Policy Brief
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Promoting Reproductive Health: A Unified Strategy to Achieve the MDGs

Debates in the country continue on the need for a national legislation, which will provide universal access to reproductive health(RH) and family planning services.

With the continuing deadlock in the passage of the RH bill, the poor population in dire need of access to RH information and services seems to be caught in a crossfire, where several women, mothers and infants die of otherwise preventable causes.

I. Introduction

Around the world, 1,500 women die everyday from complications of pregnancy or childbirth, while 10,000 babies die daily within the first month of life. Most of these deaths occur in developing countries and most are avoidable.

In the Philippines, maternal mortality rate (MMR) remains high at 162 per 100,000 live births while infant mortality rate (IMR) and under-5 mortality rate (U5MR) are 24 and 32 per 1,000 live births, respectively(FPS 2006).

The United Nations Population Fund (UNFPA) points out that women's access to effective Reproductive Health (RH) services such as family planning or birth spacing services, antenatal care, skilled attendance at birth and postnatal care would avert 30 percent of maternal deaths, 90 percent of abortion-related deaths and disabilities and 20 percent of child's deaths. The need to reassess the present RH programs and projects was also identified in the Philippines' Mid-Term Progress Report on the Millennium Development Goals (MDGs), which urged duty bearers to scale up family planning education and services, and establish innovative mechanisms for promoting contraceptives.

While the Local Government Code devolved the delivery of basic health services, including RH and family planning to local government units (LGUs) and while these services are also available in the market and are provided by private hospitals, debates in the country continue on the need for a national legislation which will provide universal access to RH and family planning services.

The Reproductive Health and Population Development bill (House Bill No. 5043/ Senate Bill No. 3122) popularly known as the RH bill, stemmed from the legislature's attempt to come up with a defined national population policy framework. However, as in the past Congresses, the RH bill is facing stiff opposition from the Catholic Church.

This policy brief aims to discuss reproductive health, its role in the attainment of the MDGs and the issues and challenges surrounding the proposed RH bill.

The SEPO Policy Brief, a publication of the Senate Economic Planning Office, provides analysis and discussion on important socio-economic issues as inputs to the work of Senators and Senate Officials. The SEPO Policy Brief is also available at www.senate.gov.ph.

II. Reproductive health policy in the Philippines over the years

The 1994 International Convention on Population and Development (ICPD), to which the Philippines is a signatory, defines reproductive health as 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 a 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 this last condition is the right of men and women to be informed and to have access to safe, effective, affordable and acceptable methods of family planning and fertility regulation of their choice, as long as they are not against the law. It is also understood that couples have the right of access to appropriate healthcare services that will enable the women to go safely through pregnancy and childbirth, and have the best chance of having a healthy infant.

Under the DoH, family planning became a component of the total health program and was viewed as a health intervention rather than a demographic one. As such, improving maternal and child health, instead of reducing fertility, became the primary concern.

With the Philippines signing the 1967 United Nations Declaration on Population which stressed that the population problem must be considered by governments as a principal element in long-term economic planning, RA No. 6365 or the Population Act of the Philippines was enacted under the Marcos administration. The said law created the Commission on Population (POPCOM) and mandated it to study the population problem and come up with the appropriate solutions.

In 1970, upon POPCOM's recommendation, the government officially launched the National Population Program (NPP) which advocated a small family size norm, and provided information and services to reduce the fertility rate.

During the Aquino administration, the focus shifted towards the right of couples to determine the number of their children, a move that was also observed in other Asian countries. In 1988, the institutional and operational responsibility of the family planning program was transferred to the Department of Health (DoH) while the POPCOM was made to concentrate on population and development activities. Under the DoH, family planning became a component of the total health program and was viewed as a health intervention rather than a demographic one. As such, improving maternal and child health, instead of merely reducing fertility, became the primary concern.

In 1991, with the passage of the Local Government Code, population policy programs were subsequently devolved to LGUs.

The Ramos government upscaled the initiative of previous administrations by redefining the country's population program from "population control" to "population management" subsuming family planning under the sustainable development framework. The sustainable development framework espouses a balance between and among population levels, resources and the environment. Then DoH Secretary Juan Flavier actively promoted family planning and reproductive health through the "Kung sila'y mahal nyo, magplano" campaign, and encouraged the use of condoms to prevent unplanned pregnancies and the spread of HIV.

NFP and the RH Needs of Filipinos

From 1969 to 2002, the country's population policies are found to be largely influenced by the Catholic Church (Herrin, 2004). The Church opposes measures to curb population growth and consistently upholds its doctrine that the sexual act should always be for the purpose of procreation and should take place only in the context of marriage. For those who need to keep their family size small, the Church recommends only one method: natural family planning (NFP), because it "recognizes the sanctity of marriage and respect for life" and helps couples develop traits such as patience, self-control and responsibility.

Natural family planning is a method used to plan pregnancy by determining the woman's fertile period. Abstinence from sexual intercourse during this time is what prevents pregnancy.

Health experts point out that NFP has its advantages, primary of which is its 96 to 98 percent effectiveness rate. NFP is also said to be safer for women since it does not use chemical agents and physical devices, hence, the absence of physical side effects. Using NFP methods also involves no expense on the part of the couples.

While NFP has its merits, it also has its disadvantages. For one, it is not an easy method to teach. It is costly as it requires extensive direct communication and training for both duty bearers and claim holders. Thus, a population policy that is solely dependent on the NFP is said to be impractical in a poor country like the Philippines. NFP cannot protect partners against sexually transmitted diseases. It also demands couples to control their sexual urges for as long as 11 straight days in a 23-day cycle as well as the keeping of daily records. Former DoH Secretary Alberto Romualdez adds that the NFP often fails with the poor because they have other important things to worry about--like where to get their next meal and thus, do not have the luxury of time to record their fertility and plan the satisfaction of their biological need.

The DoH emphasized the urgent need to raise fertility awareness among women and couples so that NFP can be more easily understood and applied as a family planning method. For women and couples who use artificial contraceptives, fertility awareness is also useful as they can resort to NFP methods in the event that pills or condoms are not available. Moreover, since NFP is the only method acceptable to the Catholic Church, DoH sees that the partnership of government units and the church in popularizing NFP has a strong potential of reducing health risks.

The Estrada administration continued the efforts of the Aquino and Ramos governments and introduced alternative demographic scenarios and other contraceptive method mixes to support fertility decline.

Under the Arroyo administration, population policy largely reflects the Catholic Church's position on family planning which emphasizes responsible parenting, informed choice, respect for life and birth spacing. Albeit acknowledging that population growth has to slow down[1], the national government is focusing solely on mainstreaming natural family planning (NFP)as the "only acceptable mode of birth control"[2] and leaves out the decision-making regarding the budget allocation for expenditures on other family planning methods to the LGUs. Amidst criticisms, President Arroyo pointed out that the government is not in violation of any law since modern contraceptives are not banned in the country and remain available commercially nationwide.

III. Reproductive health and the MDGs

Upon signing the Millennium Declaration in September 2000, the Philippines, together with 189 Member States of the United Nations, committed to raise the quality of life for all individuals and to promote human development by pursuing the achievement of the MDGs by 2015.

The MDGs are the world's time-bound and quantified targets for addressing extreme poverty in its many dimensions--income poverty, hunger, disease, lack of adequate shelter and exclusion while promoting gender equality, health, education and environmental sustainability.

Figure 1. The Millennium Development Goals

[1] The Medium Term Philippine Development Plan 2004-2010 targeted population growth to decline to 1.98 percent by 2010

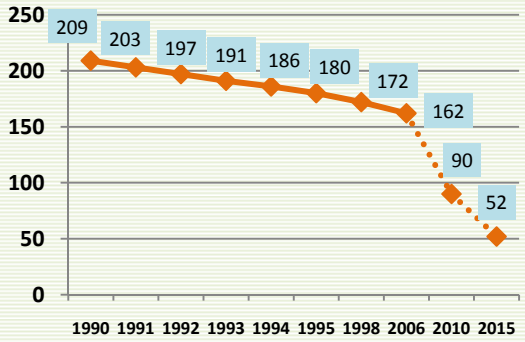
[2] DOH Administrative Order No.125, s.2002 was issued defining the Natural Family Planning Strategic Plan, 2002- 2006, which calls for the setting up of structures and activities necessary in the mainstreaming of NFP. This policy specifies the modern accepted methods of NFP, stressing the medical and sociological advantages of the approach, as well as its high efficacy of 96 - 98% user effectiveness.

Maternal health in the Philippines

Although maternal mortality rate (per 100,000 livebirths) in the country declined from 209 deaths in 1993 to 162 deaths in 2006, the plateauing trend of MMR reduction indicates that the 52-deaths target by 2015 is least likely to be achieved.

The leading causes of maternal mortality in the country are postpartum hemorrhage (20.3%), hypertension and complications of pregnancy (25%), obstructed labor, and complications resulting from abortion (9%). The slow decline in MMR, on the other hand, is traced to inadequate access to integrated reproductive health services by women, including, poor adolescents and men. (2007 MDG Progress Report)

Figure 2:. Maternal Mortality Rate per 100,000 livebirths, 1990-2015

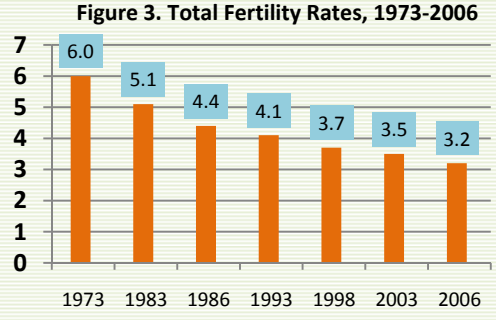


Source: NSO- 1998 data; NDHS- 1990-1995 data; FPD
**2010 to 2015 figures are targets*

Fertility rate

The country's total fertility rate has steadily declined from a high of 6.0 children per woman in 1973 to 3.2 in 2006. However, this rate is still considerably high compared to Brunei, Indonesia, Singapore, Thailand and Vietnam where women have an average total fertility rate of 2.5 (NDHS). Three factors are said to be affecting fertility rates: urban-rural disparities and the educational background and social status of the woman. Wealthier and educated women tend to have lower fertility rates than their poorer and less educated counterparts.

Figure 3. Total Fertility Rates, 1973-2006



Source: National Statistics Office

Since the MDGs are interrelated, experts recommend that strategic efforts, such as upholding human rights and improving people's access to RH services be pushed so that progress on all targets is simultaneously achieved. They emphasize that the MDGs will not be met without effective RH programs as these strengthen individuals' capacities to live more productive lives and break out of poverty traps.

Below are the elements of an RH program (as identified by UNFPA) and how they impact on women, families and the society, thereby accelerating the attainment of the MDGS.

a. Family planning information and services. Smaller families and wider birth intervals resulting from the use of contraceptives allow families to invest more in each child's education, health, nutrition and eventually reduce poverty and hunger at the household level.

At the national level, fertility reduction cuts the cost of social services with fewer people attending school or seeking medical care and as demand eases for housing, transportation, jobs, water, food and other natural resources. A study in Mexico showed that for every peso the Mexican social service system spent on family planning services between 1972 and 1984, it saved nine pesos in expenses for treating complications of unsafe abortion and providing maternal and infant care (Nortman et al, 1986). Similarly, every dollar invested in Thailand saved the government more than $16 (Chao et al,1984).Even more dramatic is the analysis in Egypt which found that every dollar invested in family planning saved the government $31 (Moreland, 19996). This projection included government expenditures on education, food, health, housing and water and sewage services.

Such scenarios open the so called "demographic window of development," where there are more productive citizens relative to dependents and where savings can increase. If the quality of governance during this period is such that savings translate into efficient and productive investments, the standard of living will significantly improve and poverty levels will be lower.

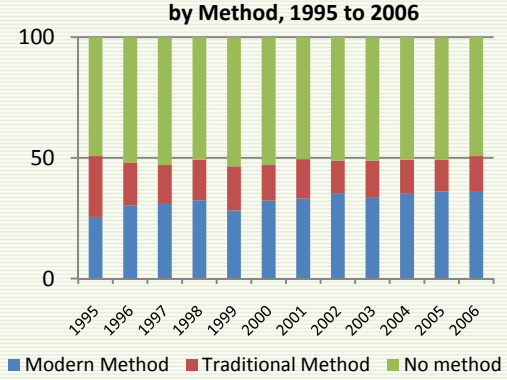
In rural areas where poverty is more evident, the reduction of fertility rates, coupled with the creation of economic opportunities will also slow urban migration and the proliferation of urban slum dwellers.

b. ***Education and counseling services on sexuality and sexual health for the youth and adolescent.*** Adolescents who have access to RH information and services are less likely to engage in risky sexual behavior, resulting in less unwanted pregnancies and curbed the spread of HIV and other sexually transmitted diseases (UNFPA 2008). Educating adolescents on sexual health gives them options in deciding the number of children they want and when to have them, as well as greater opportunities for education, work and social participation outside the home that contribute to economic and social development.

Contraception

Several survey results show that Filipino women across all socioeconomic classes desire fewer children and would like to use modern contraceptives. Yet, only 50.6 percent of Filipino women of reproductive age (15-49 years old) practice traditional and/or modern family planning methods. (FPS 2006)

Figure 4. Contraceptive Prevalence Rate by Method, 1995 to 2006



Source: NDHS & FPS, various years

As such, the unmet need for family planning (or the number of women who prefer to avoid pregnancy but are not using any form of contraception) was around 15.7 percent for all women of reproductive age and 32 percent for teenagers.(FPS, 2006)

There was, at least in the last decade, an increasing preference for modern methods (including pills and ligation) and reduced utilization of traditional methods (e.g., rhythm). However, sub-national variations in contraceptive prevalence rate (CPR) have been observed-- from a low of 19 percent in the ARMM to as high as 60 percent in Davao. CPR was lowest among poorest women, with less than four out of 10 reported to have used any family planning method.

In addition, six out of 10 prefer to give birth at home with the assistance of a traditional birth attendant rather than in a health care facility aided by a health care professional [HPDP Policy Notes vol 1 issue 2]. Such preference has important health implications – in places where mothers have difficult access to facility-based services, maternal mortality rates are higher [HPDP Policy Notes, citing Koblinsky et al. 1999] and the survival rates of newborns are lower.

Regional data have also shown that the preference for home-births appears to be location and income-related, with close to 80 percent of women in the rural areas and 90 percent in the lowest income quintile revealing such preference. In the NCR, only 30 percent prefer homebirth as opposed to almost 90 percent in the ARMM and around 80 percent in Zamboanga and MIMAROPA.

c. Maternal, infant and child nutrition and health care (including breastfeeding). Most maternal deaths can be prevented through critical interventions, which include reproductive health and family planning services, micronutrient supplementation for pregnant and lactating women, tetanus toxoid vaccination, and the establishment of Basic Emergency Management Obstetric Care (BEMOC) and Comprehensive Emergency Management Obstetric Care (CEMOC).

These health interventions not only reduce maternal deaths by about 75 percent, they are also cost-effective as saving a mother's life usually means saving the life of her newborn and that of her other children. Similarly, the healthier the mother, the healthier her children are likely to be. Studies show that children who have lost their mothers are up to 10 times more likely to die prematurely than those who have not. Therefore, a continuum of care through pregnancy and early childhood can also reduce infant and under-5 deaths.

d. Prevention and management of post-abortion complications. More than one quarter of pregnancies worldwide, or about 52 million annually, end in abortion. Many of these procedures are clandestine and performed under unsafe conditions. About 13 percent of maternal deaths are attributed to unsafe abortions, coupled with lack of skilled follow-up. Ensuring that women's need for quality contraceptive services is met results in lower number of unwanted pregnancies and reduces the incidence of abortions. Enabling health facilities to effectively manage post-abortion complications also saves women's lives.

e. Prevention and management of reproductive tract infections (RTI), HIV/AIDS and other sexually transmitted infections(STIs). High prevalence of HIV/AIDS in countries results in decreased life expectancy, overburdened health systems, weakened labor force and significantly lowered foreign investments. As over 75 percent of HIV cases are sexually transmitted, sexual and reproductive health care is a strategic point of entry for preventing the spread of the infection.

f. Elimination of violence against women and male involvement and participation in RH programs. Reproductive health problems undermine the productivity of individuals, especially women, and often push families into poverty. However, women cannot achieve gender equality and reproductive health wellness without the cooperation and participation of men. Studies have shown that it is men who usually decide on the number and variety of sexual relationships, timing and frequency of sexual activity and use of contraceptives, sometimes through coercion or violence.

Increasing men's involvement in promoting women's reproductive health improves the well-being of mothers and children and helps stop violence against them.

g. *Treatment of breast and reproductive tract cancers and other gynecological conditions and disorders as well as prevention and treatment of infertility and sexual dysfunction.* Aside from unintended pregnancies, maternal death and disability, sexually transmitted infections including HIV, women are also susceptible to reproductive tract cancers and other sexual disorders. Providing them access to treatment gives them a chance to live longer and contribute more to the social and economic development of the country.

IV. Dissecting the Reproductive Health Bill

Population-related bills filed from the 9th to 11th Congress focused mainly on controlling population growth. It was only in the 12th Congress that reproductive health issues became the primary concern of such proposals. Since then, all the succeeding bills carried reproductive health as the core issue of family planning programs.

The presence of a national policy on RH ensures individuals, especially the poor, access to RH commodities and services, regardless of the biases and the capability (or lack of it) of the LGU leaders

Authored by Senators Rodolfo Biazon, Panfilo Lacson, Jinggoy Ejercito-Estrada, Miriam Defensor-Santiago, Pia Cayetano, Loren Legarda, Ma. Consuelo Ana Madrigal, Edgardo Angara and Benigno Aquino III, SB No. 3122 (An Act Providing for a National Policy on Reproductive Health and for other purposes), aims to promote responsible parenthood, informed choice, birth spacing and respect for life in conformity with internationally recognized human rights standards. It invokes the State to guarantee universal access to medically safe, legal, affordable and quality reproductive health care services, methods, devices, supplies and relevant information.

The need for a national legislation on Reproductive Health

The passage of the Local Government Code of 1991 devolved RH and family planning programs to the LGUs. However, disaggregated data on MMR, IMR, CPR and adolescent sexual health reveal disparities of LGU efforts in delivering adequate and quality RH services.

While LGUs like Aurora, Mountain Province, Davao, Marikina and Quezon City have crafted, funded and implemented commendable RH policies (PLCPD, 2008) and programs, an urban center teeming with slum dwellers like Manila, with the issuance of Executive Order No. 003 in 2000, promoted only natural birth control methods in its family planning programs from 2000 to 2007. While the said order did not explicitly ban “artificial” contraception, it has, in practice, resulted in a sweep of these supplies and services from city health centers and hospitals, depriving many women, especially the poor, of their main source of affordable family planning supplies (Likhaan, 2007).

The presence of a national policy on RH thus ensures individuals, especially the poor, access to RH commodities and services, regardless of the biases and the capability (or lack of it) of the LGU leaders.

The issue with reproductive rights

The Catholic Bishops’ Conference of the Philippines (CBCP) and other pro-life groups agree that the RH bill makes a number of good points. CBCP admits that some of the provisions of the bill such as on maternal, infant and child health and nutrition, promotion of breastfeeding, adolescent and youth health, and elimination of violence against women, among others, are the kind of things no humane institution would have any reason to oppose. However, it believes that the bill, as it stands now, contains fatal flaws, which, if not corrected will make it unacceptable.

Opposition to the RH bill stems from having reproductive rights[3] and freedom of choice as among the guiding principles of the bill. In countries such as the United States, reproductive rights and freedom of choice together with the right to privacy were interpreted and used as the basis for legalizing abortion before the fetus becomes viable[4] (Roe vs. Wade, 1973). Citing American jurisprudence, pro-life advocates point out that since at the root of contraception is the notion that a couple can engage in sexual activity and avoid its natural consequences, acceptance of contraception also increases acceptance of abortion. Hence, couples who unintentionally conceive a child while using contraception are far more likely to resort to abortion than others.[5]

According to UNFPA studies, correct and regular use of contraceptives reduces abortion rates by as much as 85 percent and negates the need to legalize abortion.

And thus, whereas the 1987 Philippine Constitution guarantees the rights to liberty, health, equality, information and education for all citizens, as well as the right of spouses to found a family in accordance with their religious convictions, pro-life advocates remind government of its policy of upholding the right to life, and the protection of life of the mother and that of the unborn from conception.

The Church also fears that by proposing that government provide universal access to artificial contraceptives, the bill will result in promiscuity, abortions and moral decay.

Both House and Senate versions of the RH bill, however, clearly state that the proposed measure does not change the law on abortion and that abortion will remain a punishable crime. Moreso, while the RH bill allows individuals and couples to exercise their reproductive rights, they can do so provided that they do not violate existing laws.

On providing for post-abortion care

RH advocates explain that even as it provides for post-abortion care and allows access to contraceptives, the bill will not, in any way, lead to the legalization of abortion. Instead, it seeks to ensure that women needing care for post abortion complications shall be treated and counseled in a humane, non-judgmental and compassionate manner. In 2000, it is estimated that there are around half a million abortion cases or 27 abortions per 1,000 women in the Philippines. This was attributed to the difficulties women experience in obtaining information on and access to means to prevent an unplanned and unwanted pregnancy (Juarez, et al, 2005).

The experiences of other predominantly Catholic countries such as Mexico, Panama, Guatemala, Brazil, Chile, Colombia, Dominican Republic, El Salvador, Honduras, Nicaragua, Venezuela, Paraguay and Ireland, also show that while they vigorously promote contraceptive use, abortion in their countries remains to be a criminal offense. The Muslim and Buddhist countries of Indonesia and Laos also promote contraceptive use yet proscribe abortion.

[3] Reproductive rights are the basic rights of all couples and individuals to decide freely and responsibly on the number, spacing and timing of their children, to have the information and means to do so, and the right to attain the highest standard of sexual and reproductive health.

[4] A fetus is said to be "viable" if it has a chance of reaching full term or live birth. Thus, Roe vs. Wade gave American women an absolute right to an abortion in the first three months of pregnancy.

[5] The United States Supreme Court in the Planned Parenthood vs. Casey decision connected contraception and abortion.

> ". . . in some critical respects abortion is of the same character as the decision to use contraception. … For two decades of economic and social development, people have organized intimate relationships and made choices that define their views of themselves and their places in society, in reliance on the availability of abortion in the event that contraception should fail."

Best Practice

The Gattaran Cagayan case

A noteworthy local health endeavor in improving maternal health is that of Gattaran, Cagayan. For years and with assistance from the UNFPA, the said municipality maintained zero maternal deaths, thus earning recognition in 1996 from the Commission on Population as a best practice in RH care.

How was it done?

Crucial to the program's success were the establishment of birthing centers with assured quality motherhood services in far barangays of the municipality and the installation of an effective referral system to the municipal hospital in the event of birthing complications. Dr. Gilda Rosales, municipal health officer (MHO) at that time, with assistance from UNFPA, spearheaded the training of midwives and barangay health workers in maternal health and family planning, and formed them into teams who regularly checked on pregnant women.

Barangay councils passed ordinances requiring women to give birth only in birthing centers to ensure safe delivery. The councils also shouldered the electricity and water bills of birthing centers.

To make the delivery affordable, a prepaid perinatal system where a pregnant woman saves for her delivery by paying a portion of the fees during pre-natal visits was introduced. The fee covers delivery expenses as well as payment for the attending health workers. The scheme made birthing centers sustainable.

Youth groups and male motivators were also organized by the MHO to promote the dissemination of correct reproductive health information and to advocate for responsible sexuality, gender equality and reproductive rights.

The ownership of the program and the collaborative effort and participation of the entire community made zero maternal death possible.

According to UNFPA studies, correct and regular use of contraceptives reduces abortion rates by as much as 85 percent and negates the need to legalize it.

Table 11. Selected Reproductive HealthIndicators In Predominantly Catholic Countries

	Maternal Mortality Rate		Infant Mortality Rate		HIV Prevalence		Contraceptive Prevalence	
Country	**2000**	**2007**	**2000**	**2007**	**2000**	**2007**	**2005**	**2006**
Brazil	260	110	32	28	0.60	0.60	76.7	-
Chile	31	16	32	22	0.30	0.30	56.0	60.7
Colombia	130	130	21	17	0.50	0.60	78.2	78.2
Dominican Republic	150	150	34	21	1.30	1.10	69.8	69.8
El Salvador	150	170	29	22	0.70	0.80	67.0	67.3
France	17	8	4	4	0.30	0.40	75.0	81.8
Honduras	150	220	32	20	0.90	0.70	61.8	65.2
Ireland	5	1	6	4	0.20	0.20	60.0	-
Italy	5	3	5	3	0.40	0.40	60.0	-
Mexico	83	60	29	23	0.30	0.30	74.0	70.9
Philippines	180	172	29	23	-	0.10	48.9	50.6
Portugal	5	11	6	3	0.50	0.50	66.0	67.1
Spain	4	4	5	4	0.50	0.50	81.0	-
Timor-Leste	660	380	100	77	-	-	10.0	10.0

Sources: Maternal Mortality in 2005 Estimates developed by WHO, UNICEF, UNFPA, and The World Bank (WHO, 2007), Maternal Mortality in 2000 Estimates developed by WHO, UNICEF, UNFPA, and The World Bank (WHO, 2004), World Development Indicators, 2007 (http://ddp-ext.worldbank.org/ext/GMIS/home.do?siteId=2)

Public funding for family planning supplies and services

Until the start of its phase out of donation of Family Planning (FP) commodities in 2003, the United States Agency for International Development (USAID), for 36 years, has been shouldering 80 percent of the total requirements of FP commodities in the Philippines. The cost of the said commodities amounted to US$ 3 million annually.

Data shows that 58.1 percent of Filipinos who use modern artificial family planning methods rely on government for their supply of contraceptives (NSO, FPS 2006). With donor support for sexual and RH services falling short of the commitments made at the 1994 ICPD, governments of developing countries, including the Philippines, are now faced with the challenge of funding their RH programs.

The RH bill seeks to address this issue by guaranteeing the RH supplies and services in all national and local hospitals. It promotes the use of "full range" FP methods, both natural and modern and classifies FP supplies as essential medicines, mandating the government to procure them together with vaccines, and anti-tuberculosis (TB) drugs. The bill also mandates each province and city to establish or upgrade local government hospitals with adequate and qualified personnel, equipment and supplies to be able to provide basic and emergency obstetric care.

Pro-life advocates, however, are concerned that since the bill is silent on and does not renounce abortifacients, the full range of contraceptives to be procured will include those that cause early-term abortions or prevent a fertilized egg from being implanted in the uterine wall such as the RU 486 pill or the intra uterine device.

The need for an effective mechanism to ensure access to modern FP in LGUs

In 2004, the DoH issued Administrative Order (AO) 158 in 2004, which introduced the Philippine Contraceptive Self Reliance (CSR) strategy. Stemming from the country's MDG commitment of ensuring that 100 percent of women of reproductive age have access to RH services and are practicing responsible parenthood by 2015, AO 158 aims to arrange for the gradual replacement of externally donated supplies with domestically provided ones and to assure free supplies to the poorest users.

Estimated cost of FP commodity requirements (excluding sterilization) to achieve 100 percent CPR by 2015 (In Million PhP)

year	Projected FP users	Cost of condoms, injectibles, pills & IUD
2008	7,006	1,115.6
2009	8, 123	1,293.0
2010	9,302	1,477.1
2011	10.514.7	1,667.8
2012	11,766	1,864.7
2013	13.054,437	2,067.3
2014	14,378,169	2,275.5
2015	15,736, 270	2,490.4

Source: PLCPD, 2008

In line with the CSR strategy, the General Appropriations Act (GAA) of 2007 stipulated the appropriation of PhP 180 million to DOH for the operational costs of providing contraceptive services. Of the said amount, PhP 30 million is for the routine functions of the DoH in support of family planning, while PhP 150 million is for the purchase of FP commodities and the conduct of training on FP/RH.

Since the Special Allotment Release Order(SARO) for the said line item was released only in February 2008, the P150 million was constituted into the Maternal, Newborn, Child Health and Nutrition (MNCHN) Grant of 2008. The said grant was divided among regions based on the estimated number of poor women of reproductive age (WRA). At the LGU level, prior to release of funding, the DoH conducted a CSR rapid assessment from June to July 2008 to gauge LGUs' performance in the provision of FP/RH services. The areas assessed were:

- Presence of local staff designated for maternal and child health and family programs
- Training and IEC activities
- Determination of family planning commodity requirements
- Procurement of commodities budgeted
- Commodities actually procured
- Free commodities for the poor

Since it is assumed that not every LGU can provide all FP and RH services, the DoH allowed the clustering of LGUs. Local governments which exhibited capacity and good performance in the provision of FP/RH services immediately received grants. Taking note of the areas assessed, it was not surprising that among the first LGUs to receive the MNCHN grant were the 1st class LGUs in Metro Manila such as Makati, Manila, Mandaluyong, Muntinlupa and Taguig.

The 2008 GAA appropriated Php 2 billion for RH. However the utilization of the said fund by LGUs has yet to be reported. It will also be interesting to note that as of June 30, 2009, only 81.37 percent of the 2008 MNCHN grant facility under the 2007 GAA has been released.

In 2009, of the PhP 1.2 billion budget for DoH's family health program, the amount of PhP 167 million under the MNCHN grant facility is made available to LGUs that provided FP services to its constituents. The areas assessed by the DoH in the allocation and release of grant are the capacity of LGUs to achieve target MNCHN indicators (using 2010 National Objectives for Health goals) and the implementation of plans for received FP funding in 2008.

This raises a serious concern because while it is true that health services have been devolved, the poor LGUs, who are largely dependent on national government for funding and who happen to be the majority, still struggle in the areas assessed by DoH. Thus, until these poor LGUs improve their capacities in fiscal planning and management to enable them to deliver basic services, they will continue to be disadvantaged by mechanisms such as those used by the DoH.

Mandatory RH and sexuality education for school children starting from the 5th grade and up

Data from the 1994 and 2002 Young Adult Sexuality and Fertility Survey (YAFFS) show that more Filipino youth are engaging in premarital sex at increasingly younger ages, and they do so without sufficient knowledge on RH, particularly the consequences of early and unprotected sex. Curious about sex, they seek information from unreliable sources like their peers and pornographic materials, unable as they are to get that from socialization agents like their family or school. Worse, some of them learn about sex from actual experience, without fully knowing how one could get pregnant or contract sexually transmitted diseases.

More Filipino youth are engaging in premarital sex at increasingly younger ages, and they do so without sufficient knowledge on RH, particularly the consequences of early and unprotected sex.

In light of the increasingly risky sexual behavior among a significant number of youth and adolescents, the RH bill proposes mandatory education on sexuality and RH for students in the 5th grade to high school.

The six-year mandatory sexuality and RH education is being questioned by conservative groups, pointing out that allowing young people access to RH information and services will encourage promiscuity and that the State should not take over the role of parents in educating their children on sexuality.

Cross-country evidence from the UNFPA, however, show that sex education among the youth lead to responsible behavior, higher levels of abstinence, later initiation of sexuality, higher use of contraception and fewer sexual partners.

On prescribing the ideal family size

Section 16 of the House version of the bill states that: *The State shall assist couples, parents and individuals to achieve their desired family size within the context of responsible parenthood for sustainable development and encourage them to have two children as the ideal family size. Attaining the ideal family size is neither mandatory nor compulsory. No punitive action shall be imposed on parents having more than two children.*

Although the provision does not compel or punish parents with more than two children, prescribing the ideal family size is, aside from being unnecessary, is contrary to the underlying essence of reproductive rights and freedom of choice—which are the guiding principles of the RH bill.

The Senate version does not contain the said provision.[6]

[6] As of the opening of the 3rd session of the 14th Congress, the RH bill in both houses of Congress is still in the period of plenary debates and interpellation, pending approval on second reading.

Religion and Universal Access to Reproductive Health

International organizations recognize that religion, as practiced and interpreted is a powerful force, with both positive and negative impacts on government policies and development programming.

The World Bank, in its documentation of family planning and RH programs around the world, points out that having a strong Catholic Church was not the defining impediment to the expansion of family planning, rather, it was the close ties between the Catholic Church and the ruling elite on the issue of family planning.

Spain. In 1941, under the rule of Francisco Franco and with the strong influence of the Catholic Church, legislation banning the dissemination of family planning information and distribution of artificial contraceptive, such as the Birth Protection Law and the Protection of Large Families Law were passed. The said laws remained in effect for the next 35 years.

Gradual social and political changes—such as the diminishing influence of religion and of the traditional patriarchal family, the increasing number of women in the workforce and the aggressive promotion of family planning as a health intervention by medical professional have led the Spanish government to legalize the use of contraceptives and to allow family planning clinics to be established. In 1985, abortion was legalized in instances of rape, severe fetal abnormalities or if the mother's mental or physical health is at risk.

Under the current regime of Prime Minister José Luis Rodríguez Zapatero, the government is studying the possibility allowing the free sale of the emergency contraception pill in pharmacies without prescription and the expansion of conditions for legal abortions, adding economic conditions as an acceptable cause, and allowing first trimester abortions on request.

Portugal. The political and ideological principles of the Fascist regime under Antonio Salazar , which lasted for 48 years, was strongly influenced by the Catholic Church and also determined social and sexual roles of the male and female

The revolution of 1974, which ended the dictatorship also gradually liberalized policies on sex education, contraception and family planning. In 1984, abortion was legalized in certain situations upon the woman request: if it was the only way to prevent serious physical or psychological injuries or death to the woman (during the first 12 weeks); if there was a high risk of serious disease or malformation to the newborn (during the first 24 weeks); if the pregnancy was the result of a sexual assault situation (during the first 16 weeks).Several attempts have been made to change the law to make it more extensive, but without any success.

Since 1985, contraceptives are widely available at pharmacies, hospitals, and health centers. Condoms are also distributed by institutions involved in the prevention of HIV infection. The emergency contraceptive pill, however can only be availed upon doctor's prescription. Sterilization is also available.

In other instances, building bridges and entering into a sustained and constructive dialogue and partnerships between the State and the Church—one that stresses common values and shared aspirations, has led to the reproductive health.

Timor Leste. In Timor Leste, several meetings were conducted with Catholic Church leaders to raise awareness and understanding on issues related to reproductive health as well as population and development as part of the ICPD agenda.

Because of successful advocacy with the Catholic Church during the past two years (2005-2007), there is no longer aversion to the inclusion of adolescent sexual and reproductive health in school curricula. The Salesian priests are providing sexual education to Don Bosco Secondary School students while the Carmelite sisters occasionally offer sexuality orientation to groups of teenage girls.

The Ministry of Health has also partnered with the Catholic Church through the Catholic Faith Based Organization (FBO) Caritas Dili on issues of family planning, maternal and child mortality and morbidity, adolescent reproductive health, and prevention of HIV and STIs.

Colombia. In a country caught in armed conflict and poverty, the partnership between UNFPA and the local Catholic Church has been enabled through finding common ground and goals, such as striving for a respect for life, for the dignity and freedom of people, and for the education of the young in the practice of safe and responsible sexuality.

UNFPA let local religious leaders make decisions and define the scope of their political vision, since they know the risks they face if they defend principles that are not approved by the ecclesiastical hierarchy. This has allowed local religious leaders to respectfully manage their relationship with the Church, as well as to have a clear focus on results of peace and development projects (which included sexual and RH). In this relationship, the Catholic Church respects the standards of basic care services for sexual and reproductive health; however, it does not distribute supplies for family planning itself, but instead designates health workers to disseminate the contraceptive supplies directly.

V. Conclusion

The experiences of some LGUs such as Aurora, which has its own RH code and Gattaran, Cagayan where maternal death is zero, show that reproductive health can flourish in the hands of proactive and innovative local leaders and health officers even without a national legislation on RH. However, for LGUs whose local executives are biased against it, or are not resourceful enough to tap alternative sources of funding, a clear national policy on reproductive health is the only answer.

Though it does not claim to be the panacea for poverty, the RH bill holds much promise in improving the lives of Filipinos—most especially the women and the poor and thus, Congress should no longer delay its passage.

By providing women, youth and couples universal access to a full range of safe, legal and effective modern and natural family planning methods from which they can choose the one most suitable to their needs and religious convictions, the RH bill can accelerate the country's progress in attaining the MDG health goals by 2015.

In *Culture Matters: Lessons from a Legacy of Engaging Faith-based Organizations,* development experts stress the importance of incorporating language and developing advocacy campaigns that appreciate the nuances of religion and religious sensitivities in drawing support and appreciation for RH and family planning programs.

The Catholic Leadership should allow the RH bill to pass in Congress and consider forging a principled collaboration with government in the promotion of natural family planning. It should continue its efforts to educate its flock on NFP, responsible sex and parenthood, but it should also remind itself that the Philippines, while predominantly Catholic, is still a multi-faith country, and those who do not share the Church's beliefs should not be deprived of their right to other means of planning their families. Countless surveys have shown that majority of the Filipinos, including Catholics, support a reproductive health legislation.

While awaiting the long overdue passage of the RH bill, identification of the poor and the uneducated population who are most in need of access to RH services should now be started to ensure the cost-effectiveness of the program. Poverty alleviation projects and those supportive of the MDG health goals must also be scaled up and continuously monitored and assessed to ensure that they benefit the Filipinos, most especially the marginalized.

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