
SECTION 2

Fertility Levels and Trends: Implications for RH/FP Programs

This section examines levels and trends in fertility, focusing on issues related to reproductive health programs and future prospects for fertility decline. The relationship between fertility and poverty will also be discussed. Given the socio-cultural milieu and the country's relatively high fertility compared with that of other Asian countries, policy measures that may facilitate further fertility decline will be discussed.

SITUATIONER

During the 4th Asia Pacific Population Conference (APPC) in Bali in 1992, participating countries pledged to adopt strategies to attain replacement level fertility of around 2.2 children per woman by year 2020 or sooner. Replacement level fertility means couples have only enough children to replace themselves, about two children per couple.

Based on the 1998 NDHS, the Philippines is still far from achieving replacement fertility. The TFR was 3.7 in the 1995-1997 period, which is a mere 10 percent decline from the 1990-1992 TFR of 4.1 (NSO et al., 1999). The estimated TFR in 2002 is 3.2 (NSO, 1995). The Philippines lags behind other Asian countries like Indonesia, which in 1991 had a TFR of 3.02 (declining further to 2.86 in 1994). Thailand outpaced Indonesia, achieving replacement fertility of 2.17 in 1990, from a TFR of 5.4 in 1972, or a 60 percent decline in only 18 years. The Republic of Korea achieved replacement fertility of 2.1 in 1984, six years ahead of Thailand (UNFPA, 1999). Fertility declines have been modest in the Philippines, despite high female educational attainment and the relatively high status of women.

Rural women exhibited higher fertility than their urban counterparts. The urban TFR of 3.0 in 1996 represented a 15-percent decrease from the 1991 TFR of 3.5, while rural TFR minimally declined from 4.8 in 1991 to 4.7 in 1996 (NSO et al., 1999). While urban fertility in the Philippines has been substantially decreasing at all ages, rural fertility slightly decreased at young ages and minimally increased at ages 25-29 and 35-39. In comparison, Indonesia had an urban TFR of 2.4 in 1997, which is not far above the replacement level. Indonesia's rural TFR, however, was 3.0 during the same year. There are also variances in fertility among the different political regions of the country. At over 5, the fertility levels in Eastern Visayas and Bicol Regions were more than twice that of Metro Manila (2.5 TFR). These two regions are marked by low levels of development compared with other regions of the Philippines (NSO, 2001).

Family size in the Philippines is influenced by factors such as value of children, wanted fertility, unmet need for family planning, contraceptive prevalence rate, age of marriage, and education of women, among others (POPCOM, 2001). The desire for more than two children is associated with the prevailing cultural expectation that children will contribute to family welfare through helping out with household chores and provide financial security for parents in their old age (UNFPA, 1999).

According to the 1998 NDHS, the desired fertility rate in the Philippines is 2.7 children per woman, again, above replacement level. Even in urban areas, where about half of currently married women use a contraceptive method, the wanted fertility rate is slightly higher (2.3) than replacement. However, this is somewhat lower than the wanted fertility in urban areas recorded in the 1993 NDS (2.6). A slight increase was noted in the wanted fertility rate of college-educated women (i.e., from 2.4 in 1991 to 2.5 in 1996). Hence, neither urban nor college-educated Filipino women exhibited a reduction to replacement level of their wanted fertility. In rural areas in the country, desired fertility remains one child more than replacement level. The wanted fertility rate in 1996 for rural women was 3.3, which is the same as what was reported five years before (UNFPA, 1999).

One way of measuring unwanted fertility is to subtract total wanted fertility rate from TFR. This is, however, an indirect estimate for the number of births that a woman would like to bear by age 50. A more direct definition of unwanted fertility is based on whether any particular pregnancy was planned, unplanned but wanted eventually, or not wanted at all for each child born in the five years preceding the survey. With this later measure, it appears that there was an increase in unwanted fertility from 15.9 percent (1993 NDS) to 18.2 percent (1998 NDHS). However, there was a decrease in the proportion of mistimed or wanted at a later time from 28 percent (1993 NDS) to 26.9 percent (1998 NDHS). Combining the births not wanted at all and those wanted later in the three years prior to the survey shows a 2.6 percent increase in unplanned births from 43.9 percent to 45.1 percent.

Table 2-1 presents wanted fertility rates in 1991 and 1996 against the corresponding total fertility rates for the same years by place of residence and women's education level. It appears that Filipino women fail to attain their desired fertility by about one child, on average. In 1996, the actual TFR of 3.7 is higher than the wanted fertility rate of 2.7. The main reasons for this are: (a) high non-use of contraception among women who want to limit and space births; (b) non-use of contraception due to

concerns about adverse health effects and “husband’s objection”; and, (c) general higher fertility preference of husbands.

As expected, the fertility level is negatively associated with educational attainment although a monotonic decline in actual fertility is not evident in the last two national surveys. Although a slight decrease in fertility is evident among those with elementary and high school education, there seems to be minimal increases in fertility among those with no education and among those with college education. Increasing the educational attainment of the youth today would contribute to a decline in fertility mainly because schooling postpones marriage.

The inter-regional and inter-provincial analysis of fertility in the 1998 NDHS further reveals that poor regions and poor provinces have high unmet need for family planning information and services (NSO et al., 1999). Women have unmet need for family planning if they want to limit or space birth but are not using any family planning methods.

In 1993, the unmet need for FP was 26.2 percent. This declined to 19.8 percent in 1998 (see Table 2-2). The slow decline in unmet need for FP may be attributed to the following reasons: (a) strength of fertility preferences; (b) perceived risk of conceiving; (c) perceived effects of contraception on health among both husbands and wives; (d) husband’s fertility preferences; and, (e) husbands’ and wives’ acceptance of family planning (Casterline, et. al., 1997). Unmet need is high costs that are associated with practicing contraception

or getting access to the existing service delivery system (Bongaarts, et al., 1995 as cited in POPCOM, 2001b). These costs include not just the expenses for access and provision of services but also the non-money costs of the health, social, emotional, and psychological consequences for women. These two costs discourage women from availing of family planning methods (POPCOM, 2001).

The decline in unmet need for family planning is reflected in the contraceptive prevalence rate (CPR), which increased from 40.0 percent in 1993 to 46.5 percent in 1998 (NSO, 2001). The increase in CPR occurred in both urban and rural areas. However, the CPR increase was larger in urban than in rural areas. These figures indicate important progress toward contraceptive protection for couples who did not want to conceive. Program factors related to availability, accessibility, and affordability need to be improved as well as the acceptability of contraceptive practice through educational approaches and broad social changes in the values and meaning of children.

In examining the changes in the relative contribution of the proximate determinants of fertility, Cabigon (2002) and Casterline and others (1988) showed that contraception was the primary factor in explaining the fertility decline over time. Nuptiality played a minor role in curbing fertility while breastfeeding forestalled the fertility inhibiting role of contraception and nuptiality. The singulate mean age at marriage (SMAM) in the Philippines has remained at 24 years based on the 1993

TABLE 2-1. WANTED FERTILITY RATES: TOTAL WANTED FERTILITY AND TOTAL FERTILITY RATES FOR THE THREE YEARS PRECEDING THE SURVEY, PHILIPPINES 1998

Background Characteristics	Wanted Fertility Rates		Total Fertility Rate	
	1991	1996	1991	1996
Residence				
Urban	2.6	2.3	3.5	3.0
Rural	3.3	3.3	4.8	4.7
Education				
No Education	4.0	3.9	4.9	5.0
Elementary	3.7	3.3	5.5	5.0
High School	2.9	2.7	3.9	3.6
College or Higher	2.4	2.5	2.8	2.9
Total	2.9	2.7	4.1	3.7

Note from source: Rates are based on births to women 15-49 in the period 1-36 months preceding the survey.
Sources: 1998 National Demographic and Health Survey, (NSO, DOH and Macro International, 1999) as cited in POPCOM (2001b)

TABLE 2-2. UNMET NEED FOR FAMILY PLANNING SERVICES, PHILIPPINES 1998

Characteristics	Unmet Need for Family Planning (%)		
	For Spacing	For Limiting	Total
Age			
15-19	27.4	4.6	32.1
20-24	21.2	8.2	29.4
25-29	13.5	10.3	23.9
30-34	7.2	11.9	19.1
35-39	4.6	15.2	19.8
40-44	2.3	13.5	15.8
45-49	0.0	6.3	6.3
Residence			
Urban	7.3	9.0	16.3
Rural	9.8	13.4	23.3
Education			
No education	14.0	14.5	28.4
Elementary	8.1	15.8	23.9
High school	9.1	9.6	18.7
College or higher	8.1	7.5	15.6
Total	8.6	11.2	19.8

Sources: 1998 National Demographic and Health Survey (NSO, DOH and MI, 1999 as cited in POPCOM 2001b)

SAVING WOMEN'S LIVES

Case Study: The Road to Maternal Death

This is a real-life, cautionary tale about unwanted pregnancies that lead to maternal death. Nena, a housewife in her mid-20s and on her seventh pregnancy, was brought to the Regional Hospital from the District Hospital because she was bleeding profusely.

The second of 10 children born to a poor family of tenant farmers in Northern Luzon, she was asked to help take care of her younger siblings while her parents worked their landlord's farm. Nena quit elementary school after she finished fifth grade but she vowed that she would go back to school when her siblings got older. But when she turned 15, her parents married her off for economic reasons to a businessman 15 years older. She got married without knowing what marriage meant—sex, relationship, commitment, responsibility, etc.

Her husband Lito was in the wholesale-retail business that took him on frequent, prolonged travels to Manila and other major cities in Luzon. While Nena wanted to have three children, Lito wanted more so that she got pregnant almost yearly. On her own, Nena, a Roman Catholic, tried to

get a tubal ligation after delivering her third child, but the doctor told her that she must get her husband's permission, which Lito denied. Lito said as the head of the family, his wishes must be followed.

Nena followed him, despite her personal desire not to have any more children. Her time was mostly spent caring for her children. Her fourth pregnancy ended in a miscarriage from which she almost died because of heavy blood loss. She was doubly traumatized because Lito accused her of inducing the end of that pregnancy. While that was untrue, Nena felt guilty, thinking maybe she did or didn't do something, which led to the miscarriage. The doctor explained that she had done nothing to cause the miscarriage.

Nena had three more pregnancies after her miscarriage. During her sixth, she swelled and her blood pressure went up. She was brought to the hospital where she was confined for almost three weeks before she delivered her fifth child, alive. It was then that her husband's business started to fail, and they could hardly pay for the hospital bills. He went on drinking sprees, started to blame everybody for his failing business and eventually beat Nena and the children. He also forced her to have sex with him whenever he was drunk. Realizing that she could get pregnant again and her life would be endangered, Nena consulted the midwife at their community health center and requested for a tubal ligation.

The midwife referred her to the doctor at the District Hospital who told her instead to practice natural family planning, the only method approved by the Catholic Church. She approached the local priest and nuns for advice but was told that any artificial family planning method was unacceptable. They told her to bear her pains and stick with her husband through difficult times. Nine months ago, Nena felt the symptoms of pregnancy even before she missed her period. She knew that they could not afford another child, aside from the fact that her life was in danger if she went through another pregnancy. When her period did not come, she consulted the midwife at their health center who confirmed that she was pregnant. The midwife explained to her that this seventh pregnancy was high risk and gave her instructions on how she could safely carry on the pregnancy to term. Nena faithfully followed the instructions and regularly had prenatal check-ups. Meanwhile, Lito continued drinking and beating his wife.

On her 39th week age of gestation, Nena felt blood coming from her vagina. She went to the district hospital where the staff immediately referred her to the Regional Hospital. She had a condition known as Placenta Previa where the placenta was blocking the opening of the uterus. She passed out an unusually large amount of blood. The OB-Gynecology resident told Lito that they would have to do a cesarean section, and fresh whole blood was needed. He left to look for possible blood donors from his relatives in the city.

Nena grew weak from blood loss, was wheeled to the operating room where a CS was done on her. After delivering the infant and placental extraction, the doctor noted that the uterus, which was very thin, would not contract despite manual compression and drugs. They decided to do a hysterectomy but halfway, blood oozed out from bleeding points and the bleeding could not be controlled. Not long after, the anesthesiologist asked the surgeon if he wanted to send for the chaplain to give Nena the Sacrament of the Sick, to which the surgeon agreed. One OR staff said, "Another one. These women never learn to practice family planning, do they?"

Meanwhile, Lito led three relatives to the laboratory for blood typing and possible blood-letting. From the hospital paging system, he heard the information officer announce, "One transport aide with stretcher, to the OR now." It was too late. Nena had died.



NDS and the 1998 NDHS.

Experts and stakeholders attribute the slow decline in fertility in the Philippines to the following:

- Relatively weak institutional environment for the Philippine Population Program;
- Perceived influence of the Catholic Church on political leaders;
- High unmet need for family planning and reproductive health services;
- Public health infrastructure not fully developed to provide Reproductive Health (RH)-capable facilities and providers;
- Limited financial and organizational ability of nongovernmental organizations engaged in FP/RH service provision to scale-up their contributions to the FP program (they now account for only 3 percent of service provision);
- Lack of support or even active opposition of some local government leaders; and,
- Donor-driven nature of the FP program.

MAJOR ISSUES AND CHALLENGES

- TFR is still 1.5 births above replacement. The TFR declined much slower during the past decade than UN projections for the next fifteen years.
- Desired fertility remains above replacement in all major population groups.
- Unwanted fertility is still relatively high. There is still inadequate access to family planning goods and services for much of the population, especially among poor households. The traditional methods with relatively low use-effectiveness are also more prevalent among poor households.
- Local governments give less priority to population programs under devolution.
- There is a problem of contraceptive security, brought about by the anticipated phase-out of contraceptive support from the USAID starting 2003.
- The Philippine Family Planning Program still does not give sufficient emphasis to educational strategies that inculcate the value of responsible parenthood. The

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IEC component of the Program needs to go down from its predominant mass media approach to the interpersonal level. Couples, especially the women, need to be empowered so that they can decide when and how many children to have. Among those already convinced of the value of limiting family size, there is still inadequate access to family planning goods and services, especially among poor households.

FUTURE PROSPECTS AND DIRECTIONS

The Philippine Population Management Program Directional Plan (PPMP-DP) for 2001-2004 was prepared and finalized in 2000 under the Estrada Administration. On the assumption into office of President Gloria Macapagal-Arroyo, the National Economic and Development Authority reformulated the Medium Term Philippine Development Plan and Medium Term Public Investment Program for 2001-2004 to align it with the new government's anti-poverty agenda. In consonance, POPCOM updated the PPMP-DP and its companion document, the Population Investment Program (PIP).

In a meeting on 3 May 2002, the POPCOM Board of Commissioners directed the Commission to draw up a PPMP Strategic Operational Plan (SOP) and Population Investment Program (PIP) for 2002-2004. The PPMP SOP will focus on addressing the unmet need for family planning among poor couples, and the sexuality and fertility information needs of adolescents/youths, especially among the poor. The target of the national government is to reach the desired fertility level of 2.7 by 2004 and ultimately reach replacement level by 2015. The government is working strategically toward a multi-stakeholder collaboration approach that will include a partnership with the Catholic Church on Natural Family Planning (NFP) to:

- Improve service delivery for FP/RH, including the re-activation of Barangay Service Point Officers, strengthening the Community-Based Management Information System, mainstreaming of NFP Methods, and providing Home Service Delivery, among others;
- Strengthen advocacy in support of more resources for family planning and RH goods and services, including a Community Outreach Program, advocacy for male involvement in FP/RH services, and a media campaign for women empowerment, among others;
- Provide capacity building to equip service providers with necessary knowledge and skills in FP and RH; and,
- Work with the government's poverty alleviation strategy, "Kapit-Bisig Laban sa Kahirapan" or KALAH! (Arms Linked against Poverty), to strengthen family planning and reproductive health programs in poor communities.