From an NGO Lens:

The ICPD at 15 Report - Philippines

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A Note About this Report

In 2008, a group of non-governmental organizations (NGOs) composed of the Forum for Family Planning and Development (The Forum); Philippine Legislators' Committee on Population and Development Foundation (PLCPD); Philippine NGO Council on Population, Health and Welfare, Inc. (PNGOC); and the Employers' Confederation of the Philippines (ECOP) responded to the urgent need for civil society organizations to develop a report on the progress of the Philippines in terms of upholding its commitments to the 1994 International Conference on Population and Development Programme of Action (ICPD PoA) in Cairo. The International Conference on Population and Development (ICPD), convened under the auspices of the United Nations, took place in Cairo, Egypt, September 5-13, 1994. It brought together representatives from over 180 governments and 1,254 NGOs. The Programme of Action (PoA), an outcome of this meeting, adopted by 179 governments, marked a new understanding among world bodies, that population and development are inextricably linked, and that women's empowerment is the key to both. And, for the first time, the reproductive and sexual health and rights of women became a central element in an international agreement on population and development.

In preparing this report, the lead NGOs formed a Technical Working Group that included other NGOs and members from the academe. An Editorial Team was also set up composed of the lead writers, contributing writers, researchers, editors and editorial consultants. A series of dialogues and consultations were held in selected areas of the country and these were participated by civil society organizations including the media, academe and the business sector. Thus, the report presents the latest studies, data and statistics at the time of writing. At the same time, the report tried to capture the information, challenges, insights and recommendations at the community and grassroots level through the wealth of experiences of various civil society organizations at the national and local levels. While there is an attempt to try to document the many contributions and insights from the NGO sector, this report makes no claim of being comprehensive given the vast network of NGOs all over the country and the broad concerns and issues being addressed by the ICPD agenda. Moreover, this report is intended to be short to make it more reader-friendly.

The individuals and civil society organizations behind this document recognize and encourage other civil society groups working in the field of population and development, as well as reproductive and sexual health and rights to share their stories, experiences, opinions and recommendations. Through our combined efforts, a clearer picture of the state of the Philippines' reproductive and sexual health and rights will unfold to make the government more accountable and the civil society more steadfast in upholding all levels the ICPD Agenda.

Urgent Resolution for the Immediate Passage of the REPRODUCTIVE HEALTH BILL by CONGRESS

ICPD at 15 National Conference
26 August 2009
Philippine International Convention Center (PICC)

WE, the government and civil society participants to the ICPD at 15 National Conference:

Recognizing that a national, rights-based, pro-poor and comprehensive reproductive health (RH) policy is crucial in meeting the Philippines' obligations under the International Conference on Population and Development Programme of Action (ICPD POA) and the Millennium Development Goals (MDGs);

Seriously concerned with the urgent need to drastically reduce the maternal morbidity and mortality rates which affect not only Filipino women but also their families;

Convinced that as shown by all surveys through the years, the big majority of Filipinos support the passage of the RH Bills into law;

Cognizant that these proposed measures pending in both chambers of Congress have undergone lengthy discussions, that all questions have been adequately answered, and that most legislators already have their respective positions on the RH Bills;

Severely concerned that in the past months both the House of Representatives (HOR) and the Senate have not resumed deliberations on the Bills despite their being in the Order of Business each session day; and

Deeply alarmed that time is running out and that the House of Representatives (HOR) in particular is having difficulty mustering a quorum to conduct business;

Therefore, urgently call on

Our legislators to fulfill their responsibilities by being present during their sessions and by truly representing the interests of the Filipino people on this vital proposed legislation; and

The leadership of both the HOR and Senate to expedite the deliberations and already put the RH Bills to a vote.

Adopted on 26 August 2009 at the Philippine International Convention Center (PICC), Pasay City.

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"Everyone has the right to the enjoyment of the highest attainable standard of physical and mental health. States should take all appropriate measures to ensure, on a basis of equality of men and women, universal access to health-care services, including those related to reproductive health care, which includes family planning and sexual health. Reproductive health-care programmes should provide the widest range of services without any form of coercion. All couples and individuals have the basic right to decide freely and responsibly the number and spacing of their children and to have the information, education and means to do so."
ICPD Principle 8

The 1994 ICPD: Putting Sexual and Reproductive Health and Rights (SRHR) on the Global Agenda

In 1994, 179 countries signed the Programme of Action of the International Conference on Population and Development (ICPD PoA) with the Philippines being one of the signatories. The ICPD PoA set benchmarks over a 20-year period from 1994 to 2015 during which substantial accomplishments on key indicators covering population, health, development, gender equality and women's empowerment issues and concerns have to be achieved.

Held in Cairo, Egypt (hence, also referred to as the Cairo Conference), the ICPD was a milestone in the population and development discourse as it "fundamentally shifted policy direction away from demographically-driven approaches towards policies grounded on concerns for human rights, social well-being and gender equality, with particular emphasis on reproductive health and rights."[1] Prior to ICPD, "assessments of program success rested largely on the contraceptive prevalence rate (CPR)."[2] The ICPD also recognized that "the empowerment and autonomy of women… is a highly important end in itself."[3]

Moreover, family planning (FP) was grounded within the larger reproductive health (RH) framework, as one element among a constellation of services needed to ensure the reproductive health of women, men and young people. Prior to the ICPD, governments of various countries mainly implemented population programs with the objective of meeting population and fertility targets.

Among the numerous goals set by the ICPD in 1994 are the following:

- Universal access to reproductive health services by 2015;
- Universal access to primary education and closing the gender gap in education by 2015;
- Reducing maternal mortality by 75% by 2015;
- Reducing infant mortality; and
- Increasing life expectancy.

Since the signing of the agreement, there have been two five-year reviews – the first in 1999 (ICPD+5) and the second in 2004 (ICPD+10). 2009, marks the 15th year of the 20-year ICPD PoA. It offers us an opportunity to reflect on our progress to date and to take a real look at the challenges that lie ahead not only for the next 5 years, but beyond.

The ICPD and the Millennium Development Goals (MDGs)

In 2000, 189 countries including the Philippines, signed the Millennium Declaration and adopted the Millennium Development Goals (MDGs). The MDGs cover eight (8) goals that countries should focus on in their respective national poverty alleviation and development efforts that would contribute to addressing and reducing global poverty.

The eight (8) MDGs are:

1. Eradicate extreme poverty and hunger;
2. Achieve universal primary education;
3. Promote gender equality and empower women;
4. Reduce child mortality;
5. Improve maternal health;
6. Combat HIV/AIDS, malaria and other diseases;
7. Ensure environmental sustainability; and
8. Develop a global partnership for development.

The MDGs, according to the United Nations (UN), 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, education, and environmental sustainability".[4] Since their endorsement by the UN General Assembly in 2001, the MDGs have risen to the top of the development agenda, and are the common focus of priorities for the development community.[5]

While signatories-countries have begun to focus their efforts and programs in achieving the MDGs beginning 2000, many NGOs and women's organizations worldwide assert that the ICPD remains the more comprehensive document that cover a wider set of issues for addressing population, health, and development concerns. The NGOs feel that the ICPD PoA should not be in any way set aside or substituted for by the MDGs due to the fact that the ICPD sets the framework for addressing such issues and challenges on population, health and development within a gender-and rights-based analysis. Both the ICPD PoA and the MDGs cover similar issues and challenges that need to be addressed within the perspective of population, reproductive health, development and poverty alleviation.

Notably, the challenge of addressing widespread poverty in all aspects of international and national development programs is a key concern for both ICPD PoA and the MDGs. Also, the important links of ICPD PoA goals and targets to achieving the MDG targets have been established. A review of the MDGs during the World Summit in 2005 saw the introduction of MDG Target 5B to 'achieve, by 2015, universal access to reproductive health'; indicators for which were finalized in 2008.

These indicators included: (a) contraceptive prevalence rate; (b) adolescent birth rate; (c) antenatal care coverage (at least one visit and at least four visits); and (d) unmet need for family planning.

International and national organizations that work in population and development have similarly identified various elements establishing the link between ICPD and poverty and how ICPD goals buttress MDG targets. These include:

- The provision of quality sexual and reproductive healthcare services helps reduce the unmet needs for contraception, unintended pregnancy and unsafe abortion, especially among the poor. Access to quality family planning services contribute to reductions in fertility rates critical to reducing poverty and increasing women's mobility and employment opportunities.[6]

- The increase of people infected with HIV and AIDS, if unabated, may lead to a decrease in the productive working life of breadwinners that can push many of the affected families into poverty. Vulnerable groups, especially in developing countries, include young women, children and the older caregivers left with the responsibility of caring for those infected, and the children left

behind by those lost to the disease. The social and economic costs of care giving not only increase the burden on the society and the community but further exacerbate the situation of the poor.[7]

- Reducing the mortality rate among infants and children is closely linked to improving maternal health. Addressing the needs of women for reproductive health and nutrition services can meet the goal of minimizing infant and children mortality. In this aspect, empowering women through adequate information and support services related to reproductive health and nutrition, as well as improving their economic condition[8] can lead to enhanced ability of women for infant and child care. The provision of reproductive health and nutrition services can also eradicate existing discrimination against girl-child and reduce the mortality rate among girl-children.

- The feminization of migration is a phenomenon that has been increasing in the past decades to meet labor shortages in many developed countries and a trend encouraged by developing countries in an effort to alleviate poverty. However, encouraging international migration with increasing number of young women crossing borders requires management, both from the receiving and sending countries, to ensure economic gains, improvement of women's status, safeguarding their well-being to ensure productivity in a safe environment where no form of violence exists. Inevitably this means implementing programs that address their sexual and reproductive health needs.[9]

- Gender-based violence, in general, covers (a) violence occurring in the family; (b) violence occurring within the community, including rape, sexual abuse, sexual harassment in the workplace, trafficking of women and girls, and forced prostitution; and (c) violence perpetrated or condoned by the State, including custodial violence and violation of women's reproductive rights.[10]

While there are benchmarks set in ICPD and MDG on various important issues such as education, environment, migration, trafficking, and others, this NGO Report will focus on advancements (or reversals) in the Philippines in relation to the following dimensions:

- Reduction of maternal mortality;
- Reduction of unmet need for family planning;
- Ensuring universal access to reproductive health care services;
- Reducing the recourse to unsafe abortion and the management of complications from unsafe abortion;
- Ensuring young people's rights to access SRH information and services; and
- Gender equality and women's empowerment, especially removing discriminatory laws that prevent women and young people from having access to information and services on a comprehensive range of reproductive health, including family planning.

Since the concepts of reproductive health (RH) and reproductive rights (RR) are the overarching framework used for the above indicators, the NGO assessment will also look into how RH and RR have been treated and promoted/not promoted in policies and in programs.

"ICPD sets the framework for addressing issues and challenges on population, health and development within a gender- and rights-based analysis."

II. HOW HAS THE PHILIPPINES FARED 15 YEARS AFTER CAIRO

Prior to ICPD, the government had no concept of reproductive health (RH) or of the reproductive health approach.[11] Population programs that were in place mainly dealt with setting and achieving demographic targets, including reducing fertility rates, which often did not consider factors such as gender inequality and inequity and the real situation of women who were the primary targets of such programs and hence the most affected. Moreover, even if there existed programs to curb rapid population growth, lack of political conviction and support served as hindrance to effective implementation and continuity of the program.

Under the regime of President Ferdinand Marcos, birth control and family planning emerged as a strong concept with various laws enacted to implement a family planning program from the national down to the local government levels. Funded by foreign aid, the Marcos government poured resources into a family planning program that was supervised by the Commission on Population (PopCom), which was created to oversee the implementation of the program. The government also made available modern artificial family planning methods and supplies to couples; while strong emphasis on having few children was publicized in various media. Such family planning program was cut short when devout Catholic Corazon Aquino took over after the People Power Revolution. Strongly supported by the late Manila archbishop Jaime Cardinal Sin, President Aquino adhered to the Catholic Church's position against artificial methods of family planning.

Significant policy changes/reforms were initiated by the Philippine government during the immediate post-Cairo period under the administrations of President Fidel V. Ramos (1995-1998) and Joseph E. Estrada (1998-2000). Examples of these were: the creation of an Integrated Reproductive Health Program and elaboration of the RH approach; administrative orders such as AO 1-A, s1998 and AO 43, s1999 spelling out the RH policy and identifying the ten elements of RH; AO 34-A, s2000, policy on adolescent and youth health; AO 45, s2000 on the prevention and management of abortion and its complications; and AO 79 s2000 on safe motherhood.

While still not ideal and not as comprehensive as outlined in the ICPD, these were generally welcomed and accepted by many NGOs since these addressed many of the RH issues and concerns long identified by women, health and population and development NGOs. The NGOs and those supporting the institution of an RH policy also bewail the lack of continuity of previous policies that were meant to directly or indirectly support population management and reproductive health.

For instance, one major policy initiative of the Estrada administration was the registration of the emergency contraceptive, Levonorgestrel 750 mcg or Postinor, as an option that can be taken by women who had been raped. Postinor was made available on a limited basis in government-run women and child protection units (WCPU). However, Postinor was delisted by the Bureau of Food and Drugs (BFAD) in late 2001 based on the complaint of a "pro-life" group that claimed the emergency contraceptive (EC) was abortifacient, even if all studies point out that EC prevents pregnancies. Delisting Postinor removed another option to help women prevent unintended pregnancies resulting from rape or incest.

In the 1992-2000 period, there was relatively strong government-NGO cooperation on RH and FP matters, including the review processes for various international conferences. An example of GO-NGO cooperation is the holding of the first Asia Pacific Conference on Reproductive Health (APCRH) on February 15-19, 2001 attended by 1,343 delegates from 38 countries. It was so far the largest gathering of NGO managers, government workers,

researchers, legislators, local government officials, medical practitioners, youth advocates, donors and other RH professionals working in the Asia-Pacific Region. It was also the first official international event attended by Her Excellency President Gloria Macapagal Arroyo after ousting President Joseph Estrada in a people power revolution. It was here that she affirmed the four pillars of the country's population policy, namely, responsible parenthood, birth spacing, respect for human life, and informed choice. Then DOH Secretary Alberto Romualdez served as chaired the International Steering Committee while the Philippine NGO Council on Population, Health and Welfare (PNGOC) acted as conference organizer and secretariat. However, such active cooperation began to wane in recent years owing to the fundamental differences in perspectives on RH and FP between NGOs and the Philippine government. Some of the policies that have been adopted by the present administration are in direct conflict with the advocacies of NGOs working to implement the ICPD PoA and MDG. Moreover, the administration of President Gloria Macapagal-Arroyo passed on the responsibility of family planning and reproductive health to the local government units, while denying funding for the provision of family planning supplies.

The present government also developed an aversion to the term RH itself. When used in official documents and pronouncements the term RH now often has to be followed with a disclaimer that it does not include abortion. The President likewise ordered the National Commission on the Role of Filipino Women (NCRFW) to remove from the medium term program for Filipino women any reference to reproductive rights.[12] Instead of using the term "reproductive health and rights" that the President would not accept, the term "comprehensive women's health services" was used. Part of its description included "the right of women to determine the size and the spacing of their children" and the notion of "humane and compassionate treatment of women who have undergone abortion." With this, NCRFW rationalized the endorsement necessary to implement their framework.[13]

Government Adoption and Enforcement of NFP-Only Policy: Reversing the Gains of ICPD

Much of the progressive policies on RH put in place in the mid-1990s were reversed from 2001 up to the present time under the Arroyo administration. The government implemented AO 50-A, s2001 (National Family Planning policy), and AO 125, s2002 (National NFP-Only Strategic Plan). It created the DOH NFP Program and its management through AO 132, s2004 and implemented AO 125 s2002 which is the National Natural Family Planning Strategic Plan for 2002 to 2006.

The women's NGO Likhaan cited in its ICPD+10 Shadow Report published in 2004 that "initial efforts made by the previous governments that was at most towards expansion of the FP program regressed during [the GMA] administration. The allocated funds intended for the purchase of contraceptives were diverted to other health expenses on grounds that the government has a policy against purchasing contraceptives. Yet P 50 million was given to the Couples for Christ – a Catholic lay organization, to promote and teach natural family planning."[14]

As the national government passed on the implementation of population management and RH policies to the local governments, some of them took the initiative to come up with their own family planning policy. This was the case of the City of Manila when it enforced Executive Order (EO) 003 from 2000 to 2007, until a new local chief executive who was more open to FP was elected. EO 003 provides that "The City promotes responsible parenthood and upholds natural family planning not just as a method but as a way of self-awareness in promoting the culture of life while discouraging the use of artificial methods of contraception like condoms, pills, intrauterine devices, surgical sterilization, and others."[15]

The various NGOs that monitored the implementation and impact of this EO asserted that "on its face, the EO established an affirmative policy of promoting 'natural' family planning. In practice, the policy has been applied to prohibit the provision of 'artificial' family planning services in all city hospitals and health centers."[16] The EO in effect did not encourage freedom of choice among the citizens of Manila on selecting the family planning method to use. Instead, it adheres to the teaching and preference of the Catholic Church for a natural family planning method.

NGO groups such as the Reproductive Health Advocacy Network (RHAN) denounced the EO and organized a Task Force from among its members to assist the women of Manila to challenge the Executive Order and draw support from various sectors of the country. On March 2008, Lourdes Osil and 19 other women residents of Manila filed a case against then Mayor Lito Atienza and the City Health Office against EO 003. Their case was supported by RHAN member NGOs like the Linangan ng Kababaihan; Reproductive Health, Rights and Ethics Center; WomenLead; EngenderRights and five lawyers from the University of the Philippines College of Law.

EO 003 was particularly damaging to the health of poor women, men and young people in the affected communities since it effectively prevented the provision of FP information and services – except for NFP – in public facilities.[17] Legal experts and rights groups argue that EO 003 was a clear violation of the Constitutional provision guaranteeing freedom to choose the manner of FP method and of respecting religious beliefs and aspirations of the people.

A study done by Dr. Jonathan David Flavier comparing data gathered from the Department of Health (DOH) on maternal mortality rates and budget allocations for health services showed a marked difference in the situation of women's health in Manila (which forced an NFP-only policy on its constituents) and in Quezon City (which encouraged family planning and increased its budget for family planning services). The study provided "an interesting association between improved reproductive health services and better outcomes for mothers, even if other environmental or societal factors may have had an influence."[18]

While it can be argued that NFP may be the preferred method for some couples and individuals, adopting an NFP-only policy at the national and local levels drastically limits access of Filipinos to more effective contraceptive methods. Such a policy disenfranchises people, especially poor women who mostly rely on government programs and facilities for their health needs and FP supplies. Further, it exposes them to the risk of having unintended pregnancies and possible illnesses, and even death when a high risk pregnancy may endanger their health and their lives.

Moreover, while the government has given modern scientific NFP[19] a big push and has concentrated national resources in promoting it, the 2008 NDHS survey shows insignificant use of this method. Based on the survey, contraceptive prevalence rate (CPR) among married women is 51% of which 34%are modern methods, mostly the pill (16%) and female sterilization (9%). The use of the pill has increased in the past 5 years to 16% in 2008 from 13% in 2003. In contrast, users of modern NPF registered 0.5 percent in 2008 including 0.1% for Mucus/Billings/Ovulation Method and 0.4% for LAM with no change registered in the last five years. Traditional methods including Calendar/Rhythm/Periodic abstinence and withdrawal comprise 16.7% from 15.5% in 2003. Such figures suggest that even with the resources poured by the government to promote NFP, there is no significant increase in its use has been noted.

Contraceptive Self-Reliance Strategy and the Government's Zero Procurement of Contraceptives Policy

Administrative order (AO) 158 s 2004 set the guidelines on the management of donated commodities under the Contraceptive Self-Reliance Strategy. This was in view of the then looming phase out of the USAID's contraceptive subsidy to the public sector. Begun in the supposedly more affluent LGUs in 2005, the phase-out which covers mainly oral contraceptive pills and injectables was completed in 2007.

Currently, the executive department has adopted a zero procurement policy towards contraceptives and has left local government units to decide on whether they would procure supplies using their own local resources.

The above policy directions taken indicate that while the Philippine government is a signatory to the ICPD PoA as well as to the Millennium Declaration, and has participated and issued reports at every review, "there is also a large gap between what is stated and the actual implementation."[20] While it states that the country adopts a responsible parenthood approach, it has, in fact, favored and adopted only NFP.

There have been many clear setbacks in recent years and many of ICPD goals/targets will not be achieved as well as the MDG on improving maternal health (MDG 5). The National Economic and Development Authority (NEDA) itself notes that the Philippine MDG 5 Target 7 – increasing access to reproductive health services to 80% by 2005 and 100% by 2015 will not be achieved. In fact, many NGOs note that it is far from being remotely achieved.

Still, there have been some positive developments. These include the following:

National government initiatives

- Inclusion of FP (vasectomy, tubal ligation, and IUD insertion) and Post-Partum FP in the package of services covered by the National Health Insurance Scheme (PhilHealth).

- Efforts by the National Commission on Filipino Women (NCRFW) to include references to "the right of women to determine the size and the spacing of their children" and the notion of "humane and compassionate treatment of women who have undergone abortion" included in the medium term development plan for women, despite pressures from the President to remove all references to reproductive rights.

- Support of various government agencies such as the Department of Health, Department of Social Welfare and Development, Commission on Human Rights (CHR), Commission on Population, and the National Commission on the Role of Filipino Women (NCRFW) for the passage of the Reproductive Health Bill.

Legislative Initiatives

1. *Fund for RH commodities in the General Appropriations Acts (GAA) of 2007 and 2008*

   Legislators supportive of RH and FP have ensured that the Department of Health has a budget of P180 million for modern family planning in the 2007 General Appropriations Act. This amount shall be "sub-allotted by the DOH to LGUs which shall apply for the utilization of the fund for the purchase of reproductive health commodities and the conduct of family planning seminars in local communities."[21] Another P2 billion was allotted for the purpose, under the 2008 GAA.[22]

The Philippine Legislators Committee for Population and Development (PLCPD) cites that "it was not until 2007 that there had been a specific line item for family planning in the annual national budget. Such move is timely (if not late), as last shipment of commodities is scheduled in 2008."[23]

However, fund releases suffered prolonged delays due to various technicalities, including the protracted time it took the Department of Health (DOH) to draft and finalize the implementing rules and guidelines as well as difficulties encountered by LGUs regarding procurement rules and regulations.[24] Alarmingly though, while budgetary allocations were made in 2007 and 2008, these same allocations are no longer present in the 2009 budget.

2. *Filing/Refiling of Reproductive Health Bill in both Houses of Congress*

House Bill 5043: The Reproductive Health and Population Development Act of 2008
by Rep. Edcel Lagman

Senate Bill 3122: Reproductive Health and Population and Development Act of 2009
by Sen. Rodolfo Biazon

3. *Magna Carta of Women*

The Magna Carta of Women provides for a legal framework that promotes women's empowerment and prohibits discrimination against women.

The Magna Carta of Women (MCW) was signed into law on August 14, 2009. According to the National Commission on the Role of Filipino Women (NCRFW), the MCW is regarded by the government as a "comprehensive women's human rights law that seeks to eliminate discrimination against women by recognizing, protecting, fulfilling and promoting the rights of Filipino women, especially those in the marginalized sectors." While some women's groups may not see the new law as perfect or ideal, still it is hoped that it will work towards eliminating all forms of discrimination against women, especially with respect to their sexual rights and reproductive rights.

4. *Local Government Initiatives*

Some local chief executives (LCEs) have demonstrated strong leadership and much needed political will by enacting their own local level RH policies despite strong pressure from religious conservatives. Since 2005, there are five provinces, 20 municipalities and three cities that have passed their own Reproductive Health Ordinance. Noteworthy of mention is the province of Aurora, the first to pass a provincial ordinance on RH on June 1, 2005 as well as Quezon City -- which is considered a very important development since Quezon City is the biggest and one of the more influential cities in the country.

The Continuing Battle for the Passage of a Comprehensive RH Bill

Respected economists have argued that "an unambiguous and consistent national population policy is long overdue in our country"[25] They have cited that "espousing 'natural family planning only' … reflects a lack of seriousness in pursuing long-term economic development and poverty reduction."[26] They add that "caught between a hard Church and a soft State are the overwhelming majority of Filipinos who affirm the importance of helping women and couples control the size of their families and the need for government to give budgetary support for modern methods."[27]

Many legislators recognize the importance and urgency of having such a policy. Several bills have been filed in both Houses of Congress in the past ten years. However, in each case, the pressure on legislators had been so strong that none of these legislative initiatives had succeeded

so far. HB 5043 filed by Rep. Edcel Lagman is the only proposed piece of legislation for a comprehensive RH policy that has reached the plenary debate. It is still being debated on the floor and hopes are still held that the country will finally have the bill approved before the 14th Congress ends in a few months' time. Currently, there are 132 authors of HB 5043.

In 2009, Senator Rodolfo Biazon filed SB 3122 which is the Senate version of the RH Bill. It will be recalled that Biazon had filed a similar bill in the past. When Biazon ran for reelection in 2004, the Catholic Church and its allies mounted a campaign to discredit him for his staunch support for RH, calling on Catholics not to vote for him. Biazon won anyway, as did Rep, Lagman and other candidates the Church campaigned against.

Results from various surveys conducted by the Social Weather Stations (SWS) and Pulse Asia over the past several years have come up with the following findings: that majority of Filipinos favor the passage of a national law on RH. The Third Quarter 2008 Survey conducted by SWS show that 71% favor the passage of the RH Bill. Those in favor of the RH Bill are 78% in Metro Manila, 72% in Mindanao, 69% in Balance Luzon, and 68% in the Visayas. They are 77% in class ABC, 70% in class D, and also 70% in class E.[28] The Pulse Asia survey reveals that a large majority of Filipinos (82%) believe that the government should not only educate couples regarding modern methods of family planning but also provide them with services and materials on these methods.[29]

Most Filipinos are aware of the reproductive health bill pending at the House of Representatives (68%) and are in favor of the bill (63%).[30]

In its State of Filipino Mothers 2008 Report, the international NGO Save the Children cites that the "Passage of a national reproductive health policy would effectively begin the process of addressing the compromised well-being that has long been a disproportionate burden on the poor. It would avert unwanted and mistimed pregnancy, reduce the number of induced abortions, and ultimately yield lower maternal and infant mortality rates."[31]

Reproductive Health Advocacy Network

Since the 12th Congress when the first bill on reproductive health was filed in December, 2001 known as H.B. 4110 or the Reproductive Health Care Agenda of 2001, the Reproductive Health Advocacy Network (RHAN) had been in the forefront of the campaign for the passage of a national policy on reproductive health. RHAN is an alliance of 40 Civil Society Organizations with nationwide affiliations championing rights-based and gender responsive legislative policies. Fund for the advocacy campaign of RHAN comes from shared resources from among its members.

RHAN through joint interventions of each member has successfully elevated the discussion of reproductive health beyond family planning. RHAN also figures prominently in Technical Committees in both the Senate and Congress through its Secretary General elected from among the representatives and heads of its member organizations.

Summary of Some Major Relevant Indicators for the Philippines

The following is a brief discussion of some relevant data and analyses focusing on key indicators identified in the earlier part of this report.

1. FAMILY PLANNING

Key indicators include: Laws, policies and programs aimed at decreasing unmet need for family planning, ensuring universal access of all couples and individuals to RH information and services, including family planning; data on CPR, unmet need for spacing/limiting

The ICPD urged governments to "provide universal access to a full range of safe and reliable family planning methods and to related reproductive health services" by 2015. It also stressed that governments should "provide a climate that is favorable to good quality public and private family planning and reproductive health information and services through all possible channels" and "to identify and remove all the major remaining barriers to the utilization of family planning services."

However, as mentioned in the earlier discussions in this NGO report, current government policies and programs do not seem to support the ICPD recommendations. In fact, instead of removing barriers to the utilization of FP services, government itself had erected additional barriers, most notably its insistence on a NFP-only policy, a zero procurement policy, its lack of support for the enactment of the RH Bill, and its overall aversion to the use of the terms Reproductive Health and Reproductive Rights.

The national government likewise has relegated to the local government units (LGUs) the responsibility of procuring contraceptive supplies. This policy has caused problems especially where LGU officials are themselves not supportive of RH and FP and thus would not invest in contraceptive commodities, marginalizing the needs of poor couples and individuals who rely on government-supplied commodities.

Contraceptive Prevalence Rate (CPR)

While registering increasing trend over the years, the country's CPR is still very low compared to its Asian counterparts. The rate of increase has been very minimal and the practice of modern, more effective methods continue to be low (Table 1).

Table1: Trends in Contraceptive Use

Survey	Modern Methods	Traditional Methods	All Methods
1993 NDS	24.9	15.1	40.0
1998 NDHS	28.2	18.3	46.5
2003 NDHS	33.4	15.5	48.9
2008 NDHS	34.0	16.7	50.7

Calculated for currently married women, 15-44 years
Sources: NDHS 2003 and NDHS 2008, as cited in ISSA StatWatch 2008

For modern scientific NFP which is being aggressively pushed and heavily invested on by the Macapagal administration these past several years, the 2008 NDHS survey shows insignificant increase on the use of these methods (Table 2).

Moreover, the value of male involvement and participation in RH or their increased share of the contraceptive burden is another concrete translation of gender equity that continues to be neglected in the country. Until now the share of male FP contraceptive use has not gone beyond 10% and the bulk of this is due to the unreliable and non-program withdrawal method (NDHS 2003 and 2008). Beyond agonizing about the low contraceptive prevalence rate, concrete concern for women should include the encouragement of more male acceptance and use of male family planning methods like condoms and vasectomy.

Table 2: Distribution of Currently Married Women by Contraceptive Method Used

Method	2003	2008
Any method	48.9	50.7
Any modern method	33.4	34.0
Female sterilization	10.5	9.2
Male sterilization	0.1	*
Pill	13.2	15.7
IUD	4.1	3.7
Injectables	3.1	2.6
Male condom	1.9	2.3
Mucus/Billings/Ovulation	0.1	0.1
Standard days method	-	*
LAM	0.3	0.4
Other modern methods	-	*
Any traditional method	15.5	16.7
Calendar/rhythm/periodic abstinence	6.7	6.4
Withdrawal	8.2	9.8
Other traditional method	0.6	0.4
Not currently using	51.1	49.3
Total	100.0	100.0
"*" denotes figure in the cell is less than 0.05 percent		

Sources: 2003 and 2008 National Demographic and Health Surveys

Unmet need for family planning

Data from the Family Planning Survey (FPS) conducted in 2006 gave the following figures: total unmet need for spacing and for limiting is 15.7%. Unmet need for spacing is 8.4%, while the figure is 7.3% for limiting.
Filipino women are having more children than they want. Wanted fertility rate is 2.5, while total fertility rate is 3.3.

The Guttmacher Institute, in a publication titled, "Meeting Women's Contraceptive Needs in the Philippines" (2009) estimates that there are 10.2 million women at risk for unintended pregnancy. Of this number, 49% practice modern FP methods, 22% use traditional methods, while 29% do not use any method.

Non-use and use of traditional methods accounted for 9 in 10 unintended pregnancies in 1998. Meanwhile, the same study points out that nearly half (46%) of 3.1 million pregnancies each year end in an induced abortion (15%) or an unplanned birth (31%).

ICPD provisions supporting universal access to RH information and services, including FP

Assessing national unmet need for good-quality FP services
ICPD 7.16. All countries should,…assess the extent of national unmet need for good-quality family planning services and its integration in the reproductive health context, paying particular attention to the most vulnerable and undeserved groups in the population. All countries should take steps to meet the family planning needs of their populations as soon as possible and should, in all cases by the year 2015, seek to provide universal access to a full range of safe and reliable family planning methods and to related reproductive health services which are not against the law. The aim should be to assist couples and individuals to achieve their reproductive goals and give them the opportunity to exercise the right to have children by choice.

Removing all major remaining barriers to the utilization of FP services
ICPD 7.19. As part of the effort to meet unmet needs, all countries should seek to identify and remove all the major remaining barriers to the utilization of family planning services. Some of these barriers are related to the inadequacy, poor quality and cost of existing family planning services. It should be the goal of public, private and non-governmental family planning organizations to remove all programme-related barriers to family planning by the year 2005 through the redesign or expansion of information and services and other ways to increase the ability of couples and individuals to make free and informed decisions about the number, spacing and timing of births and protect themselves from sexually transmitted diseases.

Translating public support for RH, including FP, into adequate budgetary, human and administrative resources
ICPD 7.21. All political and community leaders are urged to play a strong, sustained and highly visible role in promoting and legitimizing the provision and use of family planning and reproductive health services. Governments at all levels are urged to provide a climate that is favorable to good quality public and private family planning and reproductive health information and services through all possible channels. Finally, leaders and legislators at all levels must translate their public support for reproductive health, including family planning, into adequate budgetary, human and administrative resources to help meet the needs of all those who cannot pay the full cost of services.

Universal access to full range of FP methods and related RH services
ICPD 7.16 Universal access to full range of FP methods and related RH services not contrary to law by 2005; 80% universal access to modern contraceptives

Key MDG Indicators
MDG 5, Target 5.B: **Achieve, by 2015, universal access to reproductive health**
- 5.3 Contraceptive prevalence rate
- 5.6 Unmet need for family planning
- 5.4 Adolescent birth rate

2. MATERNAL HEALTH, MORBIDITY AND MORTALITY

Key indicators include: Laws, polices and programs aimed at improving maternal health, decreasing maternal mortality and morbidity; data on maternal mortality and morbidity, care received during pregnancy, safe pregnancy and birthing, including attendance at delivery, and mortality and morbidity from unsafe abortion

The importance of significantly reducing maternal mortality and morbidity if "extreme poverty and hunger" are to be eradicated is recognized in both the ICPD PoA and MDGs. Yet, the current estimates of MMR show that the country is way behind in achieving both ICPD and MDG targets. At least 11 women die daily due to pregnancy-related causes. Some of the factors contributing to the alarming MMR include, among others: government's weak response to unmet needs of women to control their fertility, both at the policy and program levels; inadequate health services for the poor – including and especially in the field of reproductive health; and inadequate health facilities and personnel. Added to this is the lack of a clear policy for effectively addressing the sexual and reproductive health needs and respecting the SRH rights of its citizens.

Evident in NGO field reports as well is the lack of or absence of gender responsiveness of many health providers towards women and girls who require quality reproductive health care resulting from poor health status, forced pregnancy, illegal and unsafe induced abortion.

Official reports on estimated maternal mortality ratio suggest a declining trend from 209 (1993) to 172 (1998) maternal deaths per 100,000. More recent government figures cite the number at 162 (FPS, 2006). The United Nations Children's Fund (UNICEF), however, places the figure at 230.

Whether it is 162 or 230, these estimates clearly tell us that the Philippines will fall short of both ICPD and MDG. The use of a Risk Assessment and Prenatal care approach continues to be given higher priority in addressing maternal mortality in our country with little resources allocated towards emphasizing safe delivery and access to emergency obstetric care (EmOC) that has proven effective in other countries in bringing down maternal mortality rates.

NDHS data indicate that more women in 2003 preferred to go to nurses and midwives than doctors for prenatal care. Attendance by doctors for prenatal care decreased from 38.5% in 1998 to 38.1% in 2003; while prenatal care by nurses and midwives increased from 47.2% in 1998 to 49.5% in 2003. Although various postnatal care services were availed, an average of 34% of women in reproductive age did not receive post natal care services. NDHS data likewise show that although there was a slight increase in attendance of births by doctors (from 31% to 34%), nurses and midwives (from 25.5% to 26.2) from 1998 to 2003, there was a decrease in attendance in GO hospitals/health centers and homes by an average of 5 to10% for the same period.

Countries should reduce maternal mortality to levels where they no longer constitute a public health concern

ICPD 8.21. Countries should strive to effect the significant reductions in… maternal mortality levels where they no longer constitute a public health concern."

ICPD 8.22 All countries, … based on the concept of informed choice, … adequate delivery assistance that avoids excessive recourse to caesarian sections and provides for obstetric emergencies, referral services for pregnancy, childbirth and abortion complications; post natal care and family planning. All births should be assisted by trained persons, preferably nurses and midwives, but at least by trained birth attendants.

MDG Target 5.b. Achieve, by 2015, universal access to reproductive health.

Programs to reduce MMR should include information on RH, including FP

ICPD 8.26. Programs to reduce maternal morbidity and mortality should include information and reproductive health services, including family planning services. In order to reduce high risk pregnancies, maternal health and safe motherhood programmes should include counseling and family planning information.

Addressing the health impact of unsafe abortion as a major public health concern and reducing recourse to abortion through expanded and improved FP services

ICPD 8.25. In no case should abortion be promoted as a method of family planning. All Governments and relevant intergovernmental and non-governmental organizations are urged to strengthen their commitment to women's health, to deal with the health impact of unsafe abortion as a major public health concern and to reduce the recourse to abortion through expanded and improved family planning services. Prevention of unwanted pregnancies must always be given the highest priority and every attempt should be made to eliminate the need for abortion…. In all cases, women should have access to quality services for the management of complications arising from abortion. Post-abortion counseling, education and family planning services should be offered promptly, which will also help to avoid repeat abortions.

ICPD 8.21
Reduction of maternal mortality (MM) by ½ from 1990 levels by 2000 and by ½ from 2000 until 2015

ICPD 8.22
Maternal health care to include assistance by trained personnel and provision for obstetric emergencies by 2005

ICPD + 5 goal
By 2005, 80% of all births to be assisted by skilled attendants

MDG, Target 5A
Reduce by three quarters, between 1990 and 2015, the maternal mortality ratio
5.2 Proportion of births attended by skilled health personnel
MDG 5, Target 5.B:
Achieve, by 2015, universal access to reproductive health
Antenatal care coverage (at least one visit and at least four visits)

3. ADOLESCENT SEXUAL AND REPRODUCTIVE HEALTH (ASRH)

Key indicators include: Laws, policies and programs ensuring access of young people to RH information, counseling and service, including on prevention of unwanted pregnancies and STI, HIV; data to include incidence of teenage pregnancies, STI, HIV among young people 15-24 years old; knowledge on prevention of STI, HIV and AIDS

Providing young people aged 15-24 years with information and services on sexual and reproductive health has always been a contentious issue with debates often centering on the morality of discussing sexual matters with young people. Proposed inclusion of discussions on sex and sexuality in the school curricula are deemed as improper and inappropriate based on the erroneous and unsubstantiated claim that discussing these topics to young people will lead them to have sex. Teaching young people about how to effectively prevent pregnancies (outside of the prescription of abstinence) is wrongly viewed as encouraging them to engage in irresponsible sexual activities.

While adults debate on the propriety and morality of providing information and services to young people, young people themselves are often not consulted in the crafting of laws, programs and policies that will eventually affect them.

The result is a situation where millions of young people do not have access to accurate information and services that could help them prevent unintended pregnancies and exposure to STI/HIV infection. There is an estimated 15 million young people aged 15-24.[32]

Moreover, while it is recognized that abstinence is the most effective means to avoid unintended pregnancies and exposure to STI and HIV infection, the reality is that many young people are sexually active. Data from the 2002 Young Adult Fertility Survey (YAFS3) reveal that, 23% of young people aged 15-24 have had sex. The figure is 31.3% among males and 15.7% among females. Yet among those who have had sex, the practice of contraception was a low 21% during first sex encounter and 24.8% during the last sex encounter.[33]

Table 3: Fertility Rates Among Adolescents (available are only % and not the actual no. of persons)

Age Group	1993 NDHS	1998 NDHS	2003 NDHS
Age 15-19	50%	46%	53%
Age 20-24	190%	177%	178%

There is also high fertility rates among young women aged 15-24 as shown in the above table, thus it is imperative to provide them with information on STI and HIV and how such can be transmitted.

Maternal mortality rates among young people (18 years and below) are high. This is due to the fact that their young bodies are still not adequately equipped and prepared for the physical and emotional demands of pregnancy and childbirth. Often, too, young people are not able to seek health care due to the stigma of early pregnancies, usually among unmarried women.

In its State of Filipino Mothers 2008 Report, the international NGO Save the Children cites the following:

- In developing countries, complications from pregnancy and childbirth are the leading causes of death among young women aged 15 to 19;
- Studies show that adolescents in this age group are twice as likely as those over 20 to die during pregnancy or childbirth; the likelihood for girls under 15 is five times more;
- Teen mothers are less likely to seek medical help for reproductive health concerns which limit their access to skilled birth attendants and to emergency obstetric care (EmOC);
- Complications of unsafe abortion are an added risk of maternal death for young mothers accounting for 13% (or 1 in 8) maternal deaths worldwide. In the Philippines, almost half (46%) of abortion attempts occur among young women aged 13 to 24; and

- Since 1/3 of all unwanted pregnancies in the country result in abortion, it is particularly significant that 22% of women aged 15 to 24 have induced abortions.[34]

Young people also need correct and timely information to help them avoid exposure to the risks of acquiring sexually transmitted infections, including HIV. However, the table below shows that knowledge on HIV and AIDS among young people aged 15-24 remains low as reflected in the high percentage of males and women under the age bracket (72.6%) believing that there is no chance of them getting AIDS. This indicates a need to reach young people with more timely, relevant and accurate information and services.

Table 4: Knowledge of Adolescents Aged 15-24 Years on HIV/AIDS (Figures refer to the percentage)

	1994 YAFS	2002 YAFS
Thought that there is no chance of them getting AIDS		
Male, Total	66.9	72.3
Ages 15-19	68.1	71.3
Ages 20-24	65.3	74.0
Female, Total	78.3	74.3
Ages 15-19	78.7	73.9
Ages 20-24	77.9	74.9
Both sexes, Total	72.8	73.4
Ages 15-19	73.5	72.6
Ages 20-24	71.9	74.5
Total Number of Cases	9,810	13,533
Thought that AIDS is curable		
Male, Total	13.3	30.1
Ages 15-19	13.3	30.1
Ages 20-24	12.7	29.6
Female, Total	11.8	25.7
Ages 15-19	11.5	25.9
Ages 20-24	12.2	25.5
Both sexes, Total	12.5	27.8
Ages 15-19	12.5	28.1
Ages 20-24	12.5	27.4
Total Number of Cases	9,935	13,533

Adapted from Table 6.5 in YAFS3 2004

Key ICPD Provisions Supporting Young People's Access to SRH information and services

IEC activities and services concerning reproductive and sexual health, including… sex education

ICPD 6.15. Youth should be actively involved in the planning, implementation and evaluation of development activities that have a direct impact in their daily lives. This is especially important with respect to information, education and communication activities and services concerning reproductive and sexual health, including prevention of early pregnancies, sex education and the prevention of HIV/AIDS and other sexually transmitted diseases. Access to as well as confidentiality and privacy of, these services must be ensured with the support and guidance of their parents and in line with the Convention on the Rights of the Child. In addition, there is a need for educational programs in favour of life planning skills, healthy lifestyles and the active discouragement of substance abuse.

Support mechanisms for the education and counseling of adolescents in RH

ICPD 7.41. Information and services should be made available to adolescents to help them understand their sexuality and protect them from unwanted pregnancies, STIs, and subsequent risk of infertility… Motherhood at a very young age entails a risk of maternal death that is much greater than average and the children of young mothers have highest levels of morbidity and mortality

ICPD 7.47. Governments, in collaboration with non-governmental organizations, are urged to meet the special needs of adolescents and to establish appropriate programs that respond to those needs. Such programmes should include support mechanisms for the education and counseling of adolescents in the areas of gender relations and equality, violence against adolescents, responsible sexual behavior, responsible family planning practice, family life, reproductive health, sexually transmitted diseases, HIV infection and AIDS prevention….

4. ABORTION

Key indicators include: Laws, policies and programs aimed at improving access to RH information and services to reduce recourse to abortion and addressing the impact of unsafe abortion; data on incidence of abortion, hospitalizations due to complications of unsafe abortion, maternal deaths and morbidity due to unsafe abortion

The Philippines is one of the remaining few countries that have the most prohibitive laws on abortion. Despite this proscription, the Guttmacher Institute (2009) estimates that there are about 500,000 induced abortions in the country each year. The abortion rate is 27 abortions for every 1,000 women aged 15-44 years. Unsafe abortion is one of the leading causes of maternal morbidity and mortality. Annually, about 1,000 women die and around 79,000 are hospitalized from complications from unsafe abortion.[35] There are no estimates on how many are not able to make it to the healthcare facilities in time for life-saving medical intervention.

The Guttmacher Institute study also estimates that there are about 10.2 million women at risk for unintended pregnancy. Non-use and use of traditional FP methods accounted for 9 in 10 unintended pregnancies in 1998. Meanwhile, nearly half (46%) of 3.1 million pregnancies each year end in an induced abortion (15%) or an unplanned birth (31%).

The ICPD stresses that in no way should abortion be promoted as a method of family planning. However, governments should exert every effort to promote effective family planning use to prevent and to reduce the recourse to abortions. In cases where women have complications from unsafe abortions, policies and programs should be in place to provide humane and compassionate treatment and counseling. Moreover, immediate family planning counseling must be given to post-abortion patients to help prevent repeat abortions.

While there are various reasons why women have abortions, including unintended pregnancies as a result of rape or incest, studies have shown that the most effective way to prevent most abortions and reduce the recourse to abortion is to ensure access of women, men and young people to a full and comprehensive range of safe, effective, reliable, affordable, accessible and acceptable contraceptive methods.

Addressing the health impact of unsafe abortion as a major public health concern and reducing recourse to abortion through expanded and improved FP services

ICPD 8.25. In no case should abortion be promoted as a method of family planning. All Governments and relevant intergovernmental and non-governmental organizations are urged to strengthen their commitment to women's health, to deal with the health impact of unsafe abortion as a major public health concern and to reduce the recourse to abortion through expanded and improved family planning services. Prevention of unwanted pregnancies must always be given the highest priority and every attempt should be made to eliminate the need for abortion…. In all cases, women should have access to quality services for the management of complications arising from abortion. Post-abortion counseling, education and family planning services should be offered promptly, which will also help to avoid repeat abortions.

5. WOMEN'S EQUALITY AND EMPOWERMENT IN SEXUAL AND REPRODUCTIVE HEALTH

Empowerment in SRH

Progress has been made in advancing women's right to participate in social and political processes. Based on reports of the National Commission on the Role of Filipino Women (NCRFW) in 2006, these include the following milestones:

- The mainstreaming of gender and development as a key strategy is now consciously included in pursuing both national and local development plans;
- The Philippine Plan for Gender-Responsive Development (1995-2025) and the Framework Plan for Women provide directions on how gender equality and equity may be achieved in development plans;
- Efforts to protect economic rights of women and participation of women in economic decision making; and
- Legislation to protect women's human rights that for example benefit solo parents, overseas workers and victims and survivors of violence.

However, of great concern are developments affecting the protection of women's sexual and reproductive rights. Policies have been promulgated effectively banning all methods of fertility regulation, except NFP, even with the widespread knowledge that doing so impacts on the health and well being of women, especially of poor and vulnerable women. This violates women's right to sexual and reproductive health. The Arroyo administration has diverted much needed RH funds to NFP-only projects despite results of various surveys showing that a majority of Filipino citizens want a policy and program that would enable them to have access to a broad range of information and services on contraceptive methods, not just on NFP.

Referring to the situation in the Philippines, the Concluding Comments of the CEDAW in its 36th Session held in 2006 noted "with concern the persistence of patriarchal attitudes and deep-rooted stereotypes regarding the roles and responsibilities of women and men in the family and society." Their comments expressed concern as well "about the inadequate recognition and protection of the reproductive health and rights of women in the Philippines" and "the high maternal mortality rates particularly the number of deaths resulting from induced abortion, high fertility rates, inadequate family planning services, the low rates of contraceptive use and the difficulties in obtaining contraceptives.'

Gender blind or inadequate data on the state of the country's sexual and reproductive health leads to poor and sometimes ineffective program responses requiring resources to reach women, men and young people especially the marginalized and the poor. There is no sufficient data for example, to let us know incidence of early marriages, forced marriages and forced pregnancy and the extent to which these affect the girl-child. Data and statistics included in this report provide us some insight on this lack of organized information.

Eliminating violence against women (VAW)

NCRFW reports enumerate various laws that have been passed addressing violence against women and children, such as the Anti-Sexual Harassment Law of 1995, Anti-Rape Law of 1997; Rape Victim Assistance and Protection Act of 1998; Anti-Trafficking in Persons Act of 2003; and the Anti-Violence Against Women and Children (VAWC) Act of 2004.

Gender-based violence, in any form, has great impact on women's health and well being throughout their life cycle, especially on their sexual and reproductive health whether in the home, in school, in the community and areas of conflict. Organized data on VAW/C to date remains inadequate to provide a better understanding of the real gender violence situation in our country. Available data from the PNP-Women and Child Protection Center show an increasing trend in figures from 1999 (5,819 cases reported) to 2003 (7,204 cases reported).

The period of 2004 (6,271) to 2008/first semester (3,228) showed both decreasing and increasing numbers of reported VAW cases from which no trends can be concluded. However, physical injuries/wife battering was consistently the most common case reported. These reported cases included incidences of unjust vexation, abduction/kidnapping, sex trafficking, concubinage, threats, violations under RA 9262, sexual harassment, physical injuries/wife battering, acts of lasciviousness, attempted rape, incestuous rape, and rape.

Available data from one agency, however, does not provide a complete picture of the extent of violence against women and children in different conditions and situations, the causes and consequences of such actions. Organized data on the sexual and reproductive health status of women and girl-children in situations of conflict, of trafficked women and children and of OFWs remains inadequate or even nonexistent.

A review of laws and policies that discriminate against women's sexual and reproductive rights across age, class, religion and politics is very much needed if the country is to adhere to its commitments to CEDAW and other International Human Rights documents the Philippines is a signatory to.

The UN Development Fund for Women South East Asian Programme (UNIFEM SEAP) in its assessment report on the Philippines noted the following: "progressive laws are not always enforced; that despite the existence of equality under the law, women still suffer discrimination in many areas, the exploitation of women in the context of economic vulnerability, highlighting rural to urban and inter country migration, with particular attention on prostitution and trafficking; and the deficiencies in the legal system with respect to violence against women, especially domestic violence and incest."

ICPD Principle 4
Advancing gender equality and equity and the empowerment of women, and the elimination of all kinds of violence against women, and ensuring women's ability to control their own fertility, are cornerstones of population and development-related programmes. The human rights of women and the girl child are an inalienable, integral and indivisible part of human rights. The full and equal participation of women in civil, cultural, economic, political and social life, at the national, regional and international levels, and the eradication of all forms of discrimination on grounds of sex, are priority objectives of the international community.

ICPD 4.3. (a) To achieve equality and equity based on harmonious partnership between men and women and enable women to realize their full potential.

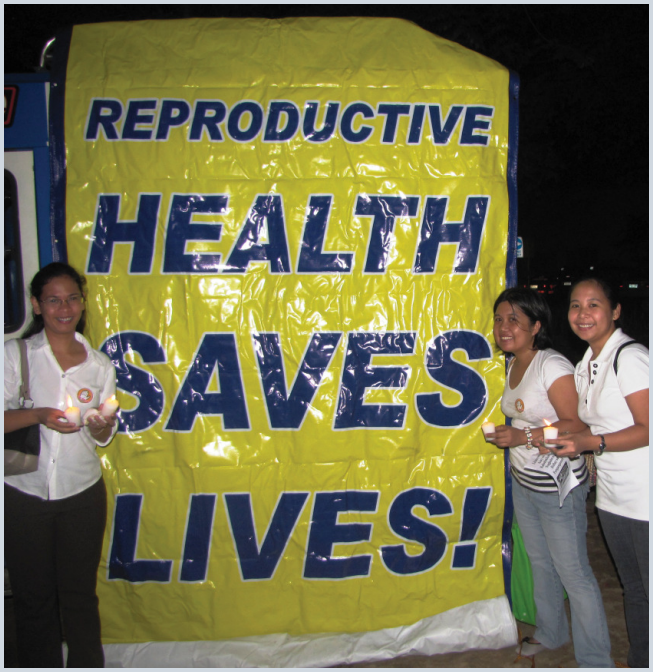
ICPD 4.4c Eliminating all practices that discriminate against women … establish and realize their rights … that relate to reproductive and sexual health.

ICPD 4.4e Eliminating violence against women

ICPD 4.4.(g) Making it possible, through laws, and other appropriate measures, for women to combine the roles of childbearing, breast-feeding and child rearing with participation in the work-force.

ICPD 4.5 "All countries should make greater efforts to promulgate, implement, and enforce national laws and international conventions to which they are party, such as the CEDAW… and to implement fully the Declaration on the Elimination of Violence against Women and the Vienna Declaration and PoA…"

MDG 3: Promote gender equality and empower women



6. POPULATION, DEVELOPMENT AND POVERTY

Key indicators include: population, population growth rate, fertility rates; incidence of poverty in the Philippines, hunger incidence, investments in health and education, other economic indicators

Investment in human resource development necessarily involves enabling its citizens to carry out their reproductive choices in consonance with their aspirations for a better quality of life for themselves and their children.

Noted University of the Philippines economist Dr. Ernesto Pernia, for example, clearly showed how the national government invests in its human resources. He points out that "the spending per capita on social services had declined in real terms from P2,487 in 1997 to P1,999 in 2004. For education the decline had been from P1,789 to P1,415, and for health from P266 to P141 over the same period. More specifically for education, annual real spending per student in public elementary and secondary schools had dropped from P8,439 to P6,554."

Pernia further pointed out that "lower-income households do not only have more children than richer families, they also have higher unwanted fertility. Wanted versus actual fertility is reported to be 3.8 vs. 5.9 children for the bottom quintile, 2.6 vs. 3.5 for the middle, and 1.7 vs. 2.0 for the top quintile, such that the corresponding gaps representing unwanted fertility are 2.1, 0.9, and 0.3.[36] As expected, the wanted-actual fertility differentials are also evident by education level and urban/rural location. "This is in a situation where poor households mostly depend (88.4% versus 70.1% overall) on public sources of modern family planning methods which are becoming scarcer with the cessation of USAID support scheduled in 2008."

At a Poverty and Hunger Symposium organized by the Employers' Confederation of the Philippines (ECOP), the Forum for Family Planning and Development and the United Nations Population Fund (UNFPA) in July 2008, Pernia pointed out that the country's burgeoning population is "a silent crisis" the effects of which can be felt in "education, health, environment and employment." The government claims, however, that it has been addressing the issues of poverty and population through its Accelerated Hunger Mitigation Program (AHMP) and Responsible Parenthood and Natural Family Planning Program.

The World Bank, in its recent quarterly report, however, expects the poverty incidence in the Philippines (32.9% in 2006) to increase this year. It further observed that even while a decline in the unemployment rate for April was reported by the government, this does not necessarily translate into increased family income. Although a drop in unemployment was registered, it was also noted that the number of workers with fixed salaries dropped with many of them working on part-time salaries. Further, government data shows that the number of self-employed and unpaid family workers increased.

Selected Poverty Indicators in the Philippines

YEAR	AVERAGE INCOME/ EXPENDITURE		PROPORTION OF POPULATION BELOW POVERTY LINE	POVERTY INCIDENCE		
	Income	Expenditure		WOMEN	YOUTH	CHILDREN
1990			33%			
2000				32.3%	24.5%	42.5%
2003	42 (Bottom 30%) 193 (Bottom 70%)	43 (Bottom 30%) 158 (Bottom 70%)				
2006	49 (Bottom 30%) 226 (Bottom 70%)	51 (Bottom 30%) 188 (Bottom 70%)	33%	29%	23.5%	38.8%

Sources: Adapted from Table 2b FIES in www.census.gov.ph 2008; Table 1.1 Target 1.A Key Indicators for Asia and the Pacific 2008, 39th Edition, Asian Development Bank, August 2008, and poverty stats in www.nscb.gov.ph, 2007. All cited in ISSA StatWatch 2008

Meanwhile, according to the Social Weather Stations final survey for 2008, the proportion of families experiencing involuntary hunger at least once in the past three months reached a new record-high of 23.7%, or an estimated 4.3 million households. The latest Hunger record is 11 points above the ten-year average of 12.6%, surpassing the previous record-high of 21.5% in September 2007. SWS cites that "Hunger has now been at double-digits for over four years, since June 2004." Additionally, "the Hunger average of 2008 is 18.5%, higher than the 2007 average of 17.9%. The measure of Hunger refers to involuntary suffering because the respondents answer a survey question that specifies hunger due to lack of anything to eat."[37]

Global experience has shown that bolstering women's reproductive rights and universal access to family planning and other reproductive health services not only contribute to reducing maternal morbidity and mortality but likewise help counter the effects of unsustainable population growth rates. Much focus has been placed on population growth rates and sustainable development; however, meeting women's and young people's unmet sexual and reproductive health needs as evidenced by recent policies and pronouncements of the Arroyo administration have not been adequately and realistically responded to if quality of life is indeed to be improved.

ICPD 3.17. Investment in human resource development, with programs specifically directed at … high quality general and reproductive health services, including family planning and sexual health care, through the promotion of sustained economic growth within the context of sustainable development…

III. CHALLENGES, CONCLUSIONS AND KEY RECOMMENDATIONS ON HOW TO MOVE FORWARD

1. Population, Development and the Eradication of Poverty

Development from a gender and rights-based perspective has always been a difficult approach especially when advocacies go against current global economic policies and dynamics. Global focus of "population control" has been propelled by this economic paradigm, on top of which is the prevailing conservative moral agenda. There is a need for a closer and systematic understanding of the interconnections of these factors as they impact on what the DAWN report (2006) calls "a reconfigured citizenship and the human rights agenda."

As mentioned earlier in this report, the use of and the strengthening of a gender- and rights-based approach call for a deviation from this kind of world order which forgets that "fertility control is a pre-requisite for poverty alleviation." A gender and rights-based approach in sexuality and reproductive health works towards achieving a balance in individual and collective rights of a nation and other nations for the greater good and well being of individuals, communities, nations and the global community.

Clearly the dynamics that unfolded for the passage of a Reproductive Health Bill reflected the conflicted decision making and the immense pressures, and even threats, faced by both legislators and SRHR advocates.

A sustained advocacy by women's groups and NGOs must be supported to clearly establish why sexual and reproductive health (SRH) is critical for population and development, poverty alleviation/reduction programs, and achieving a balance between population and economic growth and resources. This sustained advocacy agenda is needed not only at the national level but even more importantly among the citizenry who must propel the changes in policies and programs being developed and implemented by the government and legislative machineries from the local to the national levels. The coming elections in 2010 provide this opportunity.

It further calls for investment in health human development resources to provide well-trained health care providers in the government hospitals and health centers. This would require in-depth training of current and incoming health staff on a gender sensitive and rights-based provision of health information and services, especially in the area of sexual and reproductive health care. It also calls for restructuring health programs that truly respond to the basic health needs of the people which necessarily includes SRH. To sustain and maintain health personnel in all levels competitive salaries must form part of the restructuring of the health system.

2. Sexual and Reproductive Health Rights (SRHR)

Amidst the global trends of surging conservatism in the field of gender, sexuality and reproductive health, efforts to mitigate and assert the sexual and reproductive rights of women and young people by women's groups and like-minded NGOs are continuously challenged.

Maternal Mortality and Morbidity

Both the ICPD and MDG recognize the urgency of bringing down maternal mortality and morbidity rates in nations, especially in developing countries. The question is whether this concern has been translated effectively at the country level. The Philippines as we have seen in the data presented in this report has fallen short of expectations insofar as reducing maternal mortality and morbidity.

A crucial factor that contributes to this situation is the inadequate recognition and protection of the reproductive health and rights of women in our country. The effects of which we can see in the high maternal mortality rate – particularly the number of deaths resulting from unsafe induced abortions, high fertility rates, inadequate family planning services, the low rates of contraceptive use and the difficulties in obtaining contraceptives.

There is a need for measures aimed at the prevention of unwanted pregnancies. This calls for ensuring that a comprehensive range of contraceptives are made widely available and affordable and without any restriction, as well as increasing knowledge and awareness about family planning, reproductive rights and sexual rights among women and girls, men and boys.

We need a reliable database that tells us how women and young people are faring in terms of their sexual and reproductive health for all sectors to know where and what actually needs to be provided. Constructing a database that helps in effective and efficient policy and program development requires investment and must therefore be consistently advocated for. For a database to be useful to policymakers, program managers and implementers, organized and unbiased data collection must be carried out to enable a reliable analysis of the sexual and reproductive health status of women and young people.

For example, we need to be able to articulate the connection between maternal morbidity and unmet fertility regulation needs, maternal mortality and unsafe abortion, violence against women/children and its RH consequences, to name a few.

Young People's SRH Rights

High rates of teenage pregnancies create significant obstacles to educational opportunities for young girls and ultimately their economic empowerment. Young girls and boys need to be empowered in making the right decisions about their sexual and reproductive health, creating healthy and responsible relationships, and ensuring stable and fulfilling life directions.

Sexuality and reproductive health education for young people must be integrated in school curriculum, community education for out-of-school youths, children of OFWs, and others. Discussions should be focused on enabling each individual to make the right sexual and reproductive choices for their well-being and development as well as on being responsible citizens of the country. Necessarily all curricula/training modules must be designed as appropriate to age, give due recognition to their capacity to make responsible decisions with accurate, complete and appropriate information and knowledge. To feed these young people with fear about their sexuality and abilities to make right and proper decisions is a disservice to future adults.

Gender Equality and Women's Empowerment in SRH

The persistence of patriarchal attitudes and deep-rooted stereotypes regarding the roles and responsibilities of women and men in the family and society presents a major impediment to the empowerment of women. It is a root cause of why violence against women and the girl-child continues to be committed. These patriarchal attitudes and deep-rooted stereotypes contribute as well to the disadvantaged position of women in their economic, political, social and public life.

Stronger integration of SRR is needed in all gender and development and women's empowerment programs – both in government and civil society development programs with clear appropriation of budgets for SRH. This should include awareness -raising and public educational campaigns that address women and girls, men and boys, as well as religious leaders with a view of eliminating stereotypes associated with traditional gender roles in the family and in society.

3. RH Law Passage and Budget Allocation

Changes need to take place from the individual to the political levels of our society. But these changes need to be implemented and sustained by all sectors of society. To contribute to this process of change requires resources. The interconnectedness of all development efforts directed towards achieving the individual's, community's and nation's well-being necessarily must recognize the role of sexual and reproductive health at its core.

To effectively and efficiently implement this approach and realize the well-being and empowerment of the country and its citizens, we need a National RH Law passed with appropriate budget allocation, both for programs and the people who will be responsible for its implementation.

The fight for the passage of a national policy on RH wages on

House Bill 5043, principally sponsored by Rep. Edcel Lagman, and Senate Bill 3122, authored by Sen. Rodolfo Biazon, or the proposed "Reproductive Health and Population Development Acts" are now on second reading both in the Senate and the House of Representatives.

It is the first time that both bills reached plenary debates in Philippine Congress after nine years of continuous advocacy. House Bill 5043 has been up for plenary interpellation since September 18, 2008 while Senate Bill 3122 started to be debated last March 4, 2009 after the approval of its various committees on health, population and appropriations.

The period of plenary debates especially in the House of Representatives continue at a very slow pace as legislators opposed to the bill's passage have employed various delaying tactics to derail the process.

With its overwhelming multi-sectoral support and despite the slow-paced legislative approval, RH sponsors and advocates are optimistic that the bill will be approved before the 14th Congress ends.

Out of the 252 members of the House of Representatives, 132 are co-authors of HB 5043 and another 15 congressmen support the bill. In the Senate, majority of the Senators expressed their support to the principal sponsor of the bill.

Recent surveys and reports show that more than 80% Filipinos support the passage of the reproductive health bill and demand the national government to allocate budget for contraceptive supplies and other RH services. Other supporters of the bill nationwide include the academe, youth and women's organizations, labor and business associations, NGOs, local and international development agencies and media. Most government agencies have also expressed their support for the bill.

ICPD@15 PROVINCIAL CONSULTATIVE MEETING

Background

The Provincial Consultative Meetings to mark the 15th year of the International Conference on Population and Development (ICPD@15) was organized by the Philippine NGO Council on Population, Health and Welfare, Inc. (PNGOC) in partnership with the United Nations Population Fund (UNFPA). The main objective of the series of consultation meetings is to present the draft of the NGO Alternative Country Report and provide recommendations for priority actions. It also provided the opportunity to collate lessons learned and good practices that could be recognized and promoted for replication. The urgency of passing a strong RH Law was likewise discussed during the meeting and participants came up with a Plan of Action to urge local lawmakers to support the RH Bill currently being deliberated in both Houses of Congress.

The provincial consultative meetings were conducted in July 2009 in Baguio City, Bacolod City, Cebu and Legaspi City. A total of 213 representatives from concerned non-government organizations (NGOs), peoples' organizations (POs), government agencies, academe and media at the national, regional and local levels attended the said event.

HIGHLIGHTS OF THE SHARINGS AND RECOMMENDATIONS

1. On REDUCTION OF MATERNAL AND NEWBORN MORTALITY

Among strategies employed by various NGOs to help reduce maternal and newborn mortality in their respective areas include: conduct of community health orientation and maternal and child health care and family planning to mothers and fathers in the communities; conduct and updating of Training for Midwives on Maternal Health such as Life Saving Seminars (LSS)-Newborn Screening. Many NGOs in the regions are staunch advocates of family planning and the use of more effective contraception and promote this in orientation seminars.

Government agencies, on the other hand, implement the Integrated Maternal and Childhood Illness (IMCI) for immediate treatment of child illnesses in rural health centers; Basic Emergency Obstetric Care (BEmOC); conduct and implement the Responsible Parenting Movement where seminars on RH/ NFP and other FP methods are discussed in different barangays; and promote breastfeeding to all the mothers in the communities.

2. On REPRODUCTIVE HEALTH

NGOs provide medical services for adolescents such as provision of Integrated Medical Services, family planning counseling, information education through media and IEC materials development. RH lectures and capacity-building activities are also conducted for women while Adolescent Reproductive Health awareness is conducted for young people. The Reproductive Health Advocacy Network Youth (RHAN Youth) conducted a community caravan for the youth to heighten their public awareness about the current situation of adolescents/youth in relation to their sexual and reproductive health and rights.

The PNP in Legaspi shared that they have a PNP Women and Children's Desk where they give RH information through IEC at the barangay level.

In some areas, other initiatives at the barangay level include Barangay Sports and Development Program; Culture and Arts activities, and Youth Training program to help the youth to be empowered where gender equality is also discussed and promoted.

Many NGOs also actively advocate for the passage of the RH Bill.

3. On UNMET NEEDS

To help address unmet need, NGOs implement various programs to provide women, men and young people access to FP/RH services, including to effective contraception. Strategies also include advocacy with local government units to ensure information and services are available in government facilities, advocacy for the passage of the RH Bill, Lihok Filipina Foundation, Inc. from Cebu capacitated their community volunteers to effectively respond to the issue on VAWC and other related Issues; Euphrasia Development Center mobilized parent volunteers to help discuss issues on Natural Family Planning, Violence Against Women (VAWC) and Youth Empowerment session.

The Business sector has started to implement the Family Planning Management in the work place, the Employers' Confederation of the Philippines (ECOP) took a proactive role in responding to gender-based family issues affecting women's status, role, and competitiveness in the workplace. Their program set up management-initiated programs that would balance work and family life of employees.

The Commission on Population (POPCOM) initiated the Responsible Parenthood / Natural Family Planning Program where in economic assistance were encouraged for active participation of couples, this was done in collaboration / close coordination with LGU's & other stakeholders and actively promotes effective service delivery.

4. On POPULATION AND DEVELOPMENT AND POVERTY

Some NGOs implement micro-financing and health, education and nutrition programs. HOME OF HOPE in Bacolod helped their Clients earn money, save and build productive assets & attain family well being through micro-financing.

NGOs and LGUs in some areas also conduct programs such as: development and utilization of teaching modules on population and development education for elementary, high school and college; water and sanitation project for barangays within Buhisan Watershed; gender and development program; and community-based rehabilitation program for children and youth with disabilities.

On the part of LGUs, some of the strategies employed include: institutionalization of annual ASRH Camps (Ifugao) during the ASRH camps, the participants were trained on peer to peer education, the ASRH camps helped established the functionality of ASRH/Teen Centers in 4 HS and 5 community based centers; utilization of BCC through various activities like theater and cultural, modern, rock venues; sponsoring of Debate Sessions among teens; Pop Quiz and Essay contests, and Poster contests. LGUs in CAR have also established functional ASRH Teen Centers in four high schools and five community based centers.

RECOMMENDATIONS OF PARTICIPANTS

Participants made the following recommendations:

1. **On Reduction of Maternal and Newborn Mortality**

Government should provide sufficient budget allocations for programs related to Maternal and Newborn Care; Safe Home Delivery Practices that should be monitored by health care providers and trained birth attendants; strict implementation of existing laws and ordinances.

Additionally, Family Health Care Services programs in the workplace, Mothers' Class on Maternal and Child Health, and Health Programs for HIV and AIDS prevention should be conducted by NGOs, GOs and the business/private sectors.

Health services should also be brought to far flung and hard-to-reach areas.

2. On Reproductive Health

Some NGOs also emphasized the need for enhanced and age-appropriate sex education and strengthening of peer education programs. There were also suggestions to involve the youth in community outreach and values formation.

It was also recommended that the academe should conduct seminar workshops on Gender. The media should also integrate RH topics in their radio programs.

There is likewise a need to establish a database for youth, strengthened networking/linkaging and closer collaboration among GOs, LGUs, NGOs, POs, religious sectors, and the academe in programs.

NGOs also called for full support of all organizations for the passage of the Reproductive Health Bill and suggested that media support should be solicited to enhance information drive in the communiies as well as to challenge lawmakers to immediately pass the bill.

3. On Unmet Needs

Ensure availability of trained providers, commodities and health facilities; sustain responsible parenting classes.

Concluding Statements:

Ms. Paulina Nayra, Executive Director of Runggiyan Social Development Foundation shared that we need to look into knowledge management to be able to present something that is concrete for our policy advocacy. We should not be threatened; we should not be a coward in asserting our role as partner in governance especially for NGOs and also for government agencies. And we should be able to know on where to download information, where the 180M going, which district is getting this funds, whose getting how much. Aside from learning we have ourselves in a position that we need to do more, we need to assert more and think all the more that we have to work together.

Ms. Edna C.Tabanda, President, Philippine Health Social Science Association, Cordillera Chapter, she stated that the issues and concerns on population, health and environment were tackled in the Consultation Workshop and must be responded to by the collaborative efforts of the government, NGOs, academe and other civil society groups because said concerns impact on their own lives and on sustainable development. She also stressed that partnering and networking among the different stakeholders is a very effective approach in responding to development concerns.

Dr. Eden Divinagracia, Executive Director of PNGOC, states that one out of a hundred populations die due to pregnancy-related complications which are preventable. Problems such as this call for the need to provide equal opportunity for both men and women to their Reproductive Health needs. She emphasized the need to address the right of the population to have access to health services that is closely linked to improving maternal health and that government should recognize its responsibility to provide such services. Since there are limitations in the government, the NGOs should take responsibility in providing the needed assistance which government cannot provide. To help address this concerns, she is calling for the immediate passage of the RH BILL. She urged everyone to lobby to their Congressmen and policy makers for its passage and NOW is the right time to pass the bill.

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