

Facts on Barriers to Contraceptive Use In the Philippines

OVERVIEW

- Contraceptive use has hardly increased in the Philippines over the past decade. Yet women are having, on average, about one more child than they would like. More than one-fifth of married women do not want to have a child soon or at all but are not using a contraceptive method.

- Cutbacks in publicly funded contraceptive services and supplies since 2004 have reduced women's and couples' access to contraceptives. National surveys from 1998 to 2008 show that women have relied increasingly on pharmacies for contraceptive services. This switch to private-sector suppliers is likely to involve higher costs and lead to reduced access, particularly for low-income women and couples.

- Fulfilling demand for contraceptives would be especially beneficial to disadvantaged women, who use contraceptives less and experience unintended pregnancy more than their better-off counterparts. Poor women face barriers to contraceptive use such as costs, poor-quality services, lack of awareness of or access to a source of contraceptive care, and lack of awareness of methods. However, all groups of women report barriers to using contraceptives that must be addressed through improved policies and programs.

*Includes the mucus or Billings Ovulation, Standard Days, symptothermal, basal body temperature and lactational amenorrhea methods.

THE NEED FOR CONTRACEPTION

- Women in the Philippines increasingly want smaller families. According to national surveys, women aged 15–49 want 2.4 children but have an average of 3.3.

- The poorest women (those whose households fall into the lowest wealth quintile) have about two more children than they want, while those in the richest quintile have only 0.3 more children than they want—evidence of serious health and social inequities. Only 41% of the poorest women use contraceptives, compared with 50% of the wealthiest. Most of this difference is due to lower use of sterilization among poor women.

- Premarital sexual activity is increasing, creating a greater need for contraceptives among young women and men. Among all young adults aged 15–24, premarital sexual activity increased from 18% in 1994 to 23% in 2002 (from 26% to 31% among young men and from 10% to 16% among young women).¹

THE POLICY CONTEXT

- Poverty and reproductive health are headline issues in the Philippines and were especially prevalent in the May 2010 elections. Candidates often talked about what they will do for the poor, but expanding access to contraceptives has garnered limited political support, despite the interrelationship between poor reproductive health and poverty.

- The Arroyo government uses the national budget to support only modern natural family planning,* which is

approved by the Catholic Church—not to support modern “artificial” contraceptives, such as pills, injectables, IUDs and condoms.

- The Philippine health system is complex, with the national government and about 1,700 autonomous local government units (LGUs) sharing responsibility for providing health care. The LGUs are free to decide how much they will allocate to family planning services and which methods they will support.

- Manila (with a population of 1.7 million) effectively banned public and private provision of contraceptives in 2000, following the election of a “pro-life” mayor. Under pressure from church officials, the current mayor has continued the ban on public provision of contraceptives. According to recent reports, similar bans are in effect in Northern Samar and Antipolo City.

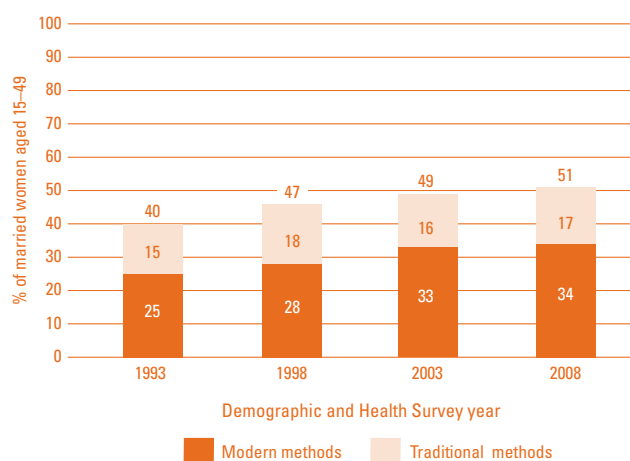
- The U.S. Agency for International Development (USAID) was the largest contributor to Philippine public contraceptive services for several decades, but phased out support between 2004 and 2008. The withdrawal of USAID's funding placed a new and critical constraint on the ability of the government, particularly poor municipalities, to meet contraceptive needs.

- PhilHealth, the national health insurance program, provides little coverage for contraceptive services. It covers tubal ligation, vasectomy and IUD insertion, but no other services or methods. PhilHealth

Figure 1

Contraceptive Use in the Philippines

The proportion of married women using a contraceptive method hardly changed over the last decade.



coverage is also skewed toward better-off citizens—mainly employees of the government and midsize to large companies. Poor people without regular employment, the self-employed and most of the rural poor must enroll on their own or be enrolled as indigents by their LGUs. Fewer than one-third of poor women (those in the poorest two quintiles) are covered by any type of health insurance.

TRENDS IN CONTRACEPTIVE USE

Contraceptive use among married women has increased very slowly in the past 10 years, from 47% in 1998 to 51% in 2008—an average increase of only about 1% per year (Figure 1). By contrast, contraceptive use increased more rapidly in the early 1990s, from 40% in 1993 to 47% in 1998.

*Refers to male and female sterilization and the IUD, injectable, pill and condom, as well as modern natural family planning.

†This total differs slightly from the percentages in Figure 2 because of rounding.

The use of modern contraceptives* among married women did not increase in recent years, remaining at 33–34% in 2003–2008. The use of traditional methods—mainly periodic abstinence and withdrawal—also remained steady, at 16–17%, during the same period.

Several factors may explain the leveling off of modern contraceptive use among married women: the phasing out of contraceptive supplies from USAID, the national government’s focus on natural family planning, the ban on public provision of modern contraceptives in Manila and other parts of the country, and policymakers’ poor attention to quality of care.

In addition, there are many local barriers to increasing contraceptive use throughout the Philippines: geographic isolation, poverty, shortages of contraceptive supplies, LGUs’ inability to procure and allocate contraceptive supplies, and a lack of male involvement in family planning.²

UNMET NEED FOR CONTRACEPTION

Twenty-two percent of married women are able to become pregnant, but do not want to have a child in the next two years or at all and are not using any contraceptive method. These women are defined as having an unmet need for contraception. An additional 17% of married women use traditional methods and are in need of more effective, modern contraceptives to have the best possible chance of preventing unintended pregnancy.

Unmet need is highest among the poorest quintile of married women (28%) and lowest among the top two quintiles of married women (around 20%).

Twenty-four percent of unmarried sexually active women aged 15–29 have an unmet need for contraception. An additional 21% of these young women are using traditional methods and have a need for modern contraceptives.

BARRIERS TO USING CONTRACEPTIVES

The most common reasons why women with unmet need in the Philippines do not practice contraception are health concerns about contraceptive methods, including a fear of side effects. Forty-four percent reported these reasons in 2008, as did 41% in 2003.

The second largest category of reasons why women with unmet need do not use contraceptives is that many believe they are unlikely to become pregnant—41% in 2008, up from 26% in 2003. Their specific reasons include having sex infrequently, experiencing lactational amenorrhea (temporary infertility while nursing) and being less fecund than normal.

The cost of contraceptive supplies has become a more common reason for nonuse in recent years. It was cited by 15% of married women with unmet need in 2008, compared with 8% in 2003. Cost is an even greater barrier among

Figure 2

Sources for Modern Contraceptives

Many women using modern methods switched from public facilities to private pharmacies between 2003 and 2008.

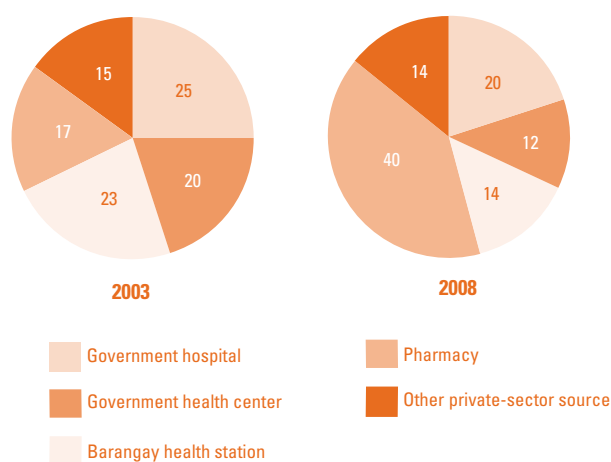
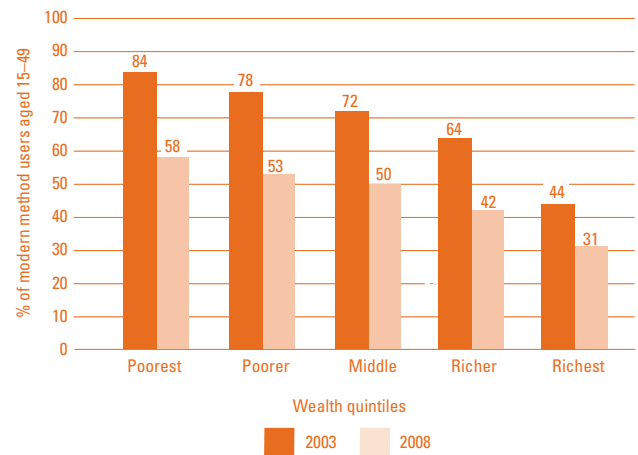


Figure 3

Public-Sector Supply of Modern Methods

The proportion of poor women obtaining contraceptives from the public sector dropped dramatically between 2003 and 2008.



those who are single and sexually experienced: According to a 2004 national survey, 42% mentioned this as a reason for not using contraceptives.³

- Opposition to family planning by women, their partners or their families is a decreasingly important factor in the Philippines. Personal or religious opposition was reported by 10% of women with unmet need in 2008, down from 18% in 2003.
- Only 5% of women with unmet need cited opposition by their partners or families as their reason for not practicing contraception. Still, more poor women than better-off women reported such opposition: 9% among the poorest quintile, compared with 3% among the wealthiest quintile.

PUBLIC-SECTOR SUPPLY OF CONTRACEPTIVES

- The proportion of modern method users who obtain their supplies from the public sector has declined sharply, from 67%[†] in 2003 to 46% in 2008 (Figure 2). Correspondingly, more users have obtained contraceptives from the private sector, particularly from pharmacies.
- All categories of public-sector facilities saw declines in the proportion of contraceptive users they serve. Declines were smaller in hospitals, however, than in government health centers and Barangay health stations.
- In the private sector, only pharmacies experienced a major change in the share of users they serve; they served 17% of users in 2003 and 40% in 2008. This means that about 23% of contraceptive users switched from a public-sector source to

private pharmacies in that five-year period.

- Among modern method users, increased reliance on the private sector has been greatest among poor women, who have the most difficulty paying for contraceptive services. While the proportion of the wealthiest women using a public source decreased 13 percentage points from 2003 to 2008, the proportion of women in the poorest two quintiles using a public source dropped by 25–26 percentage points (Figure 3).

PUBLIC-SECTOR FAILURE TO INCREASE ACCESS

- The Philippine Department of Health maintains that the primary responsibility for providing family planning services lies with the LGUs. Yet local governments do not receive sufficient funds under the revenue-sharing scheme to fully meet this responsibility. The Department of Health, which procures drugs and supplies for tuberculosis control, immunization and malaria, could also purchase contraceptive supplies, if it gave priority to family planning services.
- PhilHealth is also failing to improve access to health care, including contraceptive services, for the poor. The PhilHealth report for the first six months of 2009 showed that the poorest sector (“sponsored” members) made up 24% of membership but received only 14% of benefits, while those employed in the private sector accounted for 35% of membership, paid 62% of collections and received 84% of benefits.
- The government has not replaced the USAID-funded family planning program with a

viable public program. Thus, access to contraceptives for poor women now depends largely on the ability and willingness of LGUs to take over the program. Within the limits of their funding, LGUs can purchase contraceptives and include family planning services as part of their public health functions, but many have devoted too few resources to meet women’s needs.

- The Department of Health issued an administrative order (AO 158) in 2004 calling on the government to act as a “guarantor of last resort” by ensuring that contraceptives remain available for current users who depend on donated supplies. The order gives LGUs frontline responsibility for distributing free contraceptives to users without the means to pay. However, the strategy has failed: The public sector has not filled gaps in services; instead, it has declined greatly as a source of contraceptive supplies and services, especially for the poor.

• The government has not acknowledged that the cessation of USAID funding has reduced access to modern contraception. Rather, it claims that the new focus on natural family planning has been a success. According to the 2008 Demographic and Health Survey, however, the natural family planning program fell far short of its target of raising the use of such methods to 20%: The proportion of currently married women using modern natural family planning methods is 0.5%.

- Two reproductive health bills that are stalled in the House and Senate as of May 2010 contain various measures regarding funding for and access to family planning services. If enacted, all national and local hospitals would be required to offer family planning services and to provide them free of charge to poor patients. PhilHealth would be required to cover the full cost of family planning for three years after the use of any pregnancy-related benefit, and contraceptives would be de-

clared essential medicines to be purchased by national and local health units. In addition, the Senate bill contains a provision for a national procurement and distribution program for family planning supplies and explicitly prohibits local bans on contraception.

BENEFITS OF MEETING THE NEED FOR MODERN METHODS

- Government action to increase access to modern contraceptives is urgently needed, given the high rate of unintended pregnancies, which accounted for more than half of pregnancies in 2008.⁴ Unplanned pregnancies and births place a large and costly health burden on women, their families and the health system.
- In 2008, there were approximately 4,700 maternal deaths, more than half of which were among women who had had unintended pregnancies. One thousand of these deaths were due to unsafe abortion.
- If all women who wanted to avoid pregnancy used modern methods, there would be 1.6 million fewer pregnancies each year in the Philippines. Unintended births would drop by 800,000, abortions would decline by 500,000 and miscarriages would decline by 200,000.
- Expanding modern contraceptive use to all women at risk for unintended pregnancy would prevent 2,100 maternal deaths each year. It would also reap savings on medical care for pregnant women and newborns that would more than offset the additional spending on modern contraception.⁴

RECOMMENDATIONS

- Changes must be made in government policies, programs and health insurance coverage if the existing need for contraceptive care is to be met. These changes are especially necessary to reduce barriers for poor and low-income women and couples, to enable them to obtain the contraceptive services they need to reduce unintended pregnancy, unplanned child-bearing and unsafe abortion.
- The national Department of Health and PhilHealth should make improved family planning a major public health priority and ensure that funding is provided seamlessly from the national to the local levels, as it is for the national immunization program. The government should fulfill its role as guarantor of supplies and services for the poor.
- The national government and the relevant departments—especially the Department of Health and the Office of the President—should fully exercise their standard-setting and regulatory powers over LGUs to prevent contraceptive bans and reverse them where they exist.
- The Department of Health and LGUs must improve the quality of family planning services by complying with standards that include providing a wide choice of methods and responding to clients' actual and perceived health concerns.

Except where otherwise noted, the data are from Demographic and Health Surveys.

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