8.4 Recommendations

Following from the above, empowerment of the women in the purok seems to be necessary for them to stand up and take the initiative to manage their lives and their future. Empowerment of women will improve their status and may positively influence their decision making capacity regarding reproductive and contraceptive behaviour.

For women to be able to participate in contraceptive behaviour, it is important to involve the men in programmes related to reproductive health and contraception, especially because these are considered to be women's issues. The attitudes and values held by men towards women, children and family are the products of socialisation. Further qualitative research could illuminate the motivations and attitudes regarding contraceptive behaviour, especially the perceptions on contraception of male respondents. It is important to know the perspectives of men because this will help to develop relevant programmes for men and women.

For both aspects above it seems to be helpful to develop educational programmes for men and women regarding reproductive and contraceptive behaviour. Women could also be trained in assertiveness. Husbands could be informed about the advantages and benefits of contraception and their (co-)responsibility for family planning.

Further research would be helpful to illuminate the links between reproductive and sexual ill-health and poverty, gender and social vulnerability.

Another area of research regarding reproductive health could be to identify barriers to the use of family planning services and devise and test measures to overcome them and promote appropriate use of available services.

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